

Weighing up Cairo

Evidence from women in the South

Compiled by
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DAWN: Development Alternatives with Women for a New Era

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Foreword

This collection of case studies and DAWN documents brings to a close DAWN's efforts in the ICPD + 5 process in 1998 and 1999. Aside from commissioning research on progress in implementing ICPD commitments in selected countries in the South on the basis of an analytical framework developed by Sonia Correa, Research Co-ordinator for Sexual and Reproductive Rights, DAWN published a platform document in January 1999 for the NGO Forum for ICPD +5, and fully engaged in the UN review process.

DAWN was the focal point for one of the five themes of the NGO Forum, held in The Hague in February 1999, namely 'Linkages between reproductive health, population, environment and development'. Being focal point for this theme enabled DAWN to help shape debate at the meeting and to bring a significant number of participants to the event. There was a strong DAWN presence and engagement in the Prepcoms leading up to the UNGASS for ICPD +5 and, through Gita Sen, the network had the opportunity of addressing the UNGASS plenary.

Several of the authors of the case studies included in this book were also active participants in the ICPD +5 review process, as well as in the five year review processes for the Fourth World Conference on Women (Beijing +5) and the Social Development Summit (WSSD +5). Their sustained lobbying efforts were critical to preserving the language and spirit of Cairo in all three review processes.

A critical appraisal of these mechanisms for reviewing the implementation of UN Conference commitments, written by Sonia Correa and Gita Sen for UNIFEM in October 1999 and posted on the UNIFEM and DAWN websites in February 2000, is included in the appendices, together with their contribution to Social Watch about the review process. DAWN wishes to record its deep appreciation to the individual researchers who produced the country case studies, and to ARROW for the contribution of the Southeast Asia case studies.

Special thanks are owed to the Ford Foundation for its generous support of DAWN's ICPD + 5 work, including support for both this publication and the publication of DAWN's platform document,

‘Implementing ICPD: Moving Forward in the Eye of the Storm.’ We also thank the MacArthur Foundation and Novib for supporting the research process and the publication of the Portuguese version of the platform, Implementando o Cairo: avanços no olho do furacão, Cadernos do Observatório, No 1, Março 2000.

DAWN is grateful to Margaret Chung for her excellent editing, Sen Chung for his design work and Zephyr Edit for preparing the manuscript for publication. Our thanks also go to Romenet Za’rate for the cover artwork.

Claire Slatter
General Co-ordinator, DAWN

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First Words

~x Sonia Corrêa ~x

Between 1992 and 1994, Development Alternatives with Women for a New Era - DAWN - invested soundly in developing a Southern-based understanding of the linkages between population, development, and reproductive health and rights. The network mobilized debates and analyses in Latin America, the Caribbean Region, Africa and the Pacific in preparation for the International Conference on Population and Development (ICPD) in Cairo in 1994. DAWN was fully involved in advocacy efforts during the Cairo negotiations. We could not, then, ignore the opportunity presented by the five-year (Cairo+ 5) Review of the ICPD Programme of Action to assess and analyse the progress of implementation.

DAWN's strategy for the Cairo+5 Review was developed by conducting research into the progress and bottlenecks that had been experienced across the South during the implementation of the ICPD recommendations on reproductive health and rights. In Latin America, the research covered Bolivia, Brazil, Nicaragua, Peru, Puerto Rico, and Uruguay. A preliminary regional study was conducted in the Caribbean. Through collaboration with the Asia-Pacific Resource and Research Centre for Women (ARROW) in Malaysia, a regional study was carried out of South East Asia, covering Cambodia, Indonesia, Laos, Malaysia, the Philippines, Thailand, and Vietnam. A single country study of the Philippines was also commissioned. In South Asia, an in-depth review of the post-Cairo policy shift in India, and in the Pacific, a country study of Fiji, were organised. In Africa, an initial assessment of the situation in

West Africa was undertaken at a meeting held in Doula where six West Africa countries were represented: Cameroon, Gabon, Ghana, Ivory Coast, Nigeria, and Sao Tome and Prince.

The first round of these analyses was synthesised in a booklet "*ICPD+5: Moving Forward in the Eye of the Storm*," which was widely distributed at the various events that led up to the United Nations General Assembly Special Session of June, 1999. Between 1999 and 2000, information was collected to update the initial studies. This volume includes updated reports for twelve countries: Bolivia, Brazil, Cameroon, Fiji, Ghana, India, Nicaragua, Nigeria, Peru, Philippines, Puerto Rico, and Uruguay, and a regional assessment for South-east Asia. Unfortunately, it has not been possible to expand the regional assessment for the Caribbean.

This group of countries is quite heterogeneous. In some cases—especially Brazil, India, Peru, and the Philippines—the studies confirm the importance of the pre- and post-Cairo policy environments. The inclusion of countries not usually mentioned as being successful in implementing the ICPD Programme enriches the analysis, for they allow a comparison of these more successful countries with those where the ICPD Programme has found serious ideological or economic obstacles—particularly Nicaragua and the African countries.

Despite their diversity, the studies included here demonstrate that since 1994, some real progress has been made in improving reproductive health policies and services. As '*ICPD+5: Moving in the Eye of Storm*' concluded, a semantic revolution has clearly been underway. Everywhere family planning programs are being renamed as reproductive health programs. In most of the countries, serious efforts have been made to improve the integration of services. In all of the regions studied, various gender equality and equity initiatives are being implemented, and this reflects the synergy that has developed between the Cairo and the Beijing agendas.

Other than this positive development, DAWN's research also identifies limits, bottlenecks and challenges to the implementation of the ICPD. For the most part, wherever there is effective cooperation between the various governments, other agencies and non-government organisations (NGOs) that are involved in reproductive health and rights, and where

accountability mechanisms have been established, reproductive health policies are moving more quickly in the right direction. We found that effective dialogue between at least two of these three groups of stakeholders has been needed in order to push the ICPD agenda forward. Yet not everywhere are these bodies well established. In Asia and the Pacific, NGOs increasingly are called upon to implement some part of government policies, but not allowed enough opportunities for independent advocacy and monitoring. In India and Africa, dialogue between governments and NGOs is erratic, unstable, and subject to political dynamics. Accountability and monitoring, furthermore, cannot depend solely on the commitment and voluntary efforts of civil society organisations. If monitoring is to be effective, it needs adequate financial support and investment in institutional and capacity building.

In most countries the research has revealed that quite meagre progress has been made in respect of sexual health, abortion, adolescent health, and especially sexual and reproductive rights. Governments have moved more on the “*well behaving components of the ICPD agenda*”, and tended to leave aside those issues that require deeper institutional and cultural transformation. Action on abortion clearly illustrates this. Very few countries have reformed the relevant laws, including Ghana, which did so before the ICPD. In Brazil, under new Ministry of Health policies, abortion has become more available in cases of rape or where a woman’s life is at risk. In Peru, Bolivia and Uruguay, illegal abortion has been recognised as a major public health problem. In India and Vietnam, the safety of legal abortions has become a priority concern. Nevertheless, initiatives relating to abortion generally lag far behind the actions proposed in Paragraph 8.25 of the ICPD Programme of Action, or Paragraph 106.K of the Beijing Platform of Action. A combination of factors have contributed to this: cultural and religious opposition to the ICPD agenda; lack of conceptual clarity on abortion issues; institutional inertia; problems of policy design; and economic circumstances.

Cultural and religious resistance is clearly an important obstacle to the full implementation of the ICPD Programme of Action. In some places, particularly South-east Asia, the opposition is mild. In other countries, advocates for the ICPD are continually confronted by regressive forces. Sexist cultures and traditions and detrimental practices persist everywhere. Religious groups, especially the Catholic Church, actively

influence the reproductive rights agenda in West Africa, Latin America and the Philippines. In South America, pro-life civil society organisations are being strengthened and even minor advancements on abortion are provoking acrimonious debates. In Nicaragua, the actions of these pro-life groups are becoming increasingly hostile and women's NGOs are openly being threatened.

Another difficulty is that some key ICPD concepts still lack clarity. The concept of sexual health, for example, is usually simply translated as the prevention of sexually transmitted diseases (STDs) or HIV. Reproductive rights usually are simply interpreted as involving the right of access to reproductive health services. Other critical dimensions such as informed choice and reproductive self-determination are ignored. There is also confusion about adolescent needs. This conceptual confusion makes ICPD-related policies and programs vulnerable to attack from adversaries, and adds to the difficulty of overcoming institutional inertia.

Everywhere, institutional inertia is a major hindrance to progress on the ICPD Programme of Action. The health sector particularly is set in its ways and resists change. This is most evident in India, where implementation of the ICPD Programme requires the colossal task of turning upside down—conceptually and practically—a gigantic system that has been somewhat torpid for more than thirty years. Institutional inertia has also been a bottleneck in Brazil. There a comprehensive reproductive health program was formulated in 1985, yet ten years later, in 1995, health managers and service providers were still firmly attached to the Maternal Child Health approach. Despite the post-ICPD semantic revolution, the biggest difficulty in transforming the institutional mindset is that the Cairo agenda is often understood as merely the need to expand family planning.

Another major challenge is developing the enabling policy environment that will ensure quality of care and women's self-determination as to their sexual and reproductive health. This challenge arises at the levels of both health policy design and macroeconomics. The studies of Bolivia, Brazil, Nicaragua, Peru, Philippines, Puerto Rico, Uruguay and West Africa identify a critical aspect in implementing the ICPD Programme to be health reform, as it currently is being framed and implemented through structural adjustment policies. The privatisation schemes that are now being promoted have instead

become major obstacles to improving the quality of health services. Almost everywhere, national policies of decentralisation pose new needs for advocacy and policy monitoring. Particularly in West Africa, new requirements for cost recovery and cost-sharing in the public health systems keep poorer people away from hospitals and health centers.

There are exceptions. The Brazilian Health Reform, which is quite unlike the usual model of structural adjustment programs, has helped improve sexual and reproductive health services. In Bolivia, despite the adoption of a quite conventional health reform program, reproductive health priorities are now included in the Basic Insurance Health Package. Even so, most case studies demonstrate that reproductive health agencies, managers and advocates are not adequately interacting with the designers and implementors of health reforms, either at the global or national level.

Financing is an important element in health reform. Since 1994, the governments that are recipients of population-related aid have come closer to meeting the financial commitments made in Cairo than have the donor countries. Even so, the country studies show that in most countries, reproductive health programs still depend heavily on international assistance. In West Africa, the countries that have adopted SAPs have seen their health budgets shrink since 1994, but this has not been compensated for by increased donor assistance. Consistent data on domestic finances were only available for this study in India and Brazil. In Brazil, federal spending on reproductive health in 1997 was roughly US\$1 billion, or US\$10 per capita. In India, this investment amounts to less than US\$1 per capita. Both studies, however, demonstrate that the quality of health expenditure is as critical as the quantity of resources invested. In other words, the potential impact of 'more money' invested in sexual and reproductive health is mitigated by policy, management and accountability factors.

An even more critical influence is that the overall economic and social situation has not improved since 1994. All of the studies refer to high levels of poverty within each country as bedeviling the effective implementation of the ICPD Programme of Action. Social and economic conditions are particularly bad in Bolivia, India, Nicaragua, Peru, and West Africa. Besides openly contradicting the equity premises of the ICPD Programme, the persistence of extreme poverty and inequality is

detrimental to women's health and tends to increase gender imbalances more generally. Poverty also creates a fertile ground for regressive religious and cultural ideologies to proliferate. Poor people—especially poor men—are easily prone to fundamentalist messages.

Since 1997, all of these countries have experienced a global financial earthquake. The spectacular growth of South-east Asia was succeeded by an equally spectacular collapse that threatened the entire global economy. The effects of the Asian crisis reached West Africa, then Russia in 1998, and soon after Brazil, where it diluted the previous successes of the 1994 stabilisation plan and reduced the level of social investment. Global financial instability during 1999-2000 also contaminated the United Nation debates by aggravating North-South economic tensions. This included negotiations regarding the five year reviews of the action plans agreed to at both the 1994 Cairo Conference and at the 1995 World Conference for Women in Beijing. As DAWN has constantly emphasised since the United Nations Conference on the Environment and Development (UNCED) in 1993, this poor climate favours the fundamentalist forces that oppose the agenda for women's rights, even as they present themselves as champions for the South.


Both the Cairo+5 and Beijing+5 negotiations were painfully slow and often stalemated because of the wide differences between the South and North on economic issues, and failure to reach consensus on gender issues within the Group of 77 (G77). On both occasions, the G77 insisted that they speak with one voice on all issues, unlike their stance at Cairo or Beijing. At the same time, the Vatican evidently was working closely with the most conservative delegations to attempt to roll back the Cairo, Beijing and Vienna agreements. At the Beijing+5 negotiations, it was early evident that conservative forces were doing their best to prevent a final document from being adopted.

Despite the acrimonious debates and the insidious strategies of the conservatives, good final agreements were adopted. These agreements did not retreat from the consensual language agreed upon in 1994 and 1995. In some aspects, they even go beyond what had been achieved at Cairo and Beijing. For example, the Cairo+5 recommendations include that health professionals must be trained and services equipped to provide safe abortion wherever it is legal. The final Beijing+5 document

reiterated the fundamental support for women's sexual rights, and expanded the definitions reached in Beijing on HIV/AIDS and violence against women.

Several government delegations of the countries involved in the DAWN research were important players in these negotiations. From Latin America, Bolivia, Brazil, Peru and Uruguay gave important support in the difficult final moments of the Cairo+5 negotiations. They also supported the establishment of SLAC (Some Latin American Countries) as a regional block that by taking a distinct position from that of the G77, helped the progress of the Beijing+5 negotiations. Among Latin American countries, quite different positions were taken by Nicaragua, which systematically aligned itself with the Vatican, and Puerto Rico, which has no voice in the United Nations. The majority Latin American position was followed quite consistently by most of the other countries included here, but especially by India, Fiji, Ghana and Cameroon—and at the Beijing+5 negotiations, by the Caribbean countries.

This was not an accidental development, but one that emerged out of strenuous efforts to ensure some consistency between national policies and the international stances taken by governments. The studies included in this volume provide insights on conditions and factors at play in national settings that may favour positive outcomes in global debates on sexual and reproductive health and rights.

DAWN's Cairo+5 research provided a privileged opportunity to establish and renew partnerships and develop synergy with other networks, organizations and individuals that are advocating for reproductive health and rights. We are very grateful to every person and organization that collaborated with us in this effort. 

Cameroon

**Elvire Beleoken, Esther
Endale and Dina Nfon Priso**

1. The national context

The Republic of Cameroon stretches from the Gulf of Guinea to Lake Chad, and across quite diverse regions: an equatorial coastal zone, a belt of tropical forest, a volcanic district of high plateaus, and an area of savanna and steppes. The ten provinces of the country cover an area of approximately 475,200 km. Cameroon is a bilingual country, where both French and English are official languages. The head of Government is a popularly elected President who rules through a National Assembly of 180 deputies, of whom 12 are women. Women occupy very few of the decision-making positions in the political parties.

Cameroon's population of approximately 13.9 million is growing quite rapidly, at around 2.8 per cent a year. While the total fertility rate declined from 6.4 in the 1970s to 5.3 in 1990s, it is still high. There is potential for the population to continue growing quickly, for children under the age of 15 years constitute 46 per cent of the population, and women in the fertile age group constitute another 23 per cent. The high maternal death rate, of 550 per 100,000 live births indicates that women are considerably disadvantaged in their health status. Infant mortality is also relatively high, at 77 per 1,000 live births, and has risen from 65 per 1,000 in 1991. A preference for large families and preferential treatment for sons are common among Cameroon people of all religious and ethnic groups.

Primary school participation rates vary considerably from one part of the country to another but average 74 per cent for boys and 71 per cent for girls. Educational disadvantage is more evident in older people, for 35 per cent of women and 21 per cent of men have had no formal schooling. The low educational status of women is reflected in their work status. Nearly one third of the women do not work outside the household, and of those who do, 60 per cent work in agriculture.

Table 1 Development indicators for Cameroon

	1970s	1990s
Population size	7.5 million	13.9 million
Population growth rate (1975-1997)	-	2.8% ann. av.
Total fertility rate	6.4	5.3
Life expectancy at birth	44.3 yrs	54.7 yrs
Maternal mortality rate	-	550
Infant mortality rate	127	64
Under 5 mortality rate	215	99
Contraceptive prevalence	-	16%
	Female	Male
Life expectancy at birth	56 -s	53.4 yrs
Gross primary enrolment (6-15 yrs)	71%	74%
Adult literacy	65%	79%

Source: UNDP Human Development Report, 1999

The Cameroon economy is primarily based on agriculture. After a long period of regression, it has regained positive growth, and experienced 5 per cent per annum growth in 1997-98, and a GDP of 5,433 billion francs CFA. Since 1990, several programs of structural adjustment have been implemented. These many economic recovery plans, as well as a 50 per cent devaluation of the CFA franc in 1994, increased living costs and the impoverishment of vulnerable groups in the population, particularly women. Reduced public investment is especially evident in social

sectors such as health and education where the status of women already lags significantly behind men.

The national health care system

The proportion of the national budget spent on health has declined from 5.1 per cent in 1984-85, to 3.1 per cent in 1998-99. Table 2 shows the three levels of the health system in Cameroon. To be effective, this hierarchy presupposes that at each level, there exists the appropriate infrastructure and adequate technical equipment and trained personnel. At the Intermediate and Peripheral levels, especially, this is rarely the case. Ministry of Health records for 1998 show that, on average throughout the country, there is one doctor per 14,730 people, one pharmacist per 28,673 people, one dentist per 248,135 people, one nurse per 2,083 people, and one nursing auxiliary per 3,100 people. These ratios are considerably below those recommended by the World Health Organization (WHO).

The main sources of financing for the health sector are the national budget, community payments, and external aid assistance. The State pays for infrastructure and equipment; salaries and wages for medical, auxiliary, and administrative staff, operating expenses; and care for certain categories of patients. State expenditure on health has rarely exceeded 5 per cent of the national budget, less than half of the 10 per cent recommended by the WHO. It is now dwindling further - accounting for 5.8 per cent of the budget in 1993 but only 2.5 per cent in 1999.

Community payments principally come from the sale of medical drugs. Law 90/062 of December 1990 authorises public medical authorities to recover the costs of the drugs used under their generic names. This revenue is distributed to a decentralised management that is required to ensure that medical facilities receive adequate drug supplies and equipment. Law 92/001, which was passed in August 1992, at first allowed some medical centres to retain 50 per cent of this income to cover their operations, but this has since been raised to 100 per cent, and now applies to all public medical facilities.

Principal sources of external assistance for the health sector in Cameroon are the traditional multilateral donors, namely United Nations agencies - WHO, the United Nations Population Fund (UNFPA) and the

Table 2 The Health System of Cameroon

Level	Administrative structures	Roles	Operational structures of care
Exchange	Cabinet, the Secretary-General, General management and similar structures	Design and development of policies and the strategies	General hospitals, Central hospitals, Hospital complex Academic Center Pasteur
Intermediary	Provincial-level public health services	Technical support to the districts	Provincial hospitals
Peripheral	District-level health services	Implementation of the programs in relation to the beneficiary communities	Hospital or district integrated health centers

Source: Ministry of Health, 1995

United Nations Children's Fund (UNICEF) - as well as the European Union (EU) and the World Bank. Considerable assistance also comes from non-profit organisations, such as international non-governmental organisations (NGOs) and church groups.

Policies in place before the 1994 ICPD

In 1992, Cameroon adopted a National Population Policy that principally aimed to improve the level and quality of life within the limit of available resources, in accordance with human dignity and basic rights, and to facilitate access to voluntary family planning services. Its other objectives were to:

- ~ Improve and strengthen health infrastructure, especially for primary health care;
- ~ Promote responsible parenthood;
- ~ Address the problems of male and female sterility;
- ~ Promote and facilitate access to family planning services; and
- ~ Address the problems of adolescent pregnancies, and unwanted pregnancies in general.

A national primary health care policy was adopted in 1993. It aimed to improve people's access to and use of basic services, and to increase the availability of good quality but low-price drugs. Contraceptives were included in the national system to supply essential drugs for maternal and infant health.

Policy and service standards also adopted in 1993 for Maternal and Infant Health and Family Planning covered:

- ~ Maternal and infant health, including care in the pre-conception, prenatal, intra- and post-partum periods, as well as health services for infants, young children and adolescents; and
- ~ Family planning activities, including those relating to information, education and communication (IEC), contraception, the prevention of infertility or sterility, and education for parenthood.

Family Planning was, therefore, integrated into the health system principally in the context of maternal and infant health and to encourage birth spacing for a WHO-funded national program, 'Maternity Without Risk.'

2. The Cairo Conference

Most of the preparations for the Cairo Conference were done by demographers in the planning divisions of the Government, with no collaboration between the latter and civil society. Members of national or international NGOs that participated in the preparatory meetings for Cairo did so within the scope of their own networks. Three government ministries were particularly involved: the Ministry of Women's Affairs, the Ministry of Health, and the Ministry of Public Investment and Regional Planning.

Through these ministries, and with some NGOs, several political and legal mechanisms were established after the Cairo and Beijing Conferences:

- ~ A National Environment Management Plan, in 1996;
- ~ An Action Plan for the Integration of Women in Development, adopted in 1997;
- ~ The National Plan for Medical Development (NPMD) for 1999- 2008 which in part aims to control the spread of HIV/ AIDS through a district-level health campaign; and
- ~ The development of a Population Program Strategy for 1998-2002, adopted in 1997 with assistance from UNFPA.

NGOs participated in the formulation of these strategies. Despite the adoption of these policies on reproductive health and population, the Cairo Programme of Action has not been effectively implemented in Cameroon. This is mainly because the adoption of the various plans was not followed by a corresponding allocation of resources or plans for their implementation. Additionally, prevailing pro-natalist attitudes were reflected in vague policy statements about imbalances between the available resources and too many children, and advocacy for "responsible parenthood."

While the new policies included education about family and community life, sex, and birth control, and provision of family planning

services, it is difficult to be precise about the impact they have had so far. Overall, however, the concept of reproductive health is neither well understood nor defined in national policies. Despite the efforts of some NGOs, the concept of reproductive health remains understood only by a few intellectuals. As a result, the health services continue to “make family planning” while speaking about reproductive health.

Cameroon’s reproductive health program focuses on maternal and child health, family planning and the prevention of sexually transmitted diseases (STDs), especially HIV/AIDS. Through the Maternal and Infant Health and Family Planning Program, these issues have been integrated into the primary health care system. This integration which occurs at all levels of the health system aims to provide high quality services for these priority concerns, including the control of STDs and AIDS. All health centres and hospitals have therefore been instructed to treat family planning and maternal and infant health as integral to primary health care. Health services at all levels must also provide family planning services. Working with various international organisations and donors, the Ministry of Public Health is restoring and rehabilitating the health infrastructure, training staff, and supplying equipment and contraceptives.

The status of reproductive health services

A national study conducted in 1998 of the functional capacity and the quality of reproductive health services reached the following conclusions:

Infrastructure and equipment: While reception facilities for clients are not of particularly good quality, consultations are performed in conditions of relatively good discretion and hygiene. The main problem is the lack of adequate equipment.

Personnel: Health workers offer more services and care in connection with maternal and infant health than with family planning - which reflects the emphasis in their training. Follow-up care for patients also more often was related to post-pregnancy care and other maternal and infant health issues than to family planning. Overall, there are too few health providers in this area. In 1996, in the whole public health service, there were only 69 midwives, compared to 4,998 male nurses.

IEC material and activities: There are insufficient IEC personnel and activities in this area are generally ineffective. Most of the available materials promote family planning. They seldom cover topics of STDs and AIDS, good nutrition, child growth, or post-natal care. While IEC campaigns operate through district health centers, much of this work is done by NGOs.

Logistic and contraceptive products: A social marketing program distributes low-cost contraceptive pills and condoms, but often they are not stored well or distributors run out of stock. The availability of contraceptives is, therefore, neither permanent nor sufficient, particularly so for long-acting methods.

Overall, the services available are mostly for pre- and post-natal care and delivery, and focus more on the health of the child than on providing reproductive health choices or for other needs for women. There is little attention given to other related diseases, such as cancers of the reproductive organs, and the issue of abortion is rarely addressed. Little policy attention is given to the health of old women or adolescents.

Reproductive health services mostly involve men through projects that aim to modify their procreative behavior. These projects include:

- ~ In rural Cameroon, where family planning services are poorly developed and conservative attitudes prevail, the Ministry of Health has been operating a project in the north-west district of Nkambe. Sixty-nine traditional chiefs and male opinion leaders highly respected in their communities were selected and trained to promote family planning and distribute condoms and spermicides. They also provide information about immunisation, oral rehydration, breastfeeding and other aspects of maternal and child health. Initial results have shown some improvement in maternal and child health and greater acceptance of contraceptive services.
- ~ Since 1995, and together with UNFPA, the Ministry for Employment, Work and Social Welfare has operated a project to educate workers about family life.

Overall, however, access to reproductive health services is quite restricted. Most health centers do not provide all types of service. The requirement to pay for these services limits people's use of them, especially poorer women. This has particularly become a problem since the National Department of Social Welfare, which provided social protection services and health insurance for paid workers, has become bankrupt. There is no other health insurance scheme. Furthermore, because the necessary level of investment has not been kept up, the standard of health facilities is gradually declining.

Donor assistance to reproductive health

UNFPA has been an important partner in this work. Its assistance to the health sector concentrates on improving family planning services "through the structures of mother and infant welfare." Since 1984, *UNFPA* has developed several projects, including:

- ~ Incorporating family planning into the curricula of medical training institutions. This project has improved the training of health professionals;
- ~ Improving family planning services through the structures of mother and infant welfare, which aimed to assist the Government develop national policies on family health, and ensuring that all Cameroonians had access to the means to have the number of children that they wished. This project enabled the rehabilitation and equipment of family planning centers in Yaounde and Douala; and
- ~ Expanding and reinforcing the National Program of Maternal and Infant Health and Family Planning. This project aimed to help lower maternal and infant mortality, make maternal and infant health and family planning services more available to women and children, and help implement national policies on primary health care. This is continued in five provinces, providing for human resource development, restoration or rehabilitation of health services and of equipment and logistics at all the levels of the health service, and the supply of contraceptives.

The World Bank is another important donor to the health sector. It finances the project on “Health, Fertility and Nutrition,” which is working in 19 health districts. It aims to construct or rehabilitate health infrastructure, train health workers, help implement health policy, and provide essential drugs, equipment and logistics.

The German Co-operation Agency (GTZ) began a program in 1994 in three provinces to encourage the use of maternal and infant health services, including those to prevent STD and AIDS. In 1995, GTZ began another program for adolescent health, and now also provides for the provisioning of drugs to health districts and other special funds for health interventions.

The EU has provided assistance with an information management system to help implement the National Health Plan, and the supply of contraceptives.

The United States Development Agency (USAID) assists the health sector in Cameroon through the Family Health and AIDS Prevention project that aims to improve access to and the quality of family planning services, prevent STDs and AIDS, improve the survival of children, and develop the capacity of local institutions. Its specific objectives are: to increase contraceptive prevalence; over five years to increase the use of oral rehydration salts therapy by 20 per cent and the use of condoms by 25 percent; to reinforce the capacity of at least one institution in planning, conducting and evaluating operational research and IEC and providing training services; to increase public knowledge about family planning and prevention of HIV/AIDS; and to support exchanges and collaboration about reproductive health.

3. The status of reproductive health in Cameroon

Contraceptive use

A demographic and health survey conducted in 1991, as part of the World Fertility Study, found that few women in the fertile age-group used modern contraceptives although considerably more knew about them. Two thirds (66.4 per cent) of the women surveyed knew of at

least one modern contraceptive method. Of these women, 60.3 per cent approved of family planning, 51.4 per cent knew where to obtain contraceptives, and 23.2 per cent said they wanted to use a modern contraceptive method. From this, it was estimated that 22 per cent of the women who did not use modern contraceptives had unmet needs for contraception. The total demand for contraceptives therefore amounted to 38 per cent of women of childbearing age.

Female sterilisation was the method most commonly known by the women surveyed (53.3 per cent), followed by the pill (49 per cent). Less than half the women knew about condoms (44.1 per cent) or injections (40.8 per cent). Even fewer knew about DIU (30.1 per cent), spermicides (17.1 per cent) or male sterilization (8.1 per cent). With regard to the traditional methods, slightly more women knew about the rhythm method (44.6 per cent) or abstinence (41.1 per cent) than they did about withdrawal (37.1 per cent).

In Cameroon, sterilisation is rarely practised as a means of contraception. Few couples go themselves to health centres to request it. Doctors can perform the procedures only under strict conditions, or face a prison sentence. Sterilisation is only an option for women aged at least 35 years who have at least five children, and requires the consent of their partner and time for reflection about the decision.

The low level of contraceptive use reflects various factors. There are too few medical facilities that provide family planning services, and most of them are in the urban centres. Few long-duration methods are available, such as sub-dermal implants or sterilisation. Too little investment has been made in IEC activities to increasing awareness about the family planning services that are available at medical facilities. Although this level of information is increasing, and most women are becoming better informed about contraceptive methods, traditional attitudes and values in Cameroon still commonly support a pro-natalist mentality.

Reproductive health problems

HIV/AIDS and STDs: In 1985, a multi-sectoral National Committee for the Prevention of AIDS was set up. More recently, in July 1998, a National AIDS Prevention Service was established to carry out the directives of the NCPA.

Studies on the transmission of the virus, together with screening of pregnant women and blood banks, have shown that the primary means of HIV transmission in Cameroon is through heterosexual contact, most often affecting young adults, particularly females, in both urban and rural environments. At the beginning of the epidemic, in the 1980s, the few HIV-positive individuals were often prostitutes of Yaounde. In June 1988, a survey of 300 prostitutes confirmed that 7 per cent were HIV-positive, a figure that is now expected to be around 9 to 10 per cent. The number of HIV-positive adults has grown quickly. In 1997, UNAIDS estimated that there were 310,000 people, or almost 5 per cent of the population, living with HIV or AIDS in Cameroon. By 1999, this figure was expected to have risen to 7.7 per cent. Since the beginning of the epidemic, 540,000 cases of AIDS have been reported.¹

Women account for three out of every five people infected, and most of these are young women aged 15 to 25 years. As the number of HIV-positive women increases, so too does the prevalence of the virus among children. In the next decade, HIV and AIDS are expected to escalate in Cameroon, with an estimated 140,000 new cases occurring before the year 2005.

Despite public awareness campaigns informing people about the epidemic, some people still refuse to believe that AIDS exists. There has been no national evaluation of the effectiveness of these campaigns, or studies about how the community perceives the danger of the epidemic, or studies that could help understand the barriers that are preventing the necessary changes in people's behavior.

Another factor contributing to the increased prevalence of HIV and STDs is the socio-cultural situation in Cameroon, in particular the lack of power of the women and the absence of real political will to confront the epidemic. Because STDs are generally considered to be diseases of "promiscuous women," there has been insufficient assumption of responsibility by the national health services to combat these diseases, not just because of insufficient finance but also inadequate infrastructure or service procedures. Some patients receive prescriptions and counseling, but this is not systematised. Some traditional practices as the "vaginal showers," moreover, further complicate STDs in women. The high incidence of female infertility testifies to the prevalence of STDs.

Parasitic and infectious diseases: These diseases are prevalent in Cameroon. Malaria alone causes 43 per cent of the deaths of children under the age of five. Only 40 per cent of the population are protected by vaccine.

Abortion: Abortion is often practised in Cameroon, but this is usually done illegally and in an unsafe way. Married women often resort to abortion when their husbands prohibit their use of contraceptives. In 1991, around 40 per cent of the gyno-obstetric emergencies seen in the hospitals were related to abortions performed. There is also a rising incidence of abortion among adolescents. Because there is no policy to address the reproductive health needs of adolescents, many are exposed to unwanted pregnancies through ignorance. Furthermore, laws relating to contraception use, as well as habits and taboos relating to sexual behaviour, do not prepare young people well for their sexual life.

Traditional practices: Female genital mutilation is practised mainly in the Far North and south west of Cameroon. Some NGOs are working with Government and international agencies on public awareness campaigns against these harmful traditional practices. The lack of laws to punish practitioners, however, limits the effectiveness of awareness campaigns. Another widespread practice that is dangerous to health, yet quite ineffective, is the use of the traditional contraceptive methods, such as wearing amulets around the waist or the neck. The practice of “vaginal showers,” using grasses or other concoctions, including disinfectants, with the aim of improving hygiene, instead can have very serious consequences, especially when a woman has an STD. It can cause some poisoning or burns.

Sexual and physical violence against women and girls: Acts of violence and physical aggression occur frequently in Cameroon, and account for many visits to health services. Violence against women is excused on such grounds as a man’s right of correction of his wife, and, furthermore by the partiality of judges who mostly are men and hold similar attitudes. Sexual violence within marriage is common, especially if the woman refuses sexual intercourse, and often is fuelled by alcohol abuse. Incest also frequently occurs, but it is rarely reported to the authorities because the parents of child victims usually prefer to protect family confidentiality. Some NGOs have begun to address these problems but have yet to achieve any real impact.

When I began working in family planning in 1990, I saw six to eight women a month. Today, ten years later, somewhere between twenty and forty new women each month come seeking family planning, and between 100 and 150 clients are regularly followed up. The most popular methods with the women are injections, pills, Norplant, and IUDs. Sterilization is seldom asked for.

The number of STDs is decreasing because the women are quickly treated. These infections are often detected during antenatal consultations. When I find one, I ask for the partner to come and then treat the couple. Unfortunately the number of pregnant women who are found to be HIV-positive is increasing, but few of them take the test, both because there is no prior counseling and because they cannot afford the cost (approximately \$12).

I have noticed that requests for abortion have increased. Each week, between two and seven women require a termination, usually unmarried mothers, students and adolescents. Around ten per cent of the admissions in the hospital are due to complications from illegal abortion.

There are many cases of sexual abuse, especially against small girls. We even admitted a seven-month old infant who had been violated by a 15 year-old boy. Cases of incest and physical violence between couples are very frequent.

I can say that the female genital mutilation is practised mainly in the north of Cameroon, but there are other traditional practices that are harmful for girls. In the east of Cameroon, in order to avoid men glancing at her, each month a hot stone is applied to a girl's developing breast, a very traumatizing practice which inhibits the growth of the girl's breasts. We did not have any information on the Programme of Action and its principles. So most of us continue to do family planning while speaking about reproductive health.

Miss Kalla Lobe Rose, Midwife for 27 years at Bonassama Hospital, Douala

4. Creating an enabling environment for reproductive health

The concept of reproductive rights is not widely understood, outside of a small group of health and women activists. It is generally regarded as much less of a priority than reproductive health. Reproductive and sexual rights are far from being on the agenda of the Government programs, or even of most NGOs working in the area of reproductive health. Very few women are educated about their rights, make use of those laws, or have access to judiciary services.

The legal environment

The legal environment for reproductive health services in Cameroon is circumscribed by the following:

- ~ A law adopted in December 1990 on the right of association assisted the emergence of many associations;
- ~ A law adopted in December 1990 set up a dynamic private press.
- ~ A National Committee of Humans Rights has existed for several years.
- ~ The 1996 Constitution, in its preamble, recognises the Universal Declaration of Human Rights, as well as other international conventions relating to human rights that have been ratified by Cameroon. There are nevertheless some contradictions between statute law and common law, for some men continue to prohibit their wives from having access to modern contraception in spite of the legal provisions regarding their rights.
- ~ The Penal Code punishes rape with imprisonment from five to ten years, if physical or oral violence is used to constrain a woman to have sexual intercourse. On the question of marital rape, jurisprudence observes a careful attitude.
- ~ The Penal Code punishes incest with imprisonment from one to three years and a fine of between 20,000 FCFA

(US\$32) to 500,000 FCFA (US\$796). The perpetrator of incest can be sued and thus sanctioned only if one of the parents by blood, without limitation of degree, lodges a complaint.

- ~ The corruption of a youth is punished by imprisonment from one to five years and a fine of 20,000 FCFA (US\$32) to 1,000,000 FCFA (US\$1,292). The penalties are doubled if the victim is less than 16 years old. The guilty person can also be deprived for the same duration of parental rights of supervision or trusteeship.
- ~ Indecent behavior on a 16 year old minor is punished by imprisonment from two to five years and a fine of between 20,000 to 200,000 FCFA (US\$318). Penalties are doubled if violence was used, if the perpetrator is a person with authority over the victim, a civil servant, or a minister of religion, or if they were helped by other people.
- ~ A 1997 Bill relating to sterilisation limits this to women aged 35 years and above who have at least five children, and the consent of their partner.
- ~ Law No 80/010 of 1980 exclusively authorises pharmacists to sell contraceptives, and only on medical prescription. It also prohibits any promotion of abortion through the sale or distribution of material about or related to abortion.
- ~ The Penal Code however authorises abortion in limited circumstances. Abortion is regarded as a infanticide and the Penal Code punishes the woman who aborts as well as the person who helps her to do so. The Penal Code nevertheless allows abortion when it is necessary to save the life of a woman whose health or life is endangered by pregnancy, or if her pregnancy is the consequence of a rape.
- ~ A woman who is charged with having an illegal abortion, or agrees to have one, is liable to a prison sentence ranging from fifteen days to one year and/or a fine ranging from 5,000 FCFA (US\$7.96) to 200,000 FCFA (US\$318.38). The person who performs the abortion, even with her assent, is liable to a prison sentence of between one and five years and a fine of between 100,000 FCFA (US\$159.19) and 200,000 FCFA (US\$318.19). These

penalties are doubled if a person is known to perform illegal abortions in a regular way, or if any medical professional performs an illegal abortion. In the latter case, the professional will be permanently barred from professional office and practice.

- ~ Law No. 90/035 of 1990, regulating the profession of pharmacist, prohibits the promotion and sale of abortive drugs.
- ~ Although a national policy has been declared in regard to curbing the spread of HIV, no laws specifically refer to HIV or AIDS in Cameroon. The combination of some provisions of the Penal Code (dangerous activities) and the Civil Code, however, make it possible to repress certain acts considered to be punishable, such as the voluntary transmission of HIV.

The presence and role of opponents of the Cairo Programme of Action

Opponents to the ICPD Plan of Action intervene in the agenda of reproductive rights in discrete but often in very effective ways. These opponents mainly are:

- ~ Religious organisations, namely the Catholic Church which insists that only “natural” contraceptive methods are promoted, Muslim priests (*imams*) and fundamentalists, and officials of some new Pentecostal churches; and
- ~ Some officials of the Ministry of Education who are not supportive about the introduction of sex education into the school syllabus.

The presence and role of community advocates for reproductive rights

Cameroon has ratified all major international conventions before and after the Cairo and Beijing Conferences, and all the international conventions. The Government is therefore obligated to work through the

ministries of Health, Women's Affairs and Regional Planning to implement the ICPD Programme of Action.

There are several national NGOs that are actively working in the field of reproductive health and reproductive and sexual rights. The main activities of these NGOs are to distribute IEC materials; conduct educational talks, seminars, and workshops; train people in family planning and responsible parenthood; establish counseling centres for young people and for women on women's rights; lobby authorities; conduct other advocacy and research activities; and provide reproductive health and family planning services

The work of NGOs has nevertheless generally been isolated, weak, and limited to urban areas. Little work has been done on advocating for reproductive rights. Despite the creation of several health NGO networks, the lack of coordination among NGOs still limits the effectiveness of their activities.

The state of the partnership between NGOs and the Government

In order to function in Cameroon, associations only need authorisation from the Prefect, at least that is the theory. However, some ministries provide special authorisations in a discretionary way.

There is no single Government office in charge of NGOs, and this has encouraged the multiplication of administrative procedures. Some donor agencies require an NGO to have a special authorisation from a particular ministry before financing them, or channel their funds through the ministry. These agencies also exert pressure for NGOs to be included in the development of policies and the implementation and evaluation of programs. The lack of clear definition of the respective roles of the Government and NGOs sometimes creates duplication and some competition for resources, to the detriment of the public health services.

5. Achievements and benefits of the ICPD Programme of Action

Overall achievements

Although the Cameroon Government has adopted some policies concerning reproductive health in line with the ICPD Programme of Action, the overall implementation of this programme has not been effective. There have nevertheless been some considerable achievements.

- ~ The institutional structure for the reproductive health agenda has been strengthened by the implementation of national health plans and sectoral strategies, and through the decentralisation of the health sector.
- ~ The establishment of health districts allows for more functional and operational health planning and administration.
- ~ There is increased acknowledgement of the need for gender equity in the elaboration of the programs.
- ~ Donor agencies have supported projects that aim to improve access to health services.

Remaining barriers

- ~ There is no clear scope for effective dialogue or networking among NGOs in Cameroon working in the fields of reproductive health and reproductive rights.
- ~ The partnership between the Government and NGO has not been formalized.
- ~ The implementation of structural adjustment programs as well as the devaluation of the CFA franc has caused significant impoverishment and financial problems for the people of Cameroon, as well as the poor state of national and state budgets.
- ~ The unfavorable economic environment, including the fall in oil prices and thereby the fall in the local currency, had a negative impact on the health of Cameroon people.

- ~ Despite campaigns by some NGOs, traditional beliefs and practices hamper any improvement in the status of women in Cameroon, and delay the implementation of the Action Plans of Cairo and Beijing.

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¹ UNAIDS, June, 2000

Ghana

❧ Afua Hesse ❧

1. The national situation

The Republic of Ghana, which has been a democracy since 1992, is situated on the west coast of Africa, with the Atlantic Ocean to the south, Cote d'Ivoire to the west, Togo to the east, and Burkina Faso to the north. Ghana covers an area of 238,447 sq. km and has a population of around 18 million. The country is divided into ten administrative regions and 132 districts. In the 1980s, Ghana was hailed as the African economic recovery success story because of its economic growth especially in the second half of the decade. In the early 1990s, however, this growth began to falter, inflationary pressures increased and real GDP growth slowed (ISSER, 1996). Real per capita growth rates continued to decline from 1.8 per cent in 1990 to 1.4 per cent in 1995.

The most recent demographic figures available are from 1996. Annual population growth is estimated to be 3.1 per cent, and is fuelled by high fertility. The crude birthrate is 42 per 1,000 and the crude death rate is 12 per 1,000. Most other development indicators are well below world averages. The adult literacy rate is around 66 per cent; net primary enrolment is 44 per cent, and life expectancy at birth is 60 years - considerably higher than the average of 49 years in the 1970s, but still low on the global scale.

Development indicators for Ghana

	1970s	1990s
Population size	9.8 mill	18.7 mill
Population growth rate (1975-1997)	-	3.1% ann. av.
Total fertility rate	6.5	5.2
Life expectancy at birth	49 yrs	60 yrs
Maternal mortality rate	-	740
Infant mortality rate	111	68
Under 5 mortality rate	186	107
Contraceptive prevalence	-	20%
1990s gender gap		
	Female	Male
Life expectancy at birth	61.8 yrs	58.3 yrs
Net primary enrolment (6-15 yrs)	41.8%	45.8%
Adult literacy	56%	76%

Source: UNDP Human Development Report, 1999

In spite of various development agency efforts, health service coverage in Ghana remains low. Between 35 and 40 per cent of the population has no access to health services, and traditional health practitioners, both quacks and genuine healers, take advantage of this situation. Expenditure on health has fallen in recent years, from an all time high of 10 per cent in 1989 to 4.8 per cent in 1994 and 6.5 per cent in 1995. This reduction resulted from the Government's Economic Reform Program and cost sharing and cost recovery policies that grew into the Cash and Carry system.¹ In 1994, the World Health Organization (WHO) reported that, "Compared with the level of public health expenditures in other countries, Ghana's levels remain low despite a health reform program under the Economic Reform Program which was designed to re-organise health care delivery and promote a more effective and equitable health care system."²

Ghana has had a population policy since 1984. The Government has long recognised that high population growth and high maternal and infant mortality rates contributed to stagnating social and economic development. These problems are compounded by natural disasters such as the severe drought of 1983. The National Population Council was established to formulate this population policy in order to rekindle human development in Ghana. The Council's role was principally to facilitate and coordinate policy development, not implement it.

In 1992, African governments met in Ngor, Senegal to prepare for the 1994 Cairo Conference. Ghana participated actively at that meeting. The outcome was the 'Dakar/Ngor Declaration on Population, Family and Sustainable Development' which focused on strategies for the survival of the family. It called for broad policies to address population and reproductive health issues, environmental degradation, economic growth and poverty. Its goals for Sub-Sahara African countries included:

- ~ Decreasing the population growth rate from 3.0 per cent to 2.0 per cent; and
- ~ Raising contraceptive prevalence rates from 10 per cent to 40 per cent.³

The National Population Council coordinated Ghana's preparation for the Cairo Conference, and the ICPD convenor and chairperson, Professor F.T. Sai, was a former Chair of the National Population Council. The preparations for Cairo principally involved consulting with the members of the National Population Council, who include professionals and representatives of a wide range of public opinion in the country. The position paper that was developed however glossed over many difficulties and was overly optimistic about the achievements of the National Population Council.

Since the 1994 Cairo Conference, more attention has been given in Ghana to reproductive health and gender equity. The National Population Council has retained its coordinating role. Nevertheless, there has been decreased funding for semi-government organisations and increased donor dissatisfaction with the Government's rate and utilisation of aid funds. Affiliates of international NGOs such as the Planned Parenthood Association of Ghana, and local NGO's such as the Ghana

Midwives Association, and the Society of General Medical Practitioners have become the main organisations in partnership with the Government in implementing the ICPD Programme of Action. It has been very difficult for other NGOs to be recognised in this field or get the necessary support to expand their activities.

Since the Cairo Conference, the Ministry of Health changed the name of its implementing unit from Maternal and Child Health Unit to the Reproductive and Child Health Unit. Despite the name change, the emphasis continues to be on family planning. The unit also continues to face the problems of insufficient personnel and finance to carry out its functions effectively, and adolescent reproductive health issues still get little attention. Training needs to be intensified in order to shift the mind-set of health workers.

A strong rights advocacy lobby is only now emerging within Ghana's NGO community. The organisation of women lawyers (FIDA) has taken the lead in this effort. Their efforts so far have resulted in new legislation to outlaw the practice of female genital mutilation.

Ghana is fortunate that, perhaps because of cultural bias, the traditional opponents of the ICPD Programme of Action are not very vocal or effective in the country. The Catholic Church, for example, is present but many of its members in Ghana use modern contraceptives and regularly practice family planning. While there are still strong objections against any review of abortion laws, NGOs have vigorously taken up the issue of post-abortion care and now provide these services.

Gender issues

The 1992 Constitution of Ghana explicitly recognises economic rights, education rights, cultural rights and practices, women's rights, children's rights, rights of the disabled, and rights of the sick.

Although no laws overtly discriminate against women, and the Government has affirmed its commitment to promote equality between men and women, considerable gender inequality still exists at all levels of society. Women are largely absent from the highest levels of state and power structures. Persistent covert gender discrimination is replicated

throughout Ghana society by negative socio-culturalisation. Opportunities for girls are still mainly confined to rearing families. There is official recognition, however, that programs aiming to improve education must take into account the factors that keep the enrolment and retention rates for girls lower than for boys.

Traditional culture is still very strong, especially in the rural areas. For example, a study in Kayoro, a rural community, found that domestic power relationships ensured that men controlled their families (which are mainly polygamous), that women were the property of males, and men control family finances and thereby women's health seeking behaviour. Decision-making is vested in males from an early age.

Before the Cairo Conference, the issue of gender violence was rarely mentioned. Although the Constitution ensures equal rights for all, violence against women remains very much a 'silent' crime relegated mainly to that of 'domestic incidents.' After the Cairo Conference, awareness has begun to be raised about the scope and nature of gender violence, particularly the kinds of violence that are perpetuated in the name of 'culture.' These include the practice of '*Trokosi*' or 'shrines slave brides,' a form of ritual servitude that is practised in some parts of the country; issues surrounding widowhood rites; and 'witches' villages, where women suspected to be witches are banished and punished. Other associated issues, such as rape, molestation, and child sexual abuse are also now documented, highlighted and discussed. There is now more information available about violence against women, because several studies have been commissioned.

A law enacted in 1996 criminalised the practice of female genital mutilation. The enforcement of this law is still difficult. NGOs throughout the country are using discussion methods rather than legal avenues to challenge the social, cultural and religious issues involved in this practice, to prevent the practice from merely going underground. A review of other legislation in Ghana is needed so that these laws can deter the perpetrators of this crime.

Poverty and remedies for alleviating poverty

In Ghana, poverty is mainly rural. The phenomenon of the urban poor is becoming increasingly common as young people, especially girls,

leave rural communities to seek greener pastures in the urban cities. Most of the urban poor are self-employed whereas the rural poor work in subsistence agriculture. The key characteristics of the destitute and poor are disability, old age combined with lack of adult children, widowhood and childlessness.⁴ The issue of poverty has not been specifically desegregated by gender, although Boateng et al (1990) noted that 75 per cent of households fell below the national poverty line of \$100 per capita. He found that the poor were concentrated in large rural farming households, especially those with non-literate heads of household.

The Government has declared that no matter where they live or their station in life, all Ghanaians should be able to count on a minimum level of 'human security' namely, 'safety from such chronic threats as hunger, disease, repression and protection from sudden hurtful disruptions in the patterns of daily life- in homes, workplaces and the community.'⁵

In Ghana, the feminisation of poverty occurs everywhere, but it is most evident in the North, the most depressed part of the country. Life-cycle changes are more likely to plunge women into poverty, especially widows, aged or childless women, or women with young children. Various forms of discrimination restrict women's access to land, credit, and education, and in turn limit their ability to be productive and rise above poverty. In severely degraded environments, women carry extra burdens of labour. They disproportionately bear the pressure of food insecurity, especially in the lean season. Women have less access to labour-saving and time-saving technologies. Time-honoured labour intensive production methods are still practised, especially in rural communities where the customary and traditional ties remain strongest.

Some of these burdens on women are being tackled. Government and NGOs are supporting schemes to shorten distances to water sources in rural areas. The Government has introduced small-scale community valley-bottom irrigation schemes in order to improve opportunities for dry-season gardening. Government and NGOs, such as the Hunger Project, are offering micro-credit facilities to enable women to develop small businesses that will generate income and decrease their level of poverty. More emphasis is being given to developing functional literacy and credit programs that support sustainable development through capacity building. Current official programs in Ghana that have poverty reduction objectives include:

- ~ Free, compulsory and universal basic education for all children;
- ~ The Medium Term Health Strategy of the Ministry of Health;
- ~ 'A Child Cannot Wait,' the National Program of Action of the Ministry of Health;
- ~ The Umbrella Program for Sustained Employment Generation, of the Ministry of Employment and Social Welfare;
- ~ The National Action Program for Poverty Reduction, of the Ministry of Local Government and Rural Development and UNDP; and
- ~ The Medium Term Agricultural Development Strategy, of the Ministry of Food and Agriculture.⁶

A Government document named 'Vision 2020,' which describes a new development framework for the country, articulates similar initiatives. These programs are at various stages of development and implementation and their impact cannot be well measured yet. Gender issues are being given direct attention and the building of women's capacity and participation in government is being addressed. Cabinet has approved affirmative action for women, to include at least 40 per cent of government appointments, but this proposal has yet to gain parliamentary and presidential assent.

2. Assessing ICPD Implementation

The enabling environment

The Government of Ghana is trying to address various forms of social and economic inequity, especially poverty among women. While various schemes have aimed to increase the economic autonomy and empowerment of both men and women, many have been donor dependent and therefore not sustainable. Moreover, because of the continuing decline of the economy and the volatility of Ghana's currency, people there have seen continual erosion in the value of their money and property, and a deepening state of general poverty.

Government has made great efforts to decentralise health services to meet the needs of the more disadvantaged people. Numerous health posts, health centres and hospitals have been built, but as there has not been a corresponding increase in the training of health workers. Many facilities therefore remain unused through lack of personnel. From 1989 to 1994 the percentage of the population that lacked access to modern health facilities did not decline, but remained at around 40 per cent, although there is considerable regional variation in this.⁷ The relationship between various ministries such as Local Government and Health remains unclear. There is no clear division of their functions at district and regional levels.

Sexual and reproductive health and rights

In the early 1990s, the total fertility rate for Ghana was 5.5 but this has evidently declined since. Contraceptive use, however, remains low, at 10 per cent for modern methods and 20 per cent for all methods. The reason for this phenomenon of declining fertility rates but static contraceptive usage rates is unclear and more research is needed. There has been suggestion that it is caused by 'lost' pregnancies but there are no data on abortions, nor research into any underlying behavioural changes.

Fertility behaviour in Ghana is greatly influenced by traditional cultural beliefs and practices. Women, especially from lower socio-economic groups, usually marry young and have many children. Studies have confirmed that the number of children a woman has is in inverse proportion to her education. Although it is officially discouraged, many men practise polygamy.

Even before the Cairo Conference, the National Population Policy incorporated some - but not all - of the fundamental principles and objectives encompassed by the Programme of Action. For example, Chapters VII and VIII of the Programme note that family planning programs should improve their quality of care. In Ghana, responsibility for sexual and reproductive health programs lay with the Ministry of Health, within which a small body called the Maternal Child Health (MCH) Unit coordinated and implemented these policies. As staffing in this unit was, however, grossly

inadequate, its work was mostly restricted to safe motherhood and the expanded Program of Immunisation. Little attention was given to other aspects of sexual and reproductive health.

In 1996, the Government adopted a National Economic and Social Development Plan for the period up to 2020. In 1997, it adopted a National Reproductive Health Service Policy and Standards. The implementation of these policies has posed some problems. The redirection of activities from vertical family planning programs to reproductive health programs, of which family planning is just one component, is still problematic although some change has occurred. On the whole, while there has been more understanding about the concept of reproductive health since the Cairo Conference, its implementation is still lacking in many areas. The current health clinics and their staff are still geared towards providing Family Planning services, and there is very limited access to a broader range of reproductive health services. Pre-natal care is fairly widely available for Traditional Birth Attendants have been trained, although their impact has not been as significant as first hoped. In 1989, 83 per cent of women sought ante-natal care from trained personnel but only 40 per cent of births took place with their help. By 1992, this latter figure had increased to 45 per cent - but was generally lower than this in the rural areas where the Traditional Birth Attendants had been expected to have most effect on lowering infant and maternal mortality.⁸

In 1997, untrained people attended 40 per cent of all births, while most new health facilities remained largely unused.⁹ For most women, the barriers of cost, distance, and dependence on their husband's consent still restrict their access to proper health care. Many women must deliver and care for themselves at home. Specialised gynaecological care, including cancer screening, is available only at a few centres in the regional capitals. Besides being geographically inaccessible, these services are too expensive for most women, especially those who live in the rural areas. As a result, maternal mortality remains high and targets for its reduction have not been met. While there is considerable regional difference in these rates, the disparity is particularly evident between urban and rural areas.

Around 40 per cent of all maternal deaths in Ghana result from preventable causes such as unsafe abortion. Other high risk factors include high maternal age, anaemia, and short intervals between pregnancies.¹⁰

The actual number of women who die each year from unsafe abortions is not known. The recently revised law relating to abortion provides that a woman can obtain an abortion lawfully if two physicians can attest that continuing the pregnancy would be detrimental to her mental or physical health. This liberalises the law somewhat, except that many physicians are unwilling to 'volunteer' this information. Post-abortion care is available in most health institutions. Although many health workers require retraining in compassion, there are no reports of women being denied care.

As explained above, the training of health workers has not kept pace with the expansion of health care facilities. Many are still unused. Patients complain about the quality of care in others. Another disincentive to the use of these facilities, especially by women and children, is the 'cash and carry' system in government health clinics, which requires patients to pay cash first for service. The official exemptions to this policy, such as free care for pregnant women and aged people, do not translate into real operational services. Often the amount of funds disbursed to individual health institutions is inadequate for the many patients, and the institutions are themselves unwilling to finance these special services.

The prevalence of HIV/AIDS in Ghana has risen steadily and now affects between three and four per cent of the population. The National AIDS Control Program (NACP) has had little impact on the epidemic's progress. While it has somewhat unfairly been accused of being a 'conference attending' organisation, the NACP has significantly helped increase public awareness about the disease even if it has not managed to effect any behavioural change because of the ingrained culture and attitudes of the people. It has also not succeeded in demystifying the disease, such that it would seem that no-one dies of AIDS in Ghana. There is no free treatment for HIV/AIDS patients in Ghana, and drugs are not freely available. There is instead a proliferation of native and traditional healers with largely unsubstantiated claims of cure for the disease. This has compounded the difficulty of changing people's behaviour, as many people do not believe there is no cure for the disease.

Reproductive rights

In Ghana, the issue of reproductive rights is still not well understood. Traditional attitudes prevail about the behaviour of people. Many men associate women who use contraceptives with promiscuity, although they make no such judgements about men who 'display their masculinity'. The links between reproductive rights and the basic needs of women have not been well explained. Women's rights and health activists are only beginning to tease out the nuances in the light of cultural norms and to adapt these to our situation, for to directly confront local culture would not yield the desired results. The challenge is enormous. In such a strong traditional culture where women have little reproductive autonomy, it is difficult to see how they will come to exercise the reproductive rights which both the ICPD Programme of Action and the Ghanaian constitution state are theirs by right.

Women do not have access to the full range of contraceptives. Their choice is limited by the general non-availability of modern contraceptives. Health workers also tend to withhold information on the various contraceptives that are available, further limiting the choice. Implantables are both unpopular and little available. Women in Ghana have, however, been fortunate in that there has never been overt or covert coercion to use any particular family planning method, but the decision has been left to the couple or individual concerned.

The area in which most progress has been made is in addressing violence against women. Various rights groups have raised awareness about this problem, which was previously considered to be a 'domestic' issue. Pappoe et al. (1997) documented a high incidence of violence in a series of case studies they conducted (still unpublished) from interviews with over 4,000 women across the country. More than 50 per cent of the women they spoke to had refused to talk about their assault to anyone. The Police have established a special Women and Juvenile Unit where violations of women and children, such as rape, can be reported for investigation. Victims are encouraged to prosecute the perpetrators of these crimes. This has challenged the traditional view that domestic

incidents should be settled at home, but rapidly has gained popularity as a source of relief for women. The success of the Unit is evident in that in 1997, over 2,000 cases were prosecuted and in 1998, over 22,000 reported cases were reported. The figures continue to rise. Similar units are now being set up in each regional capital and will eventually exist in each district capital. Women are thereby being encouraged to pursue their rights, despite the social and cultural insistence that they remain subservient.

Services for Refugees

The Government has taken no specific measures to address the reproductive health needs of refugees or displaced persons. The most recent groups to enter Ghana have escaped the conflicts in Liberia and Sierra Leone. Reproductive health services for these people are mainly provided by NGO's such as the Planned Parenthood Association of Ghana and are limited to clinics in the refugee camps.

3. The roles of NGOs and their relationship with Government

The National Population Council, the organisation entrusted to implement the ICPD Programme of Action, has not been able to enlarge its managerial capacity or extend its implementation links beyond the NGOs it has traditionally worked with. More has been accomplished by the National Council on Women and Development (NCWD), a para-statal organisation established by Government decree in 1975 to promote the advancement of women in Ghana. For many years the NCWD has attempted to coordinate the activities of various women's groups and NGOs. Yet it is only since the Cairo Conference that their capacity to coordinate these organisations throughout the country has really been felt. Soon after the Cairo Conference, the NCWD identified key areas within the Programme of Action and organised a meeting with its affiliated women's groups to discuss them. The work of the NCWD is nevertheless greatly hampered by inadequate funding, being thereby unable to carry out their monitoring and coordinating role effectively. They have, however, achieved success in some areas, including initiating a review of legislation on negative widowhood practices.

Civil society organisations such as local women, youth, religious groups and trade unions have been involved in researching, designing, implementing, monitoring and evaluating reproductive health programs. Since the Cairo Conference, the atmosphere of cooperation between Government and NGOs has become more cordial. Some NGO's - especially international organisations or those with international links - are recognised as almost equal partners, although without any access to official funding. For the most part, the Government respects their autonomy. NGOs operating in Ghana must be formally registered in order to have official status, and there are well defined and recognised entitlements. The proliferation of NGO's has accelerated in the latter part of the 1990s.

Government services are generally few and far between in rural areas of Ghana. There NGOs have taken the place of Government in providing health services. Religious groups support most of the rural clinics and hospitals that provide reproductive health services. In the past, they were left to their own devices. Now the Government helps support them by paying their staff salaries, but does not interfere with their principles or programs. While this is a considerable benefit for rural communities, the difficulty is that the types of services that are available depend very much on the religious philosophy of the group concerned. The full range of reproductive health services called for in the ICPD Programme of Action may not therefore be available in any particular locality.

The NGOs involved in providing, supporting or advocating for reproductive health or rights include:

- ~ The Planned Parenthood Association of Ghana;
- ~ The Ghana Registered Midwives Association;
- ~ The Ghana Social Marketing Foundation;
- ~ The Federation of Women Lawyers (Ghana) (FIDA);
- ~ The Association of Voluntary Surgical Contraception (AVSC);
- ~ The Society of Ghana Women Medical and Dental Practitioners (SGWMDP); and
- ~ Various religious organisations, such as the Protestant, Catholic, and Charismatic Churches.

Their programs in Ghana support the following efforts:

- ~ Welfare programs and relief aid;
- ~ Skills training;
- ~ Credit assistance and poverty reduction;
- ~ Institutional building;
- ~ Community development;
- ~ Gender specific projects; and
- ~ Health including reproductive health

As discussed earlier, although various NGOs are implementing the Programme of Action, there has been little attempt by the Government to coordinate or integrate their activities, or to offer them support. The well-established NGO's are moving away from implementing projects to expanding their capacity to operate full programs, especially in the rural areas. For the most part, there has been little follow-up or monitoring of NGO activities by the Government because of the shortage of financial and material resources. Furthermore, the institutional capacity of these organisations has not expanded to keep pace with the demands that are being put upon them.

Although democracy has existed since the establishment of the 1992 Constitution, people in Ghana - particularly women - do not yet demand accountability from the people in power. The war on corruption in Ghana has to be sustained at all levels of society and politics in the country. There is also no tradition in Ghana of expecting or demanding accountability from any service provider. Very gradually, clients are coming to do so from NGOs and Government. While Government is only slowly coming to terms with these demands, NGOs have responded more quickly, perhaps because they have always needed to be accountable to their donors and funders.

4. Financial resources

Bilateral donor agencies have increased their support for poverty-reduction activities in Ghana. Most of their funding goes to institutional strengthening and only 22 per cent go to activities that directly address poverty. Only a small portion of the international donor funds promised for

the implementation of the ICPD Programme of Action have been delivered. This has prevented the progress of some programs to implement the commitments made by Ghana to the ICPD. The National Population Council has not yet completed its evaluation of the progress made on the ICPD Programme.

In connection with these ICPD commitments, the Government has increased its spending on the following areas:

- ~ Reproductive health and family planning services;
- ~ The reproductive health needs of adolescents;
- ~ Primary health care services;
- ~ Sexually transmitted diseases, including HIV/ AIDS; and
- ~ Female school enrolment.

The structural adjustment programs of the Government have also reduced the spending power of the country's currency, as well as the effective percentage of GDP spent on health in general and reproductive health in particular. Corruption has also eroded the resources available to the Government.

As a result, it has been difficult to mobilise domestic resources for population programs. Donor agencies provide funds for activities relevant to the ICPD Programme through a common 'basket' which the Ministry of Health disburses. This is known as the Sector Wide Approach. The money effectively becomes a part of the Government's fund and is disbursed according to its priorities for the Ministry of Health. The poor institutional capacity of Ministry of Health units has prevented all the allocated funds from being used and the 'surplus' money had to be returned to the Government's general fund. This problem has brought to the fore the lack of real partnerships between NGOs working on these issues and the Government. Donor agencies are also beginning to criticise this system as it reduces their effective control over these resources and what their contribution is able to achieve.

In regard to HIV/AIDS programs, some NGOs have taken the approach of gaining the support of private sector organisations to fund their activities, principally information and education programs for their workers. ⁴³

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Nigeria

✧ **Bene Madunagu** ✧

1. The national situation

Most African countries south of the Sahara currently face political, social or economic crisis. Various countries suffer political instability or civil war, and with it high levels of poverty, low levels of development, frequent natural disasters and persistent economic depression. This situation seriously affects the implementation of the International Conference on Population and Development (ICPD) Programme of Action throughout Sub-Saharan Africa. Six years after the ICPD Conference in Cairo in 1994, reproductive health is still generally very poor. Health services are inadequate, maternal and infant mortality is high, fertility is high, and few women use modern contraceptives.

In his statement to the Hague Forum on Cairo+5, Chris Ugokwe, Chairperson of the African Population Commission, asserted that, "Since the Dakar-Ngor Declaration and the ICPD Programme of Action, many African countries have undertaken a broad range of actions and have revised their population and development policies, made changes in their institutional infrastructures, and focused their attention on reproductive and sexual health and rights and gender issues." This contribution describes the extent to which this has happened in Nigeria.

Nigeria is the most heavily populated country in Africa, with almost 104 million people. The country is a federation of 36 states, and the Federal Capital Territory is located at Abuja. The states are subdivided into 589 local government areas. Structurally, therefore, there are three tiers of government in Nigeria: federal, state and local. National policies are defined and monitored by the Federal Government. The state and local governments are charged with implementing these policies.

Table 1 Development indicators for Nigeria

	1970s	1990s
Population size	57 mill	103.9 mill
Population growth rate (1975-1997)	-	2.8% av. ann.
Total fertility rate	6.9	5.2
Life expectancy at birth	42.7 yrs	50.1 yrs
Maternal mortality rate	-	1,000
Infant mortality rate	120	112
Under 5 mortality rate	201	187
Contraceptive prevalence	-	6%
	1990s gender gap	
	Female	Male
Life expectancy at birth	51.5 yrs	48.7 yrs
Net primary enrolment (6-15 yrs)	-	-
Adult literacy	50.8 %	68.5%

Source: UNDP Human Development Report, 1999

Although Nigeria's Constitution provides for the executive, legislative and judicial branches of the Government to act independently, effective rule is by the Army, which suspended the legislature by decree and limited the scope of the power of the judiciary. This situation has prevailed in Nigeria for 30 of its 38 years of existence as an independent country. Judges who dare to challenge the military often are removed.

In 1986, the Nigeria Government adopted a package of structural adjustment polices, which are being administered by the World Bank. Since then, various economic austerity measures have been prescribed and implemented by the Government, as well as currency devaluation (and consequent inflation), a reduction in government subsidies, privatisation of state enterprises, and a very steep reduction in government spending on social sectors including education, health, transportation and general welfare.

These policies have contributed to the escalation of rural poverty and deterioration of existing health care facilities.¹ Poverty is contributing to over-exploitation by peasant farmers of the little arable land available, despite its very low yield, and increased rural-urban migration. In turn, this contributes to the deterioration and over-stretching of facilities in the towns and cities. The conventional indicators of development status are generally in reversal. National average infant and maternal mortality rates are high by international standards, but they are even higher in some regions of Nigeria and may be rising.

Nigeria's very high maternal mortality and morbidity rates point to the low status of women in the country. In rural areas, where almost 80 per cent of the population lives, maternal death rates have been estimated up to 1,800 per 100,000 live births. Life expectancy at birth for women in Nigeria is approximately 51 years. Women are also very under-represented in politics and decision-making. There are no women members of the Federal Ruling Council, no women military administrators in any of the 36 states, nor any women chairs of Local Government councils. In summary, no woman is in any visible political or policy-making position.

This situation prevails despite Nigeria being signatory to the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC). It is also a signatory to the African Charter of Human and People's Rights which forms part of the domestic legal system. The 1979 Constitution of Nigeria also prohibits discrimination based on sex.

The slow speed^¾ or almost absence^¾ of policy changes to reflect the Cairo Programme of Action can be attributed to political instability and inconsistency, as well as to the high turnover of policy makers in all the three tiers of governance. Even where policy exists, conservative,

sexist forces that adhere to traditional, religious or cultural beliefs frustrate its implementation. The undemocratic military leadership does not provide an enabling environment for more progressive policies, and there are no alternative democratic structures of governance.

2. Nigeria's health care system

In 1987, expenditure on health in Nigeria accounted for 0.8 per cent of the national budget. A year later, this had risen to 4.9 per cent. By the early 1990s, one third of the population still lacked access to basic health services, and there were only 21 doctors per 100,000 people.² Table 2 shows recent budgeted resources for health. Health expenditure has increased, but not enough to accommodate the recommendations of the Cairo Programme of Action.

Table 2 Public expenditure on health in Nigeria, 1994-98

Year	Capital Health Expenditure (\$N.mill)	Recurrent Health Expenditure (\$N.mill)	Expenditure on health as of total national budget
1994	—	—	2.7%
1995	1,759.7	2,746	2.5%
1996	1,659.5	3,638	3.4%
1997	4,720.4	2,623	5.0%
1998	4,860.5	7,070	4.9%

Since 1975, the Nigerian Government has used the primary health care (PHC) approach in providing national health care. The definition of PHC in Nigeria's National Health Policy meets World Health Organization (WHO) standard guidelines for general health services, namely, preventive, curative, promotional and rehabilitative care.

Providing basic health care is the responsibility of local Governments, under the supervision of State Ministries of Health. At this

primary level of care, the PHC programs provide a variety of services, through a total of 1,071 Local Government and private health centres, clinics, dispensaries, first aid stations and maternity centres.³ These centres were designed to provide basic health care, health education, simple laboratory tests, preventive care services, pre natal and post natal care for mothers, family planning, immunisation for children, oral dehydration therapy and nutritional education.⁴ Service providers at this primary level are supposed to refer patients to secondary and tertiary levels for specialised services.⁵ The practice, however, is much below these expectations.

The secondary level of care is provided at the state level and consists of 119 district hospitals and 780 general hospitals. This secondary level is designed to provide comprehensive community health care, with more specialised laboratory and other facilities than at the primary level.

Tertiary level care is the responsibility of the Federal Government, which also formulates health policy and provides specialised technical assistance and services. This tertiary level consists of 13 teaching hospitals and other urban-based tertiary institutions that provide largely curative services. The under-funding of these institutions that has come about through the application of the structural adjustment policies, excessive military spending and undemocratic government has substantially reduced the effectiveness of this hierarchy of services.

Government cuts in social services spending, including the health sector, have encouraged the emergence of high-cost private health systems that are beyond the reach of most people. In principle, the Federal, State and Local Governments are required to finance and provide medical and hospital services, but, in practice, their response is very poor. This situation has persisted since the ICPD Conference in Cairo, mainly because the repressive military rule and poor human rights record in Nigeria has brought international sanctions against the country.

No new policies have been formulated to specifically address women's health issues. Nor has much research been conducted in this field. There has been much rhetoric about women's empowerment, but no concrete critical debates that have contributed towards positive change. Rather than main-streaming gender concerns into government activities, a new ministry was created which in practice has further marginalised

women. The Women's Ministry has implemented no new policies or programs that address gender differences or women's health, or sought to increase knowledge and understanding about women's health, their health needs or sexual and reproductive rights.

Furthermore, since 1986, public health services have adopted the following cost recovery mechanisms:

- ~ *The sale of drugs and accessories:* Patients have to buy all drugs prescribed, including cotton-wool, syringes and needles, from the hospital, private pharmacies, or patient medicine stores. The current practice in rural and urban slums is to consult a medicine dealer—usually a person with no formal health training—and ask for a dose to counter whatever symptoms they describe. Some of these medicine dealers freely hawk medicines, including antibiotics, in the streets and open markets, even past their expiry dates. A new creation of the military Government called the Petroleum Trust Fund (PTF), which acts like an alternative government, also supplies drugs through its drug stores in all the states of the federation. These stores claim to supply drugs at reduced prices but there is no mechanism to check any price exploitation. Some wealthy businessmen, furthermore, buy off the PTF stock of drugs and sell them at high prices through their own drug stores.
- ~ *Purchase of Hospital Cards:* Patients must pay for their hospital card before any consultation with the medical officer. At each subsequent visit, payment is required before the person's file is retrieved.
- ~ *Administration fees:* Both in-patients and out-patients must pay fees to cover the administration costs of the service centre, even in a Government or public-owned facility.
- ~ *Blood transfusions:* Patients must make their own arrangements to buy blood and blood products for their treatment. Usually blood banks are in short supply or cannot store blood because of constant electricity failures.
- ~ *Treatment costs:* Patients admitted for surgery or for childbirth must pay for the theatre and anaesthesia, and

supply candles and matches in case of a power failure. Irrespective of an emergency or the seriousness of the patient's situation, cash must be paid before any attention is given. Even having one's blood pressure or weight taken attracts a fee.

As a result of these costs, many women patronise quacks, traditional healers or spiritual homes, for they cannot afford modern medical care even in Government-run hospitals and health clinics. Either Government health decision-makers are not informed about the commitments the Government made in Cairo, or there is no political will to implement the ICPD Programme of Action^{3/4}especially since it favours women who are under-represented and under-valued among the decision-makers.

3. Preparations for the Cairo Conference

The Department of Population Activities of the Ministry of Health was responsible for preparing Nigeria's contribution to the Cairo Conference. An expert group helped to draft the country position paper for the conference. The NGOs that participated in the PrepCom process together formed the Coalition of Nigerian NGOs on Health, Population and Development (CONNOHPD) which held workshops across the country to mobilise the views of the 'Voices from Below' on population policies. The information gathered was used to lobby official representatives and was also published into a booklet that was widely circulated throughout Nigeria and at the Cairo Conference.

The Department of Population Activities of the Federal Ministry of Health was about to set up an implementation committee for the Cairo Programme of Action when it was suggested that they wait for the outcome of the Beijing Conference, so both action plans could be implemented together. During this time, the Ministry for Women Affairs was created. This new ministry took over the implementation of both the Cairo and Beijing programmes of action, on the grounds that women's issues were central to both - but this instead complicated the outcomes of both. Women became pawns in the confusion that ensued from the actions of an undemocratic military Government that has no sustainable processes of governance.

Women and health care

Nigeria has no social security system.⁶ Although the National Health Policy requires that the State and Local Governments provide health subsidies, this provision has been negated by the application of the structural adjustment policies. Traditional health care providers enjoy wide patronage. Women shy away from hospitals because of the costs they involve in time and money, but also because of the attitudes of health providers and the common belief that pregnancy is natural and therefore does not require special health care.

Traditional and spiritual healers are also the last resorts for intractable illnesses. While decisions as to when to seek medical attention are influenced by economic cost, there is a general lack of scientific knowledge about many illnesses.⁷ Breast cancer, for example, is commonly thought to come from evil forces. STDs are seen as diseases only of promiscuous people, and AIDS is considered by many to merely be an advanced STD. Government has done little to increase public understanding about HIV/AIDS. Much of this work is being done by NGOs, for HIV/AIDS is considerably more serious an epidemic than the number of reported cases would suggest. The number of cases has been grossly under-reported because it is derived from hospital records, where perhaps only about 20 per cent of infected people are seen.

Contraception is viewed as the responsibility of women. Even traditional methods are targeted at women, but this responsibility is not backed up with power to make decisions on such issues. The husband's consent is often required before a woman will be attended to at a family planning clinic. Contraceptive prevalence is low: 7.5 per cent for all methods and 3.8 per cent for modern methods.⁸ Among married women, the most common modern methods of contraception are the pill (29.7 per cent) and injected methods (24.3 per cent). The private sector is the primary source of contraceptives for women. Most cannot afford their cost. There is no law that explicitly regulates the sale or use of contraceptive drugs or devices or prohibits the advertising of contraceptives or the distribution of contraceptive information.

Existing policies and programs, such as the Safe Motherhood Initiative, Primary Health Care, and Maternal and Child Health services,

target women in their reproductive years, providing services that women must pay for. There has been much talk about the empowerment of women through credit schemes but very little about women's sexual and reproductive rights or health, except by NGOs. One measure of the lack of seriousness about women's health is the absence of facilities to address serious health problems among women, such as cancer. There are only two mammogram machines in all of Nigeria, both privately owned and therefore inaccessible to all but a few women.

There is public denial about the prevalence of abortion, although hospital records reveal that poorly performed abortions are a major health problem for women of child bearing age.⁹ Of an estimated 50,000 maternal deaths each year, around 20,000 result from the complications of unsafe induced abortions. Even so, under Nigerian law, abortion is permitted only when a woman's life is in danger from a pregnancy. This restriction on abortion has not been removed since the Cairo Conference, despite the advocacy of many NGOs. On the other hand, some NGOs also impose their religious values on the issue of abortion, a problem expounded upon by Dr. Rakiya Booth, Director of Christian Health Association of Nigeria (CHAN) at the National Conference on Adolescent Reproductive Health in Nigeria, in January 1999.

'Way back in 1994, Ms. Susan Crane of International Family Health in London visited us in CHAN in the company of Mrs Ayo Tubi, the country representative of IPAS, to introduce the subject of Post Abortion Care, most especially Manual Vacuum Aspiration as an alternative to Dilatation and Curettage. I must say that in CHAN we were not very conversant with the subject at the time and the idea of Manual Vacuum Aspiration did not sink well with us. Then there was the question of the word 'abortion.' To us in CHAN, as to many others even today, 'abortion' meant only criminally induced termination of pregnancy, and as Christians we could not be associated with such. Because of this idea that we had, it was not easy at that time to see the needs of women who come to our hospital with complications of abortion, neither was it easy for us to manage these women non-judgmentally.

Let me add here that the story is now different in CHAN. Through awareness seminars, they understood that:

Abortion is usually considered to be a problem of women, both married and unmarried. When programs are planned to look into this problem, young women, who are equally affected with the problems of unwanted and early pregnancies and the complications of abortion, are often left out.

Many women face a destructive cycle of repeated unwanted pregnancies and unsafe, often illegal, abortions. In many instances, comprehensive family planning is lacking.

STD services are rarely linked to post-abortion care and often women with complications of abortion also have one STD or another' (Booth 1999).

Following these decisions, in the last quarter of 1995, CHAN started to provide post-abortion complication services with the full involvement of International Family Health and IPAS. Throughout Nigeria, particularly the rural areas, unsafe abortions are nevertheless common and post abortion care is unskilled and not affordable, if available at all.

Unlike abortions, sterilisation is legal if performed for life, health, eugenic or contraceptive purposes.¹⁰ It is not, however, a common method of contraception in Nigeria - much less so, in fact, than abortion, which is illegal. The fact that many women choose abortion indicates their assertion of their reproductive rights, even if clandestinely, so declaring that women will exercise the right of choice over what happens to their bodies.

Adolescent Reproductive Health

The Federal Government produced a National Adolescent Health Policy in 1995, after the Cairo Conference. In the section on Sexual and Reproductive Health, the policy states that, "Emphasis here is on responsible sexual behaviour and positive attitudes to sexuality as a means of preventing unwanted pregnancies..." This does not address other sexual and reproductive health needs of adolescents. It is only in the area of female genital mutilation, or female circumcision, that some progress has

been made, although no law yet prohibits the act. In January 1999, however, a collaborative partnership among Government, funding agencies, and NGOs developed a framework to implement the provisions of the Adolescent Health Policy.

The implementation of the Cairo Programme of Action by Nigerian NGOs

Several health-related NGOs have recently established themselves in Nigeria, particularly since the Cairo Conference. They are addressing various issues of the ICPD Programme of Action, from environmental issues, adolescents' and women's empowerment, human rights and reproductive health. Some of the significant contributions these NGOs are making towards implementing the ICPD Programme are:

- ~ Since 1995, CHAN, in partnership with IFH and IPAS, has been providing Post Abortion Care, including evacuation of retained products of conception, post abortion family planning, screening for and education on STDs and HIV, and linking up with other health institutions for patient referral. This shows that comprehensive reproductive health services can be developed when there is a will to do so;
- ~ Since 1996, the Planned Parenthood Federation of Nigeria has included sexuality education in its adolescent reproductive health programs;
- ~ The Association for Reproductive and Family Health provides sexuality and reproductive health education through its Family Life Education or Life Planning Education, counselling and clinical services. Its mission to develop a holistic and innovative health services has included setting up model service delivery points that encourage the active participation of their clients. One of the Association's successful programs is 'Promoting Improved Adolescent Reproductive Health in Ibadan Metropolis,' an initiative supported by the British Department for International Development (DFID);
- ~ Action Health Incorporated conducts sexuality education, peer training, counselling and clinical services for

- adolescent girls and boys; and
- ~ Girls' Power Initiative is unique in the sexuality, sexual and reproductive health and rights training it provides for adolescent girls. The program also provides skills training, recognising that the prevalence of poverty among adolescents makes them vulnerable to sexual exploitation. GPI also provides counselling and referral services.

The achievements of Nigerian NGOs were summarised in their joint report to the Hague Forum. These included:

- ~ Training of some health and para-legal workers on Reproductive Health and Rights;
- ~ Making reproductive health services available for women and adolescents in some areas;
- ~ Conducting research on important health and rights issues;
- ~ Holding photo exhibitions, seminars and workshops to increase public awareness about reproductive health and rights in Nigeria; and
- ~ Conducting reproductive health workshops and projects with groups of people with disabilities.

4. Summary and conclusions

Since Cairo, there has been an upsurge of NGO activity to increase public awareness about issues of women's empowerment and reproductive health, and the sexual health and rights of adolescents. While there has been increased public and media discourse on women issues, some of this has been quite cynical. For instance when a woman asserts her views on an issue, other people may make derogatory remarks, such as, "These Beijing people have come again," or, "What do you women want?" There has been a conscious mobilisation of women through the '100 Women Group' strategy to increase political awareness and involvement of women in electoral politics and national decision-making.

Through the ICPD process, a Coalition of Nigerian NGOs on Health, Population and Development was created to mobilise the views of

civil society and disseminate information about the Programme of Action to the community in simple language and form. A partnership of NGOs, relevant governmental ministries, and religious institutions has produced national guidelines on sexuality education.

In 1998, the National Council of Health recommended the adoption of Comprehensive Reproductive Health in the context of Primary Health Care, in line with the ICPD Programme of Action.

In January 1999, the Federal Ministry of Health, UNFPA, WHO, UNICEF, international foundations, other funding agencies, and NGOs, together produced a framework for the implementation of the National Policy on Adolescent Reproductive Health.

In March 1999, the National Immunisation Board was created to support the Expanded Program on Immunisation that would reduce infant mortality by eliminating childhood infections such as poliomyelitis. Efforts to sensitise young people about responsible sexual behaviour have included research and documentation on issues affecting adolescent and women's health, including violence against women; and greater collaboration among NGOs, donors, the media, communities and government.

NGO and Government are, in partnership, working towards a national policy to eliminate Female Genital Mutilation, and have drafted a national policy on STDs and AIDs.

Barriers and constraints

The undemocratic military dictatorship in Nigeria creates an environment that inhibits democratic policy changes or national action to support human rights. The large military budget, including the cost of keeping troops in foreign countries, drains the economy. So too do corruption by national leaders and the debt servicing of dubious loans. Sanctions by the international community against Nigeria due to its poor human rights records also reduce the amount of resources available for reproductive health services and programs in Nigeria. The overall lack of transparency and accountability by the Government and its agencies work against real policy reform, especially that which would benefit women.

The implementation of Structural Adjustment Policies has also reduced government spending on social services and health. Nigeria's dependence on oil for foreign exchange and fluctuating and declining oil prices have also lowered government spending.

The high incidence of poverty in Nigeria seriously affects people's well being. Furthermore, the obsolete equipment and lack of a culture of maintenance in government institutions contribute to failing public utilities and infrastructure. Only about 50 per cent of people in Nigeria have access to potable water. The national electricity and communication systems are poor and irregular throughout the country.

The conservatism of senior civil servants and the persistent emphasis by ill-informed policy makers on fertility limitation together work against real progress on the ICPD Programme. Government officials often perceive NGOs to be competitors, not partners, and therefore block well meaning efforts by the latter. As a result, few credible NGOs are involved in programs that support women's rights and the inclusion of a gender perspective in national policies. Furthermore, there generally is insufficient accurate information available from relevant government institutions to make well-informed policy choices or interventions.

The lack of skilled health personnel is exacerbated by inadequate incentives or remuneration to retain the few skilled people there are in the country, and most trained experts leave for foreign countries.

Sexist and dehumanising cultural practices, such as female genital mutilation, bride price, and wife inheritance rights violate women's human rights and expose them to health risks. Three types of law exist in Nigeria, namely Sharia Law for the Muslim North, the statutory or so-called Civil Law established by the British colonialists, and customary law. All discriminate against women, either directly or through the absence of special forms of protection. For example:

- ~ Section 55 of the Criminal Code permits wife battering.
- ~ Section 357 of the Criminal Code excludes married women from the provision of rape; Regulations 122, 124 and 127 of the Police Act discriminate against police women in regard to marriage and single parenthood. A policewoman

- must obtain and show proof of being of good character in order to be allowed to marry. No such demand is made of a policeman. If an unmarried policewoman becomes pregnant, she is dismissed from duty;
- ~ There are no laws on domestic violence, no national policies against sexual harassment in the workplace or schools, no laws to prevent trafficking in girls and women; and no law regarding a minimum age at marriage that can stop the child marriage of girls; and
- ~ Under the Sharia Law, marriages can be arranged regardless of the consent and age of the woman. Seclusion of women is widely practiced, and a man can divorce his wife unilaterally by '*Talaq*,' by saying, "I divorce you," three times, an action that is not available to women.

Although Nigeria ratified CEDAW in 1985, discriminatory laws and practices still exist. The Government lacks the political will to create or review laws on the rights of women. There has also been a failure to translate conference documents and treaties into national policies and laws, and this contributes to the persistence of discrimination against women. For example, in the preamble to the Peoples' Bank and Community Bank, which was created to assist mainly rural women to get loans for cottage industries, women must have their husbands as guarantors, or use her or her husband's landed property as collateral. A woman cannot in effect contest for political position in her husband's community, where she may be regarded as a non-indigene, or in her parents' place, where she is regarded as no longer part of the community, but 'sold out' through her bride price. When a male is assaulted, the law regards it as a crime for which the penalty is three years in prison. The same offence against a woman is taken as a misdemeanour, a petty offence, and receives only a warning, not a jail sentence.

Recommendations

A government of popular democracy would be better able to implement policies that guarantees the well-being of citizens. Without a popular democratic government that involves all sectors of the population, including marginalised and oppressed women, adolescents, ethnic minorities, peasants and workers, poverty will continue to erode the wellbeing of the people.

There is a need to observe the provisions of the constitution. Obsolete laws must be reviewed in order to meet the present realities. Where laws to protect the rights of women do not exist, they should be created and enforced. Discriminatory and dehumanising practices must be abolished in law. There is need to harmonise the three types of law existing in Nigeria in line with the changing level of development and in accordance with the Programs of Action of the UN Conferences, Conventions and Treaties.

Governments must be responsive to people and carry out their responsibilities without abandoning them to NGOs. The problem of poverty must be addressed in a fundamental way, by social transformation through people-oriented policies.

Funding for NGOs that demonstrate transparency, accountability and gender equity through their programs should be supported by international funding agencies. There is need to build up the capacity of NGOs so that they can better complement Government services.

There is need for research, documentation and dissemination of sex disaggregated data, in order to inform policies and the planning and implementation of programs.

Conference documents must be widely circulated in an accessible form and language, and implementation plans drawn up in collaboration with all stakeholders. Media organisations should be educated and mobilised to disseminate this information.

5. Postscript

Since this paper was first written, a new political environment has been created in Nigeria with a change from military dictatorship to civilian government. Some important developments affecting reproductive health and rights have also taken place.

The change from the military to the civilian regime took place on May 29, 1999 when the current president of the Federal Republic of Nigeria, General Olusegun Obasanjo, was sworn into office. One campaign promise of the new President was the allocation of 30 per cent of all

appointed decision-making positions to women, but this promise was not honoured. The representation of women in decision-making positions has hardly improved. There are only four women out of a total of 49 ministers; three women out of the 109 senators; and eleven women among the 360 members of the House of Representatives. There is no female governor in any of the 36 states. Evidently the position of women has not changed much.

In October 1999, Islamic Sharia Law was introduced in Zamfara State in Northern Nigeria. The Governor of Zamfara claimed that the Sharia Law was instituted in order to fight prostitution, gambling, and other vices. The actual practice has been that in Zamfara state single women have been directed to get married within three months or lose their jobs. Women are prohibited from using public transportation with men. A man had his hand amputated for stealing a cow. These are but a few of the human rights violations presently occurring, five years after the Cairo Conference.

In February 2000, the Governors of Niger and Sokoto in Northern Nigeria signed bills under which Sharia Law is expected to come into effect in May 2000. The governors of Kano and Yobe states were reported to similarly be about to initiate Sharia Law in their states. When this action was being considered in Kaduna state, where there is a larger popular of Christians, it sparked a religious war with ethnic and political undertones which caused the loss of lives and property. The situation is still volatile despite a controversial "suspension" of the Shaira Law pronouncements. A coalition of women's organisations in Nigeria issued a joint statement about the unconstitutional restrictions imposed by Shaira Law and called on the Government to stop these human rights violations.

One issue addressed in the ICPD Programme of Action (Section 7.35) concerns violence against women and rape. Section 357 of Nigeria's Criminal Code also defines and stipulates punishment for rape. Yet women and girl victims of rape are jeered at and ridiculed, and the crime is trivialised. On November 7, 1999 newspapers throughout Nigeria reported that soldiers had rampaged in Choba, a city in the oil-producing Rivers State in Southern Nigeria. Choba women and teenage girls had been raped. The Government dismissed the report off-handedly, without instituting a formal enquiry.

On April 11, 2000, the Federal Ministry of Health inaugurated a National Working Group on Adolescent Reproductive Health to advocate,

promote and protect the reproductive health and wellbeing of young people throughout Nigeria. The objectives of the working group are to:

- ~ Deliberate on ways to promote the health and development of young persons in Nigeria;
- ~ Identify ways to achieve the strategies of the Adolescent Reproductive Health Framework of 1999;
- ~ Develop a two-year work plan based on the National Strategic Framework; and
- ~ Decide on ways to resuscitate the school health program in Nigeria.

The present civilian regime presents a more conducive and enabling environment for action to improve the sexual and reproductive health of girls and women. Many women's NGOs are also now working to create support for gender justice in Nigeria. ❄️

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¹ UNDP, 1999.

² Petchesky and Judd, 1998.

³ Delano, 1993.

⁴ Oyeneye, 1983.

⁵ Ministry of Health, 1988.

⁶ International Federation of Women Lawyers, 1997.

⁷ International Reproductive Right Research Action Group, 1995.

⁸ International Reproductive Right Research Action Group, 1995.

⁹ R. Booth, 1999.

¹⁰ International Federation of Women Lawyers, 1997.

Nigeria

❧ **Bene Madunagu** ❧

1. The national situation

Most African countries south of the Sahara currently face political, social or economic crisis. Various countries suffer political instability or civil war, and with it high levels of poverty, low levels of development, frequent natural disasters and persistent economic depression. This situation seriously affects the implementation of the International Conference on Population and Development (ICPD) Programme of Action throughout Sub-Saharan Africa. Six years after the ICPD Conference in Cairo in 1994, reproductive health is still generally very poor. Health services are inadequate, maternal and infant mortality is high, fertility is high, and few women use modern contraceptives.

In his statement to the Hague Forum on Cairo+5, Chris Ugokwe, Chairperson of the African Population Commission, asserted that, "Since the Dakar-Ngor Declaration and the ICPD Programme of Action, many African countries have undertaken a broad range of actions and have revised their population and development policies, made changes in their institutional infrastructures, and focused their attention on reproductive and sexual health and rights and gender issues." This contribution describes the extent to which this has happened in Nigeria.

Nigeria is the most heavily populated country in Africa, with almost 104 million people. The country is a federation of 36 states, and the Federal Capital Territory is located at Abuja. The states are subdivided into 589 local government areas. Structurally, therefore, there are three tiers of government in Nigeria: federal, state and local. National policies are defined and monitored by the Federal Government. The state and local governments are charged with implementing these policies.

Table 1 Development indicators for Nigeria

	1970s	1990s
Population size	57 mill	103.9 mill
Population growth rate (1975-1997)	-	2.8% av. ann.
Total fertility rate	6.9	5.2
Life expectancy at birth	42.7 yrs	50.1 yrs
Maternal mortality rate	-	1,000
Infant mortality rate	120	112
Under 5 mortality rate	201	187
Contraceptive prevalence	-	6%
	1990s gender gap	
	Female	Male
Life expectancy at birth	51.5 yrs	48.7 yrs
Net primary enrolment (6-15 yrs)	-	-
Adult literacy	50.8 %	68.5%

Source: UNDP Human Development Report, 1999

Although Nigeria's Constitution provides for the executive, legislative and judicial branches of the Government to act independently, effective rule is by the Army, which suspended the legislature by decree and limited the scope of the power of the judiciary. This situation has prevailed in Nigeria for 30 of its 38 years of existence as an independent country. Judges who dare to challenge the military often are removed.

In 1986, the Nigeria Government adopted a package of structural adjustment polices, which are being administered by the World Bank. Since then, various economic austerity measures have been prescribed and implemented by the Government, as well as currency devaluation (and consequent inflation), a reduction in government subsidies, privatisation of state enterprises, and a very steep reduction in government spending on social sectors including education, health, transportation and general welfare.

These policies have contributed to the escalation of rural poverty and deterioration of existing health care facilities.¹ Poverty is contributing to over-exploitation by peasant farmers of the little arable land available, despite its very low yield, and increased rural-urban migration. In turn, this contributes to the deterioration and over-stretching of facilities in the towns and cities. The conventional indicators of development status are generally in reversal. National average infant and maternal mortality rates are high by international standards, but they are even higher in some regions of Nigeria and may be rising.

Nigeria's very high maternal mortality and morbidity rates point to the low status of women in the country. In rural areas, where almost 80 per cent of the population lives, maternal death rates have been estimated up to 1,800 per 100,000 live births. Life expectancy at birth for women in Nigeria is approximately 51 years. Women are also very under-represented in politics and decision-making. There are no women members of the Federal Ruling Council, no women military administrators in any of the 36 states, nor any women chairs of Local Government councils. In summary, no woman is in any visible political or policy-making position.

This situation prevails despite Nigeria being signatory to the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC). It is also a signatory to the African Charter of Human and People's Rights which forms part of the domestic legal system. The 1979 Constitution of Nigeria also prohibits discrimination based on sex.

The slow speed - or almost absence - of policy changes to reflect the Cairo Programme of Action can be attributed to political instability and inconsistency, as well as to the high turnover of policy makers in all

the three tiers of governance. Even where policy exists, conservative, sexist forces that adhere to traditional, religious or cultural beliefs frustrate its implementation. The undemocratic military leadership does not provide an enabling environment for more progressive policies, and there are no alternative democratic structures of governance to do so.

2. Nigeria's health care system

In 1987, expenditure on health in Nigeria accounted for 0.8 per cent of the national budget. A year later, this had risen to 4.9 per cent. By the early 1990s, one third of the population still lacked access to basic health services, and there were only 21 doctors per 100,000 people.² Table 2 shows recent budgeted resources for health. Health expenditure has increased, but not enough to accommodate the recommendations of the Cairo Programme of Action.

Table 2 Public expenditure on health in Nigeria, 1994-98

Year	Capital Health Expenditure (\$N.mill)	Recurrent Health Expenditure (\$N.mill)	Expenditure on health as of total national budget
1994	—	—	2.7%
1995	1,759.7	2,746	2.5%
1996	1,659.5	3,638	3.4%
1997	4,720.4	2,623	5.0%
1998	4,860.5	7,070	4.9%

Since 1975, the Nigerian Government has used the primary health care (PHC) approach in providing national health care. The definition of PHC in Nigeria's National Health Policy meets World Health Organization (WHO) standard guidelines for general health services, namely, preventive, curative, promotional and rehabilitative care.

Providing basic health care is the responsibility of local Governments, under the supervision of State Ministries of Health. At

this primary level of care, the PHC programs provide a variety of services, through a total of 1,071 Local Government and private health centres, clinics, dispensaries, first aid stations and maternity centres.³ These centres were designed to provide basic health care, health education, simple laboratory tests, preventive care services, pre natal and post natal care for mothers, family planning, immunisation for children, oral dehydration therapy and nutritional education.⁴ Service providers at this primary level are supposed to refer patients to secondary and tertiary levels for specialised services.⁵ The practice, however, is much below these expectations.

The secondary level of care is provided at the state level and consists of 119 district hospitals and 780 general hospitals. This secondary level is designed to provide comprehensive community health care, with more specialised laboratory and other facilities than at the primary level.

Tertiary level care is the responsibility of the Federal Government, which also formulates health policy and provides specialised technical assistance and services. This tertiary level consists of 13 teaching hospitals and other urban-based tertiary institutions that provide largely curative services. The under-funding of these institutions that has come about through the application of the structural adjustment policies, excessive military spending and undemocratic government has substantially reduced the effectiveness of this hierarchy of services.

Government cuts in social services spending, including the health sector, have encouraged the emergence of high-cost private health systems that are beyond the reach of most people. In principle, the Federal, State and Local Governments are required to finance and provide medical and hospital services, but, in practice, their response is very poor. This situation has persisted since the ICPD Conference in Cairo, mainly because the repressive military rule and poor human rights record in Nigeria has brought international sanctions against the country.

No new policies have been formulated to specifically address women's health issues. Nor has much research been conducted in this field. There has been much rhetoric about women's empowerment, but no concrete critical debates that have contributed towards positive change. Rather than main-streaming gender concerns into government

activities, a new ministry was created which in practice has further marginalised women. The Women's Ministry has implemented no new policies or programs that address gender differences or women's health, or sought to increase knowledge and understanding about women's health, their health needs or sexual and reproductive rights.

Furthermore, since 1986, public health services have adopted the following cost recovery mechanisms:

- ~ *The sale of drugs and accessories:* Patients have to buy all drugs prescribed, including cotton-wool, syringes and needles, from the hospital, private pharmacies, or patient medicine stores. The current practice in rural and urban slums is to consult a medicine dealer - usually a person with no formal health training - and ask for a dose to counter whatever symptoms they describe. Some of these medicine dealers freely hawk medicines, including antibiotics, in the streets and open markets, even past their expiry dates. A new creation of the military Government called the Petroleum Trust Fund (PTF), which acts like an alternative government, also supplies drugs through its drug stores in all the states of the federation. These stores claim to supply drugs at reduced prices but there is no mechanism to check any price exploitation. Some wealthy businessmen, furthermore, buy off the PTF stock of drugs and sell them at high prices through their own drug stores.
- ~ *Purchase of Hospital Cards:* Patients must pay for their hospital card before any consultation with the medical officer. At each subsequent visit, payment is required before the person's file is retrieved.
- ~ *Administration fees:* Both in-patients and out-patients must pay fees to cover the administration costs of the service centre, even in a Government or public-owned facility.
- ~ *Blood transfusions:* Patients must make their own arrangements to buy blood and blood products for their treatment. Usually blood banks are in short supply or cannot store blood because of constant electricity failures.

- ~ *Treatment costs:* Patients admitted for surgery or for childbirth must pay for the theatre and anaesthesia, and supply candles and matches in case of a power failure. Irrespective of an emergency or the seriousness of the patient's situation, cash must be paid before any attention is given. Even having one's blood pressure or weight taken attracts a fee.

As a result of these costs, many women patronise quacks, traditional healers or spiritual homes, for they cannot afford modern medical care even in Government-run hospitals and health clinics. Either Government health decision-makers are not informed about the commitments the Government made in Cairo, or there is no political will to implement the ICPD Programme of Action - especially since it favours women who are under-represented and under-valued among the decision-makers.

3. Preparations for the Cairo Conference

The Department of Population Activities of the Ministry of Health was responsible for preparing Nigeria's contribution to the Cairo Conference. An expert group helped to draft the country position paper for the conference. The NGOs that participated in the PrepCom process together formed the Coalition of Nigerian NGOs on Health, Population and Development (CONNOHPD) which held workshops across the country to mobilise the views of the 'Voices from Below' on population policies. The information gathered was used to lobby official representatives and was also published into a booklet that was widely circulated throughout Nigeria and at the Cairo Conference.

The Department of Population Activities of the Federal Ministry of Health was about to set up an implementation committee for the Cairo Programme of Action when it was suggested that they wait for the outcome of the Beijing Conference, so both action plans could be implemented together. During this time, the Ministry for Women Affairs was created. This new ministry took over the implementation of both the Cairo and Beijing programmes of action, on the grounds that women's issues were central to both - but this instead complicated the outcomes of both. Women became pawns in the confusion that ensued from the actions of an

undemocratic military Government that has no sustainable processes of governance.

Women and health care

Nigeria has no social security system.⁶ Although the National Health Policy requires that the State and Local Governments provide health subsidies, this provision has been negated by the application of the structural adjustment policies. Traditional health care providers enjoy wide patronage. Women shy away from hospitals because of the costs they involve in time and money, but also because of the attitudes of health providers and the common belief that pregnancy is natural and therefore does not require special health care.

Traditional and spiritual healers are also the last resorts for intractable illnesses. While decisions as to when to seek medical attention are influenced by economic cost, there is a general lack of scientific knowledge about many illnesses.⁷ Breast cancer, for example, is commonly thought to come from evil forces. STDs are seen as diseases only of promiscuous people, and AIDS is considered by many to merely be an advanced STD. Government has done little to increase public understanding about HIV/AIDS. Much of this work is being done by NGOs, for HIV/AIDS is considerably more serious an epidemic than the number of reported cases would suggest. The number of cases has been grossly under-reported because it is derived from hospital records, where perhaps only about 20 per cent of infected people are seen.

Contraception is viewed as the responsibility of women. Even traditional methods are targeted at women, but this responsibility is not backed up with power to make decisions on such issues. The husband's consent is often required before a woman will be attended to at a family planning clinic. Contraceptive prevalence is low: 7.5 per cent for all methods and 3.8 per cent for modern methods.⁸ Among married women, the most common modern methods of contraception are the pill (29.7 per cent) and injected methods (24.3 per cent). The private sector is the primary source of contraceptives for women. Most cannot afford their cost. There is no law that explicitly regulates the sale or use of contraceptive drugs or devices or prohibits the advertising of contraceptives or the distribution of contraceptive information.

Existing policies and programs, such as the Safe Motherhood Initiative, Primary Health Care, and Maternal and Child Health services, target women in their reproductive years, providing services that women must pay for. There has been much talk about the empowerment of women through credit schemes but very little about women's sexual and reproductive rights or health, except by NGOs. One measure of the lack of seriousness about women's health is the absence of facilities to address serious health problems among women, such as cancer. There are only two mammogram machines in all of Nigeria, both privately owned and therefore inaccessible to all but a few women.

There is public denial about the prevalence of abortion, although hospital records reveal that poorly performed abortions are a major health problem for women of child bearing age.⁹ Of an estimated 50,000 maternal deaths each year, around 20,000 result from the complications of unsafe induced abortions. Even so, under Nigerian law, abortion is permitted only when a woman's life is in danger from a pregnancy. This restriction on abortion has not been removed since the Cairo Conference, despite the advocacy of many NGOs. On the other hand, some NGOs also impose their religious values on the issue of abortion, a problem expounded upon by Dr. Rakiya Booth, Director of Christian Health Association of Nigeria (CHAN) at the National Conference on Adolescent Reproductive Health in Nigeria, in January 1999.

'Way back in 1994, Ms. Susan Crane of International Family Health in London visited us in CHAN in the company of Mrs Ayo Tubi, the country representative of IPAS, to introduce the subject of Post Abortion Care, most especially Manual Vacuum Aspiration as an alternative to Dilatation and Curettage. I must say that in CHAN we were not very conversant with the subject at the time and the idea of Manual Vacuum Aspiration did not sink well with us. Then there was the question of the word 'abortion.' To us in CHAN, as to many others even today, 'abortion' meant only criminally induced termination of pregnancy, and as Christians we could not be associated with such. Because of this idea that we had, it was not easy at that time to see the needs of women who come to our hospital with complications of abortion, neither was it easy for us to manage these women non-judgmentally.

Let me add here that the story is now different in CHAN. Through awareness seminars, they understood that:

Abortion is usually considered to be a problem of women, both married and unmarried. When programs are planned to look into this problem, young women, who are equally affected with the problems of unwanted and early pregnancies and the complications of abortion, are often left out.

Many women face a destructive cycle of repeated unwanted pregnancies and unsafe, often illegal, abortions. In many instances, comprehensive family planning is lacking.

STD services are rarely linked to post-abortion care and often women with complications of abortion also have one STD or another' (Booth 1999).

Following these decisions, in the last quarter of 1995, CHAN started to provide post-abortion complication services with the full involvement of International Family Health and IPAS. Throughout Nigeria, particularly the rural areas, unsafe abortions are nevertheless common and post abortion care is unskilled and not affordable, if available at all.

Unlike abortions, sterilisation is legal if performed for life, health, eugenic or contraceptive purposes.¹⁰ It is not, however, a common method of contraception in Nigeria - much less so, in fact, than abortion, which is illegal. The fact that many women choose abortion indicates their assertion of their reproductive rights, even if clandestinely, so declaring that women will exercise the right of choice over what happens to their bodies.

Adolescent Reproductive Health

The Federal Government produced a National Adolescent Health Policy in 1995, after the Cairo Conference. In the section on Sexual and Reproductive Health, the policy states that, "Emphasis here is on responsible sexual behaviour and positive attitudes to sexuality as a means of preventing unwanted pregnancies..." This does not address other sexual and reproductive health needs of adolescents. It is only in the area of female genital mutilation, or female circumcision, that some progress has

been made, although no law yet prohibits the act. In January 1999, however, a collaborative partnership among Government, funding agencies, and NGOs developed a framework to implement the provisions of the Adolescent Health Policy.

The implementation of the Cairo Programme of Action by Nigerian NGOs

Several health-related NGOs have recently established themselves in Nigeria, particularly since the Cairo Conference. They are addressing various issues of the ICPD Programme of Action, from environmental issues, adolescents' and women's empowerment, human rights and reproductive health. Some of the significant contributions these NGOs are making towards implementing the ICPD Programme are:

- ~ Since 1995, CHAN, in partnership with IFH and IPAS, has been providing Post Abortion Care, including evacuation of retained products of conception, post abortion family planning, screening for and education on STDs and HIV, and linking up with other health institutions for patient referral. This shows that comprehensive reproductive health services can be developed when there is a will to do so;
- ~ Since 1996, the Planned Parenthood Federation of Nigeria has included sexuality education in its adolescent reproductive health programs;
- ~ The Association for Reproductive and Family Health provides sexuality and reproductive health education through its Family Life Education or Life Planning Education, counselling and clinical services. Its mission to develop a holistic and innovative health services has included setting up model service delivery points that encourage the active participation of their clients. One of the Association's successful programs is 'Promoting Improved Adolescent Reproductive Health in Ibadan Metropolis,' an initiative supported by the British Department for International Development (DfID);
- ~ Action Health Incorporated conducts sexuality education, peer training, counselling and clinical services for

- adolescent girls and boys; and
- ~ Girls' Power Initiative is unique in the sexuality, sexual and reproductive health and rights training it provides for adolescent girls. The program also provides skills training, recognising that the prevalence of poverty among adolescents makes them vulnerable to sexual exploitation. GPI also provides counselling and referral services.

The achievements of Nigerian NGOs were summarised in their joint report to the Hague Forum. These included:

- ~ Training of some health and para-legal workers on Reproductive Health and Rights;
- ~ Making reproductive health services available for women and adolescents in some areas;
- ~ Conducting research on important health and rights issues;
- ~ Holding photo exhibitions, seminars and workshops to increase public awareness about reproductive health and rights in Nigeria; and
- ~ Conducting reproductive health workshops and projects with groups of people with disabilities.

4. Summary and conclusions

Since Cairo, there has been an upsurge of NGO activity to increase public awareness about issues of women's empowerment and reproductive health, and the sexual health and rights of adolescents. While there has been increased public and media discourse on women issues, some of this has been quite cynical. For instance when a woman asserts her views on an issue, other people may make derogatory remarks, such as, "These Beijing people have come again," or, "What do you women want?" There has been a conscious mobilisation of women through the '100 Women Group' strategy to increase political awareness and involvement of women in electoral politics and national decision-making.

Through the ICPD process, a Coalition of Nigerian NGOs on Health, Population and Development was created to mobilise the views of civil society and disseminate information about the Programme of Action to the community in simple language and form. A partnership of NGOs, relevant governmental ministries, and religious institutions has produced national guidelines on sexuality education.

In 1998, the National Council of Health recommended the adoption of Comprehensive Reproductive Health in the context of Primary Health Care, in line with the ICPD Programme of Action.

In January 1999, the Federal Ministry of Health, UNFPA, WHO, UNICEF, international foundations, other funding agencies, and NGOs, together produced a framework for the implementation of the National Policy on Adolescent Reproductive Health.

In March 1999, the National Immunisation Board was created to support the Expanded Program on Immunisation that would reduce infant mortality by eliminating childhood infections such as poliomyelitis. Efforts to sensitise young people about responsible sexual behaviour have included research and documentation on issues affecting adolescent and women's health, including violence against women; and greater collaboration among NGOs, donors, the media, communities and government.

NGO and Government are, in partnership, working towards a national policy to eliminate Female Genital Mutilation, and have drafted a national policy on STDs and AIDs.

Barriers and constraints

The undemocratic military dictatorship in Nigeria creates an environment that inhibits democratic policy changes or national action to support human rights. The large military budget, including the cost of keeping troops in foreign countries, drains the economy. So too do corruption by national leaders and the debt servicing of dubious loans. Sanctions by the international community against Nigeria due to its poor human rights records also reduce the amount of resources available for reproductive health services and programs in Nigeria. The overall lack of

transparency and accountability by the Government and its agencies work against real policy reform, especially that which would benefit women. The implementation of Structural Adjustment Policies has also reduced government spending on social services and health. Unfavourable market forces and Nigeria's dependence on oil for foreign exchange have caused oil price fluctuations and declines to also lower government spending.

The high incidence of poverty in Nigeria seriously affects people's well being. Furthermore, the obsolete equipment and lack of a culture of maintenance in government institutions contribute to failing public utilities and infrastructure. Only about 50 per cent of people in Nigeria have access to potable water. The national electricity and communication systems are poor and irregular throughout the country.

The conservatism of senior civil servants and the persistent emphasis by ill-informed policy makers on fertility limitation together work against real progress on the ICPD Programme. Government officials often perceive NGOs to be competitors, not partners, and therefore block well meaning efforts by the latter. As a result, few credible NGOs are involved in programs that support women's rights and the inclusion of a gender perspective in national policies. Furthermore, there generally is insufficient accurate information available from relevant government institutions to make well-informed policy choices or interventions.

The lack of skilled health personnel is exacerbated by inadequate incentives or remuneration to retain the few skilled people there are in the country, and most trained experts leave for foreign countries.

Sexist and dehumanising cultural practices, such as female genital mutilation, bride price, and wife inheritance rights violate women's human rights and expose them to health risks. Three types of law exist in Nigeria, namely Sharia Law for the Muslim North, the statutory or so-called Civil Law established by the British colonialists, and customary law. All discriminate against women, either directly or through the absence of special forms of protection. For example:

- ~ Section 55 of the Criminal Code permits wife battering.
- ~ Section 357 of the Criminal Code excludes married women from the provision of rape; Regulations 122, 124 and 127 of the Police Act discriminate against police women. A

policewoman must obtain and show proof of being of good character in order to be allowed to marry. No such demand is made of a policeman. If an unmarried policewoman becomes pregnant, she is dismissed from duty;

- ~ There are no laws on domestic violence, no national policies against sexual harassment in the workplace or schools, no laws to prevent trafficking in girls and women; and no law regarding a minimum age at marriage that can stop the child marriage of girls; and
- ~ Under the Sharia Law, marriages can be arranged regardless of the consent and age of the woman. Seclusion of women is widely practiced, and a man can divorce his wife unilaterally by '*Talaq*,' by saying, "I divorce you," three times, an action that is not available to women.

Although Nigeria ratified CEDAW in 1985, discriminatory laws and practices still exist. The Government lacks the political will to create or review laws on the rights of women. There has also been a failure to translate conference documents and treaties into national policies and laws, and this contributes to the persistence of discrimination against women. For example, in the preamble to the Peoples' Bank and Community Bank, which was created to assist mainly rural women to get loans for cottage industries, women must have their husbands as guarantors, or use their own or their husbands' land as collateral. A woman cannot in effect contest for political position in her husband's community, where she may be regarded as a non-indigene, or in her parents' place, where she is regarded as no longer part of the community, as she has been 'sold out' through her bride price. When a male is assaulted, the law regards it as a crime for which the penalty is three years in prison. The same offence against a woman is taken as a misdemeanour, a petty offence, and receives only a warning, not a jail sentence.

Recommendations

A government of popular democracy would be better able to implement policies that guarantees the well-being of citizens. Without a popular democratic government that involves all sectors of the population,

including marginalised and oppressed women, adolescents, ethnic minorities, peasants and workers, poverty will continue to erode the wellbeing of people.

There is a need to observe the provisions of the constitution. Obsolete laws must be reviewed in order to meet the present realities. Where laws to protect the rights of women do not exist, they should be created and enforced. Discriminatory and dehumanising practices must be abolished in law. There is need to harmonise the three types of law existing in Nigeria in line with the changing level of development and in accordance with the Programs of Action of the UN Conferences, Conventions and Treaties.

Governments must be responsive to people and carry out their responsibilities without abandoning them to NGOs. The problem of poverty must be addressed in a fundamental way, by social transformation through people-oriented policies.

Funding for NGOs that demonstrate transparency, accountability and gender equity through their programs should be supported by international funding agencies. There is need to build up the capacity of NGOs so that they can better complement Government services.

There is need for research, documentation and dissemination of sex disaggregated data, in order to inform policies and the planning and implementation of programs.

Conference documents must be widely circulated in an accessible form and language, and implementation plans drawn up in collaboration with all stakeholders. Media organisations should be educated and mobilised to disseminate this information.

5. Postscript

Since this paper was first written, a new political environment has been created in Nigeria with a change from military dictatorship to civilian government. Some important developments affecting reproductive health and rights have also taken place. This section summarises these changes.

The change from the military to the civilian regime took place on May 29, 1999 when the current president of the Federal Republic of Nigeria, General Olusegun Obasanjo, was sworn into office. One campaign promise of the new President was the allocation of 30 per cent of all appointed decision-making positions to women, but this promise was not honoured. The representation of women in decision-making positions has hardly improved. There are only four women out of a total of 49 ministers; three women out of the 109 senators; and eleven women among the 360 members of the House of Representatives. There is no female governor in any of the 36 states. Evidently the position of women has not changed much.

In October 1999, Islamic Sharia Law was introduced in Zamfara State in Northern Nigeria. The Governor of Zamfara claimed that the Sharia Law was instituted in order to fight prostitution, gambling, and other vices. The actual practice has been that in Zamfara state single women have been directed to get married within three months or lose their jobs. Women are prohibited from using public transportation with men. A man had his hand amputated for stealing a cow. These are but a few of the human rights violations presently occurring, five years after the Cairo Conference.

In February 2000, the Governors of Niger and Sokoto in Northern Nigeria signed bills under which Sharia Law is expected to come into effect in May 2000. The governors of Kano and Yobe states were reported to similarly be about to initiate Sharia Law in their states. When this action was being considered in Kaduna state, where there is a larger population of Christians, it sparked a religious war with ethnic and political undertones which caused the loss of lives and property. The situation is still volatile despite a controversial "suspension" of the Sharia Law pronouncements. A coalition of women's organisations in Nigeria issued a joint statement about the unconstitutional restrictions imposed by Sharia Law and called on the Government to stop these human rights violations.

One issue addressed in the ICPD Programme of Action (Section 7.35) concerns violence against women and rape. Section 357 of Nigeria's Criminal Code also defines and stipulates punishment for rape. Yet women and girl victims of rape are jeered at and ridiculed, and the crime is trivialised. On November 7, 1999 newspapers throughout Nigeria reported that soldiers

had rampaged in Choba, a city in the oil-producing Rivers State in Southern Nigeria. Choba women and teenage girls had been raped. The Government dismissed the report off-handedly, without instituting a formal enquiry.

On April 11, 2000, the Federal Ministry of Health inaugurated a National Working Group on Adolescent Reproductive Health to advocate, promote and protect the reproductive health and wellbeing of young people throughout Nigeria. The objectives of the working group are to:

- ~ Deliberate on ways to promote the health and development of young persons in Nigeria;
- ~ Identify ways to achieve the strategies of the Adolescent Reproductive Health Framework of 1999;
- ~ Develop a two-year work plan based on the National Strategic Framework; and
- ~ Decide on ways to resuscitate the school health program in Nigeria.

The present civilian regime presents a more conducive and enabling environment for action to improve the sexual and reproductive health of girls and women. Many women's NGOs are also now working to create support for gender justice in Nigeria.

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Brazil

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1. Before Cairo

In the late 1970s, Brazil started a long and tumultuous democratization process, accompanied by continued economic crises. The first civil president was elected, by indirect vote, in 1985 and a new constitution was approved in 1988. The first directly elected president (1989) was, however, impeached three years later on charges of corruption. From 1980 to 1994, eight economic stabilization plans, five price freezes, and five currency changes were implemented. The last inflation control strategy adopted in 1994, the '*Plano Real*,' despite its initial success, was derailed by the 1997-1999 global financial crisis, and this led to an emergency agreement with IMF and a further currency devaluation. Only in the first half of 2000 did Brazil's economy show slight signs of recovery, but whether this growth can be sustained remains to be seen.

Health policies and demographic patterns have also dramatically changed over the last three decades. During the 1970s, the number of patients admitted to public hospitals jumped from 2.9 million to 9.6 million, an increase that was achieved through the contracting out of public services to private operators. Even so, in 1980, 30 million people still did not have access to health services, management of the system was fragmented, and most services were hospital based. Since then Brazil has mobilised to remedy these distortions.

During the 1970s, fertility decreased rapidly. Over the decade 1970 to 1980, fertility declined around 25 per cent nationally, and up to 30 per cent in some regions. This was an unanticipated impact of policies implemented during the military regime, namely the combined expansion of hospital networks, consumer credit, and communication systems - particularly TV - and wider coverage by the social security system. Changes resulting from these interventions led to a preference for smaller families and created among women a growing demand for fertility regulation.

As democratisation progressed, political demands gained momentum for health reform and a clear policy response to women's reproductive needs. The health reform movement led to the provisions of the 1988 Constitution that established the Universal Health System. This provided integrated and decentralised services that included social control mechanisms. Unlike other countries, health reform in Brazil was implemented as a component of fiscal adjustment, yet, to the contrary, it strengthened the public sector and increased public financing. From the early 1980s, feminist groups were already struggling for public distribution of contraceptives and for the legalisation of abortion.

In 1982, a Congress Investigation on Population discussed the fertility decline. Two years later in 1984, the Ministry of Health launched the Women's Comprehensive Health Program (PAISM), which encompassed pre-natal care, birth and post-natal assistance, cancer prevention, care of sexually transmitted diseases, adolescent and menopausal care, and contraception assistance. PAISM preceded the Cairo agenda by a decade. Despite religious lobbying from both Catholics and Protestants, the Constitutional Reform of 1986-1998 did not include the 'the right to life since conception' premise, but instead guaranteed the rights of individuals to make their own reproductive decisions, along with public access to family planning services and information.

Preparations for Cairo took place in 1993 and 1994 during a period of political transition. The priority of the Ministry of Health was to reduce infant mortality, and PAISM had returned to a conventional maternal-child health approach. In preparing for the ICPD, however, PAISM's original program principles were revived. In September 1993, women's organisations met at the National Congress, where both PAISM implementation and abortion legalisation were confirmed as the priority demands.² The positions adopted by the Brazilian Government in Cairo, and one year later in Beijing,

were consistent with the 1988 Constitution, and had been endorsed by civil society.

2. The Post-Cairo Challenges

Between 1984 and 1988, PAISM introduced technical standards, distributed educational materials, provided training, and improved awareness among health professionals. Feminist NGO's were involved in these initiatives. After 1989, economic, institutional and political turmoil hindered its implementation. By 1995, in spite of ten years of sustained advocacy and effort, not much had been achieved. Most Ministry of Health policy-makers and local managers for the Universal Health System were not acquainted with either the PAISM guidelines or the Cairo or Beijing recommendations. Moreover, reproductive health indicators clearly indicated that a new and consistent policy framework was required, in order to fulfil Brazil's international commitments.

Maternal Mortality

In spite of Brazil's long-standing maternal and child health policy, maternal mortality in 1990 was estimated at 114 maternal deaths per 100,000 live births - an unacceptable situation in a country where over 85 per cent of births occurred in a hospital setting. It had long been known that over 90 per cent of maternal deaths could be avoided if pre-natal and obstetric care was improved, especially for incomplete abortions. By 1995, the major causes of maternal mortality were pregnancy-related high blood pressure (hypertension), followed by infection, hemorrhage and abortion.

From 1985, Maternal Mortality Committees were created in various states. In March 1994, the Ministry of the Health declared May 28 to be the National Day of the Reduction of Maternal Mortality. On this day, evaluations were to be undertaken of the quality and efficacy of maternal health programs at all levels of the Universal Health System. Soon afterwards, a National Commission for the Prevention of Maternal Mortality was established, and the 'Safe Motherhood Initiative' gained importance in the Ministry of Health. This National Commission did not really get under way and the effectiveness of the State committees was uneven.

By 1996, no major improvement could be observed at the clinic level, as the testimony of Dr. Tania Lago, the coordinator of PAISM, demonstrated:

“In a hospital run by the state of São Paulo, women were walking around wrapped in sheets, with no underwear. The management’s explanation was that if their clothes remained at the hospital, they would be stolen, and then the women would blame the hospital for the theft... Faced with such primitive conditions, any change would be significant.”

Contraceptive Assistance

Until 1985, the public health system did not offer contraceptive methods. The demand from women was responded to by non-governmental family planning agencies, and also by the market. The quality of information and care provided by these outlets was poor, and side effects and failures were common. Gradually, women started to discredit reversible methods of family planning. In a context where abortion was illegal, this favoured a preference for female sterilisation. By the late 1970s, tubal ligation began to be offered by private hospitals, contracted services, and individual physicians. The ambivalent legal status of tubal ligation gave rise to various schemes to facilitate access, such as associating it with cesarean operations, or paying physicians separately. In some areas, especially the Northeast, a perverse system of bartering votes for sterilisation occurred during election periods.³

Between 1986 and 1996, contraceptive use among married women grew from 65.8 per cent to 76.7 per cent. The use of the pill declined from 28.7 per cent to 20.7 per cent. A significant increase was observed in condom use, from 1.3 per cent to 4.4 per cent, and vasectomies, from 0.6 per cent to 3.4 per cent. But sterilisation rates also rose from 31.1 per cent to 40.1 per cent. Tubal ligation accounted for 52.3 per cent of the married women who were contraceptive users. In preparing for the Cairo Conference, Dr. Elza Berquó coined the expression “*the culture of sterilisation*” to describe the preference for female sterilisation that involved women of different generations and races, and physicians themselves.

By 1996, this situation still existed, and contributed to unnecessarily high caesarean rates and the limited range of contraceptive choices offered by the Universal Health System.

Abortion

Brazil's Penal Code of 1940 authorises abortions in only two instances: rape and life-threatening circumstances. Until the late 1980s, however, access to any abortion procedure was practically non-existent. In 1985, a legislative initiative was launched in Rio de Janeiro to make this access mandatory, but although the bill was approved in the State Assembly, it was vetoed by the Governor. A different approach was adopted in São Paulo. According to legal experts, the Penal Code automatically permitted access to abortion services for the allowed cases. A first 'legal' abortion service began operating in Jabaquara Hospital in 1989. By 1994, however, only one other service had been established. While these services did not require specific legislation, a bill (PL20-1991) was introduced in Congress in 1991 to ensure universal access. Soon after the Cairo Conference, besides PL-20/91, four other bills were pending at the National Congress, all intending to expand the legalisation of abortion.

Besides making 'legal' abortion accessible, great challenges remained with respect to post-abortion care. In 1996, the public health system carried out 300,000 post-abortion curettages. Women who sought out public services after undergoing a clandestine abortion were still being brutalized and, in many cases, the quality of their medical care left much to be desired.

Other critical issues

A consistent policy should also address other relevant aspects of sexual and reproductive health. By 1998, implementation of the adolescent health program was limited and uneven. Cervical cancer screening remained very restricted. Most importantly, the incidence of HIV-AIDS in women was skyrocketing. The ratio of infected males to infected females declined from 40:1 in the mid-1980s, to 6:1 by the mid-1990s.

3. The Policy Environment

New federal and state administrations were inaugurated in early 1995. This political environment offered an opportunity to revive the reproductive health agenda. In that year, preparations for the Fourth World Conference for Women in Beijing had a great impact on the media, institutions, and society. This was a step forward, for the Platform of Action from the Beijing Conference reaffirmed and extended the agreements reached at Cairo on health and reproductive rights, especially regarding abortion and sexual rights. Nevertheless, the economic stabilisation program was imposing ever-tighter fiscal constraints, and this was constraining federal public spending, particularly in the social sectors. By 1998-1999 this situation was further aggravated by a devaluation crisis. In Congress, State reform was the legislative priority, and this further delayed important debates relevant to the implementation of the Cairo and Beijing recommendations.

Overall health policy also remained unclear. From 1993, decentralisation rules and technical-political mechanisms for the Universal Health System were being consolidated, and in 1994, primary care strategies were adopted. Financial instability however persisted. Only at the end of 1996 were health funding constraints temporarily resolved by creating a new source of financing, namely the Temporary Fee on Financial Transactions, which collected a tax of 0.20 per cent from all bank transactions. In August 2000, the Brazil Senate finally approved PEC-1999, a constitutional amendment that identifies the sources of health financing and the distribution of responsibility between federal, state and municipal levels.

Since 1995, the quality of services provided by the Universal Health System services has been a major issue of public debate. New ideas about reforming the system have circulated, most advocating the privatisation of services for higher income groups and basic health services for lower income groups. Between 1995 and 1998, however, there were three different health ministers, and widespread restructuring of programs and personnel.

Table 1 Brazil's Universal Health System

Coverage: Universal, free, all-inclusive benefit package. The Universal Health System provides over 70 per cent of out-patient and hospital care. In 1997, it was responsible for 11.8 million hospitalizations and more than 320 million medical appointments. For approximately 120 million Brazilians, the Universal Health System is the sole source of medical care.

Services: Services are organized under a hierarchical structure. Decentralisation rules aim to transfer responsibility for service provision to local government. The Ministry of Health is responsible for establishing norms and regulations, and the State Governments are involved in planning.

Community Health Agents Program (PACS) This program supports the work of health agents, mostly women, who conduct follow-up visits and health education. Each agent is responsible for around 166 households.

Family Health Program (PSF) This program works with PACS to promote health, basic care and door-to-door assistance. Teams comprise a general practitioner, nurse, nurse's aid and community agents. Each is responsible for between 600 and 1,000 households.

Endemic Diseases and Sanitation: The Federal Government is responsible for basic sanitation and the control of endemic diseases.

Management: The implementation of the Universal Health System requires a system of negotiation between the Federal, State and Municipal Governments. At state level, Bipartite Commissions involve both state and local health departments. At the federal level, the Tripartite Commission includes the Ministry of Health, the National Council of State Health Departments, and the National Council of Municipal Health Departments.

Accountability Mechanisms: At federal and state levels, and in most municipalities, health councils have been established. Half of the participants are users, and the other half comprises government officials, service providers and health workers. Health councils are responsible for monitoring the implementation of programs and expenditure of health funds. National Health Conferences are held every four years, and involve preparatory activities in the states and municipalities.

Reproductive Health and Health Reform

The structure and goals of the Universal Health System were designed around experiments and programs that took shape during the 1980s. PAISM was among these pioneer initiatives, but it developed in a different way, as a special program to cater for specific target groups and epidemiological problems. After 1995, one of the most difficult tasks was to reactivate PAISM's reproductive health agenda while at the same time adjusting the organisation's strategies to mesh with the operating modality of the Universal Health System, in particular its goals of integration and decentralization.

A major task in the post-Cairo and Beijing period was to reduce the fragmentation of reproductive health programs and their isolation from one another. In 1988, a special program was set up for adolescent health and the National AIDS Program was established. The National Cancer Institute continued to monopolise national policies on cervical and breast cancer, through its chain of hospitals and diagnostic centres.

By 1995, PAISM was working mainly with coordinating offices at state level. The program had almost no contact with local area managers. Most state and local managers were not convinced of the importance of responding to reproductive health needs.

Accountability Mechanisms

In early 1995, a reproductive health and rights activist was appointed to the National Health Council. Later that year, a presidential decree created the National Commission on Population and Development as an advisory body to monitor policies and conduct studies on areas relevant to population and development, in line with ICPD recommendations. In March 1996, the National Council on Women's Rights signed an agreement with the Ministry of Health to implement a cervical cancer program and improve contraceptive assistance.

In November 1996, the Women's Health Cross-Sectorial Commission (CISMU) began operation as a National Health Council, together with the National Commission on Population and Development, the National Council on Women's Rights, and the National Feminist Network for Reproductive Health and Rights. These efforts helped to reactivate and

support a comprehensive reproductive health policy. The work performed by these bodies aided dialogue and collaboration between various program components - pre-natal and obstetric care, cervical cancer, adolescent health, abortion, and HIV/AIDS - that had been operating separately.

Since 1998, the CNPD and the National Council on Women's Rights have facilitated dialogue and analysis on the implementation of the Cairo and Beijing action plans. Most importantly, these institutions have helped ensure Brazil's progressive stance in the Cairo+5 and Beijing+5 negotiations at the United Nations in 1999 and 2000.

Ministry of Health initiatives

In July 1997, new Ministry of Health coordinators, strongly committed to PAISM, were appointed. A new Minister took office in April of the following year and the pattern of coordination shifted again. Since 1997, however, reproductive health, in its broadest sense, has been high on the Ministry's agenda. Factors that have contributed to this are:

- ~ The long history of advocacy for sexual and reproductive health and rights, including the previous existence of a consistent policy frame and the Federal Government's priority for integrated health services for women;
- ~ Allocation of additional resources to reproductive health and the definition of new program strategies, including the restructuring of PAISM's national coordination system; and
- ~ The general emphasis in the health sector on primary health care, decentralisation of services, and the sharing of exemplary experiences.

Prenatal Care: The expansion of primary health programs has brought about a significant increase in pre-natal consultations, from 1.8 million in 1994 to 7.6 million in 1998, with almost 80 per cent of this increase occurring after 1997. Even so, in 1998 the average number of consultations per pregnancy remained very low, at around three clinic visits. In 1999, to address this, the goal of providing at least six consultations per pregnancy was incorporated into the Pact for Health, agreed to by the Universal Health System at all three levels of its operation: federal, state and municipal.

Obstetric Assistance: A state-level referral system has been created for high-risk pregnancies. This has involved the re-structuring of 158 hospitals and maternity wards throughout Brazil. The Ministry of Health has also raised by 30 percent the fee for childbirth procedures, for both the services used and doctors.

Measures have been taken to reduce the high rates of caesarean births, for these are associated with high levels of maternal and neo-natal morbidity and mortality. A maximum number of caesarean to normal deliveries has been set, above which hospitals are not paid by the Universal Health System. This ceiling figure is gradually being brought down, from 40 per cent in late 1998 to 30 per cent by mid-2000.

New birth procedures, including the use of anaesthesia during normal delivery, have been introduced. Research has found that practitioners have opted to perform caesarean deliveries because anaesthesia was not available to deal with complicated deliveries in other ways. The impact of providing anaesthesia was immediate: the Universal Health System found that the annual rate of caesarean deliveries dropped from 32 percent in 1998 to 28 per cent less than a year later. In 1999, a new program has been developed to encourage the establishment of natural childbirth units across the country.

Data collection on maternal and child health: Data collection on maternal and neo-natal morbidity and mortality is being improved. The Ministry of Health has lobbied for the approval of new legislation (Law no. 9.534/97), to guarantee free registration of births and deaths. This will assist poor people who often can not afford to pay for birth and death certificates. It will also improve Brazil's vital statistics and health indicators, especially on maternal mortality.

Maternal mortality: A benchmark for maternal mortality was set in 1994 at 114 per 100,000 live births, but this is now considered too high, even taking into account the wide regional variations that exist. New goals for maternal mortality reduction have been defined. The Ministry of Health also is mobilising and supporting Maternal Mortality Committees. Currently, 27 of these committees operate at state level, 151 at a sub-regional level, 249 at municipal level and 38 within hospitals. In early 1999, the National Commission of Maternal Death was reactivated.

Cervical Cancer: In 1996, the Ministry of Health signed a Protocol of Cooperation with the National Council of the Woman's Rights, to work together on contraceptive provision and cervical cancer prevention. A pilot program started in five capital towns that same year, coordinated by the National Cancer Institute. Two years later in 1998, the Ministry launched a large national program that aimed to screen four million women over 35, who had not previously been screened, and train 1,300 health professionals. Known as the 'Cervical Cancer Campaign,' this program involved cervical cancer coordination units at state levels in screening 3.1 million women at a cost of R\$57 million (approximately US\$35 million). More resources were given to state health departments to continue the program.

Feminist advocates and public health activists criticised several aspects of the Cervical Cancer Campaign. Its scale and pace across the country sent existing programs into disarray. No proper referral system was established to treat the cancers that were detected. In early 1999, the program went back to the National Institute of Cancer. Further monitoring of its progress has become very difficult, even for CISMU.

Contraceptive Assistance: The Ministry of Health has tried several times through the Universal Health System to resolve problems of access to contraceptives. Given the prevailing 'culture of sterilisation' and logistical difficulties with the purchase and distribution of reversible methods, this has been difficult. Since 1996, progress has been made in distributing condoms through programs for sexually transmitted diseases (STDs) and AIDS. The Ministry of Health has also supported an introductory trial for female condoms and approved emergency contraception for women who have been raped. There has been no consistent articulation between these efforts and the work of PAISM. By mid-2000, the Ministry was providing reversible contraceptive methods through the Universal Health System.

Abortion: Since 1995, the debate over abortion has been constant and heated in both the public and legal domains. These debates have nevertheless had a positive impact on national policy. While in 1994, only two 'legal' abortion services were operating, by 2000, 26 services had been established. In October 1998, the Ministry of Health adopted the 'Protocol for the Care of Women Victimized by Violence,' which regulates procedures for providing abortion in the two situations permitted by law.

STDs and HIV: The two main links between the National HIV/AIDS Program and PAISM have been acceptability trials conducted for female condoms and the development of a strategy to address vertical transmission of HIV, through testing, counseling and AZT treatment. There has been little other connection. Media campaigns focus principally on women and the use of male condoms is being stimulated largely through women's health activities.

Intensive efforts are being made to expand free STD and HIV testing among women through pre-natal services and other means. World Bank support for the national HIV-AIDS Program also supports women's NGOs working in HIV prevention. The Ministry of Health has also sponsored a national survey on sexuality that has involved interviews with 3,600 households. Infection among married women is high and rising, and public concern with risky male behavior has grown.

Black Women's Health: The Ministry of Health is implementing a Sickle Cell Disease Program, which, in a few municipalities, has been integrated into the Family Health Program and the Community Health Agents Program. Financial support has been provided for research and clinical activities in two Quilombo communities, in the states of Sergipe and Bahia.⁴ Another important measure has been the introduction of ethnicity as a standard category of information to be included on birth and death certificates.

Youth: The Adolescent Health Program is being re-structured. In 1999, an International Seminar on Adolescent Pregnancy was conducted. Educational materials being produced encourage health and education professionals to adopt contemporary approaches to youth issues such as sexuality, HIV prevention and early pregnancy. Training is being conducted for health professionals at all levels of the Universal Health System.

Health, Gender and Violence: The Ministry of Health participates in two committees of the National Human Rights Program: Domestic and Sexual Violence against the Woman, and Violence against Children and Youth. These committees are working to define common guidelines and strategies. The Ministry also provides technical support to states and municipalities that are implementing strategies to prevent violence and care for its victims, particularly in regard to legal abortion services. Community health agents are being trained in women's human rights.

4. Health expenditures: their volume and composition

At a conservative estimate, public and private health expenditures in Brazil total around R\$50 billion, which represents almost 7 per cent of GDP and amounts to R\$320.00 per capita. In 1995, the public sector invested the equivalent of R\$21.7 billion on health, approximately 3.3 per cent of GDP, or R\$140.00 per capita.

The Federal Government is responsible for 63 per cent of public expenditure on health. The 26 states and the capital contributed 20.6 per cent of the public health budget. The remaining 16.4 per cent came from funds generated by the 5,506 Brazilian municipalities.

Private expenditure includes direct expenses made by families and corporate expenses on health plans for employees and dependents. In 1996, direct family expenses in the metropolitan regions reached R\$ 13.3 billion, or 1.8 per cent of GDP. Extrapolated to other regions of the country, this amount would total R\$22.1 billion nationally, or 2.9 per cent of GDP. Corporate expenditure was estimated to be R\$5.1 billion, or 0.7 per cent of GDP in 1996.

Reproductive health expenditure

Between 1995 and 1997, federal expenditure on reproductive health grew 34 per cent, from R\$834 million in 1995 to R\$1.119 billion in 1997. As a percentage of all Ministry of Health out-patient and hospital expenditure, spending on reproductive health increased from 11.2 per cent in 1995 to 13.6 per cent in 1997 (Table 2).

Table 2. Federal Government Expenditure on Reproductive Health, 1995-97
(Figures in Reais \$thousand, Dec.1997)¹

Description	1995	1996	1997
Total expenditure on reproductive health:	834,249	912,681	1,119,495
Out-patient care services	134,073	149,021	157,070
Hospital services ²	694,263	715,419	716,576
Women's Health coordination	5,315	4,785	3,059
STDs and HIV/AIDS	-	41,148	242,790
Condoms	598	2,308	
Total Ministry of Health expenditure:	18,506,000	15,855,000	19,036,000
Total out-patient services	3,804,308	4,088,639	4,364,554
Total hospital services	3,659,491	3,830,812	3,831,955
Expenditure on reproductive health as % of:			
Out-patient and hospital services	11.2	11.5	13.6
Total Ministry of Health expenditure	4.5	5.7	5.9

Notes:

1. The exchange rate is US\$1 = R\$1.8.
2. Includes procedures related to male reproductive health of R\$ 26.2 million in 1995, and of R\$ 24.9 million in 1996. For 1997, the amount of hospital expenditures was estimated based on the percentage observed in 1996.

International funds

In 1996, US\$28 million was invested in Brazil in activities related to reproductive health. Compared to domestic expenditure on reproductive health, this is a small amount. Aid donors have, however, encouraged useful flexibility in government programs, as with HIV-AIDS prevention, and most importantly have supported NGO advocacy work.

Table 3 International Funds for Projects and Programs
Related to ICPD

US\$12.4 million for STD/AIDS prevention , a large percentage of which is a World Bank loan;
US\$5.5 million, most from UNFPA and USAID , for reproductive health services and family planning;
US\$3.3 million for IEC, advocacy and sex education , through programs developed primarily by NGOs;
US\$3.3 million for research on policies and population data , most provided by multilateral and bilateral organizations and NGOs;

US\$1.5 million for programs to supply contraceptives;
US\$2.0 million for gender equity and women's empowerment.

5. Legislative change

In 1995, the National Congress requested presidential ratification for a law to enforce the 1988 Constitution in regard to family planning. In January 1996, the President ratified the bill but vetoed the provisions covering surgical sterilisation. The National Commission on Population and Development, the National Feminist Network on Reproductive Health and Rights (RedeSaude) and other civil society organizations protested against the veto. The President requested the Congress to raise his own vetoes. The Law No. 9600 was finally approved in August 1997. Some of its contents, particularly the prohibition against performing the procedure after childbirth, are being contested. Research is underway to assess its implementation.

Table 4 Laws relating to Family Planning

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- ~ Right to surgical sterilisation for both men and women over the age of 25, and for persons aged at least 21 years who have at least two living children.
 - ~ Access to fertility regulation services, including counselling, must be provided by a multi-disciplinary team, to discourage early sterilisation.
 - ~ The prohibition of surgical sterilisation of women in labour, immediately after labour, or after an abortion. Exceptions allowed

in cases of proven need, for health reasons, and if there is a history of successive caesarean births.

- ~ Whether a man or woman is sterilised, his or her partner must give their approval.
 - ~ Mandatory reporting to the Universal Health System administration is required for all surgical sterilisations that are conducted.
 - ~ The inducement or instigation of individuals or groups to undergo surgical sterilisation is prohibited, as is requiring sterilisation certificates or pregnancy tests, for any purpose.
 - ~ The Ministry of Health will register, inspect and control all institutions and services that operate or do research in the area of family planning, to ensure that only institutions that offer all options of reversible contraception means and methods are authorised to conduct surgical sterilisations.
 - ~ Penalties will be established for physicians who do not comply with the law.
-

Since 1995, there have been continual debates about abortion. During the Beijing Conference, a constitutional amendment was proposed to the National Congress to include the premise of 'right to life from the time of conception.' From October 1995 to March 1996, the proposal was discussed by a Special Commission, which ultimately rejected it. In August 1997, prior to the Pope's visit to Brazil, the Constitution and Justice Committee agreed that the Universal Health System could provide abortion in the two cases permitted by law. The Minister of Health declared he would request this to be vetoed by the President, and the conservative parliamentary block requested the bill to be voted again in the House. Women's organizations launched a campaign in favour of the amendment, including sending 20,000 postcards of support to the Congress. The provision has not been debated since November 1997.

After these heated debates, CISMU mobilised the National Council of Health to request the Ministry of Health for a protocol that would allow the universal establishment of abortion services for the two situations permitted by law. The protocol was finally adopted in October 1998, and provides for comprehensive health care for women victimised by violence. Conservative forces in Congress immediately called a vote on its constitutionality. This vote took place in August 1999, and the conservatives were defeated. In 2000, the Catholic Church again launched a public campaign against the protocol. Another vote over its constitutionality was scheduled for September 2000.

The Penal Code is being reformed. Proposals have been made to increase the circumstances in which abortion is permitted, to include lethal fetal anomalies and serious risks to women's health. It has also been proposed to reduce the penalties against women who resort to abortion. Given the tense atmosphere of abortion debates in recent years, gaining approval for these recommendations will require great mobilisation on the part of feminist and progressive sectors.

In 1996, a federal law was approved providing for free and universal distribution of anti-retroviral drugs by the Universal Health System. Brazil is the only developing country in which AIDS treatment is covered by public funds. Unlike other infectious diseases, HIV/AIDS decimates both rich and poor people. Advocacy for the new law therefore involved a diverse range of social groups. Furthermore, a policy was already in place that provided an 'enabling environment' for this new law to be passed. The law is proving to have a positive effect in reducing mortality from AIDS.

6. Continued advocacy efforts

Both long before and since the Cairo and Beijing Conferences, strong advocacy by NGOs has been critical to advancing policies governing reproductive and sexual health and rights. Public debates have been a powerful strategy against conservative forces, especially on abortion. Community mobilisation has helped reverse vetoes against the Family Planning Law. The work of gay and HIV-AIDS related NGOs was vital to securing the free drug law.

Since 1997, Social Watch Brazil has systematically analysed the national implementation of the Beijing and World Social Summit resolutions. In 1998, RedeSaude detailed one hundred exemplary illustrations of Cairo implementation in both government and NGO programs and initiatives, as a contribution towards the Cairo+5 Review. In 2000, the Brazilian Women's Network for Beijing assessed the progress that has been made on the policies implemented after 1995.

In considering the course of policy development in Brazil, there existed in 1995 a 'formal predisposition' on the part of the Brazilian Government to implement the reproductive health and rights commitments made at Cairo and Beijing. On one hand, the progress and achievements that have been made would not have been possible without the sustained

and continued pressure from civil society, particularly to counter the political forces that openly oppose the Cairo agenda. On the other hand, in 1995 knowledge and understanding among legislators, policy makers and the general public about sexual and reproductive health and rights was very limited, and this situation has improved.

7. Constraints on action

Although the Brazilian experience is in many ways a 'successful' example of Cairo and Beijing implementation, problems remain. Investment in health in Brazil is much higher than in many developing countries, although per capita expenditure is low relative to national GDP (0.7 per cent). Although stability in health funding was achieved in 1996, it has again been upset by the recent financial crisis. Since 1998, the Ministry of Health has been constantly struggling with the Ministry of Finance for additional resources. The special fund from a percentage of bank transactions, established as part of the IMF agreement, has been increased in size, but is no longer exclusively earmarked for health. It now must also cover the rising social security deficit. In early 2000, the Minister of Health opened a strong debate with IMF itself, stating that the capacity of his Ministry to improve critical matters such as sanitation, was being curtailed by the Fund's rules for calculating the public deficit.

It is also important to note the correlation between the great inequality that characterizes income distribution in Brazil and health demands and policy definitions. After 1995, the Universal Health System was correctly re-oriented towards providing basic health care and promoting healthy behaviour. Without systematic and structural policies to correct inequalities, no matter which way it is expanded and improved, the public health system will be vulnerable to being flooded with demands that are not necessarily related to health, but to poverty. Public investment in health is critical, but it is just part of the broader goal of eradicating poverty and reducing inequality.

Weaknesses are still evident in the policies implemented after 1998 - one example being the Cervical Cancer Screening Campaign. The public health system was not sufficiently prepared to meet the targets defined by the campaign. In six weeks, 3,263,000 women were examined, and advanced cervical cancer was detected in 4,700 of them. By 1999,

however, many of these women still had not been properly referred for treatment. Feminist NGOs consider that this particular policy was 'contaminated' by the political climate and the objectives of the 1998 presidential campaign.

Conventional areas of concern, such as maternal and child health and cervical cancer, have had more prompt and efficient attention than others. It is good that persisting bottlenecks in these longstanding programs have been resolved. Nevertheless, it is also important to note that more pressure and advocacy has been required to move public policy in new and sensitive areas such as violence and abortion. Finally, the concept of reproductive rights has been more widely used and understood in Brazil than in some other countries, yet many people are still unclear as to what reproductive rights exactly mean, other than access to good reproductive health care. This is particularly true amongst legislators and legal personnel. Much remains to be understood and promoted in regard to the legal and policy implications of sexual rights.

8. Lessons Learned

Three Steps Forward, Two Steps Backwards

Ten years of PAISM history demonstrate that the time between the formulation of a new policy and its actual implementation is necessarily long. The impact of a new agenda in the institutional and service environments occurs by successive approximations. In this process political-institutional dynamics, divergent interests, and financial considerations all interact.

Reproductive Health and Health System Reform


For a decade, impediments in consolidating the Integrated Health System were hurdles in the implementation of PAISM. The adoption of the Cairo and Beijing agendas coincided with a positive evolution in the implementation of the Universal Health System: namely stabilisation of funding and decentralisation. These conditions were very favourable because of inherent characteristics of the Universal Health System: public investment, universality, gratuity, and the priority given to basic health care. In order to harmonise the ICPD agenda with the Universal Health

System, vertical models had to be overcome. In Brazil, what was at stake was not the vertical bias of family planning, but a vertical program that contained all the components set forth in paragraph 7.3 of the ICPD Programme of Action. Brazil's experience indicates that integration of all reproductive health actions is necessary, but not sufficient. Reproductive health must be made a 'system priority.'

Financial Resources

In Brazil, health expenditures, both public and private, are relatively high compared with other developing countries, but investments in reproductive health are relatively low when compared to total expenditures. Local experiences show that when adequate system operation, clear priorities, and social control are in place, the impact of additional investment is enormous. It is crucial to emphasise both the quantity of resources and the quality of the expenditure made.

Advocacy and Accountability

Both aspects have proved to be essential in the long road from the inception of PAISM in 1983 to recent achievements. On one hand, if it were not for the sustained work of sexual and reproductive health and rights activists, this story would certainly be a different one. The creation of better accountability mechanisms has, however, provided new opportunities for policy monitoring and quick reactions at critical times. 

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Bolivia

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1. The national situation

This paper describes the progress and difficulties that Bolivia has faced in implementing the Programme of Action agreed to at the International Conference on Population and Development (ICPD) held in Cairo in 1994. The ICPD marked a turning point in international understanding about population problems, from the previous emphasis on demographic processes, to a greater recognition of human rights—including reproductive rights—as being central to population policies. The agreements reached at both Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995 reaffirmed the existence of political will to respect human rights and to facilitate the exercise of these rights. The action plans drawn up at these conferences acknowledge that a greater role for women in the public sphere is necessary if these rights are to be fully exercised. By subscribing to these international conventions, Bolivia has recognised and accepted obligations and is responsible for them. The ICPD+5 review, of which this paper is part, summarizes the progress that has been made since 1994 in meeting these commitments.

From Maternity Health to Reproductive and Sexual Health

Bolivia was once a backward and conservative country in providing for reproductive and sexual health. This situation began to change in the late 1980s, and more so after the ICPD in 1994.

In 1982, the National Board of Population of the Ministry of Planning and Coordination produced a document entitled 'Considerations for a Population and Health Policy in Bolivia.' This described three fundamental aims for the national population policy, namely to:

- ~ Reduce the infant mortality rate;
- ~ Redistribute the population to fully occupy national territory; and
- ~ Distribute wealth in more equitable ways.

A decade later, these strategies were incorporated into the National Strategy for Development, in which environmental and reproductive health issues figured for the first time.

Up until the 1980s, non-profit private organisations, acting almost clandestinely, were responsible for most of the progress made on reproductive rights—by, for example, protesting against the sterilisation of peasants; the closure in 1974 of the family planning centres of the Ministry of Social Security and Public Health; and the 1997 Supreme Resolution prohibiting public institutions from providing family planning services.

Debate about population issues and reproductive health has been sustained in Bolivia by politics. On various occasions, Government has referred to matters of 'national sovereignty' and 'optimal population density'; union organisations and NGOs have referred to 'northern countries' interventionist policies'; and the Catholic Church has buried discussion about family planning policies behind the issue of reducing maternity morbidity and mortality rates. Despite this complicated situation, international cooperation agencies such as the United States Agency for International Development (USAID) and the United Nations Population Fund (UNFPA) have supported the efforts of NGOs to promote family planning within the framework of women's health.

Development indicators for Bolivia

	1970s	1990s
Population size	4.8 mill	7.8 mill
Population growth rate (1975-1997)	-	2.3% ann. av.
Total fertility rate	6.1	4.4
Life expectancy at birth	45.8 yrs	61.4 yrs
Maternal mortality rate	-	180
Infant mortality rate	144	69
Under 5 mortality rate	243	96
Contraceptive prevalence	-	45%
1990s gender gap		
	Female	Male
Life expectancy at birth	63.2 yrs	59.8 yrs
Net primary enrolment (6-15 yrs)	95%	99%
Adult literacy	77%	92%

Source: UNDP Human Development Report, 1999

Despite initial opposition, the promotion of family planning was made possible in Bolivia after 1983 through the cooperation of labour unions, rural organisations and other NGOs. Together with health NGOs, worker organisations proclaimed their concern over the high mortality of women. They organised health services, including the distribution of modern contraceptives, at their union premises. This common cause of improving reproductive health brought together different sectors of the community.

At the international level, organisations such as the World Health Organization (WHO), the United Nations Fund for Children (UNICEF), and UNFPA have helped encourage the gradual incorporation of the family planning issue into a more integrated understanding of reproductive and sexual health. This in turn has encouraged women's organisations to ally themselves with health organisations, and the Bolivian State to incorporate the concepts of reproductive and sexual health into its policies.

In 1989, the Government of Jaime Paz Samora included in its National Plan for Survival, Maternal Health and Infant Development, a section on reproductive health. This presented strategies to assist women and adolescents of fertile age avoid unwanted pregnancy, and to provide, as appropriate, sexual education programs and contraception services.

In 1990, the National Reproductive Health Program was established, and this gave women's rights more prominence. From the previous emphasis on 'mother-child' services, the new program approached women's health in a more integrated way. It established the National Board for Coordination in Reproductive Health, and four sub-boards: Research, Communication Education Information (CEI), Services and Training. This multi-institutional effort, which included the participation of NGOs, government institutions, and international development agencies, has assisted the continuity of health policy through successive governments: those of Paz Samora (1989-1993) and Sanchez de Lozada (1993-1997). An important place in the national political agenda has also been maintained for the National Plan for the Accelerated Reduction of Maternal, Perinatal and Infant and Child Mortality (the 1993 Life Plan), which gives strong support for women's health and reproductive health.

From 1993, a series of structural reforms started to take effect, through the application of the Popular Participation, Decentralisation and Educational Reform Acts. Resources were transferred, and greater autonomy was given to the nine Department Prefectures and 311 Municipal Governments in planning and executing public investment projects. A national infant and maternity health insurance scheme, known as Basic Health Insurance, was established to subsidise pre- and post-natal health services, and provide free childbirth attention for women and services for children under the age of five.

In education, the public budget was re-assigned in favour of basic education. The aims of the Educational Reform Program were to improve primary and secondary education, increase the access of rural women to schools, improve the education of teachers, and allow children to begin school in their mother tongue. The program promotes respect for human rights and encourages the development of healthy sexuality—both biologically and ethically—as the foundation for responsible family life.

2. Preparations for Cairo

Bolivia arrived at the ICPD with a national declaration based on a wide-based consensus that reflected the work and experience of various people and institutions active in the population and health fields. The declaration recognized the variety of issues that need to be considered in population policies, beyond the basic demographic aspects.

Initial drafts of the National Report and Declaration of Bolivia were developed through the National Population Forum, and its regional committees in Cochabamba, Oruro, Santa Cruz, Sucre and Tarija. The meetings involved various government and NGO representatives. Women's organisations had no permanent representation, but their position was expressed through feminist women in important public posts, and by health NGOs that incorporated into the discussion important concepts about reproductive and sexual health.

The Declaration took into account four principal factors: the links between economic growth and poverty; the links between social equity and reproductive and sexual health; the rational use of natural resources, and the quality of governance. The Declaration noted the need for women's sexual and fertility decisions to be respected, and for a more democratic role for women in family and society. It had a lot in common with the document later agreed upon at Cairo.

3. Evaluating ICPD implementation in Bolivia

Of the ICPD Programme of Action, Bolivia has given priority to:

- ~ Improving reproductive and sexual health within the framework of human rights;
- ~ Increasing equality in gender opportunities, and
- ~ Addressing poverty and sustainable development.

Reproductive and sexual rights

There has been a growing awareness among health and women organisations, aided by international aid agencies, about the importance

of considering the linkages between issues such as health, identity, gender, power relationships and reproductive and sexual rights. The Government of Bolivia has accepted the involvement and views of civil society.

Even before the Cairo Conference, reproductive and sexual health programs in Bolivia had transcended the maternal-child health concept. It was not until after the Cairo and Beijing Conferences, however, that a more integral approach was introduced, one that considered health within the broad framework of human rights, especially reproductive and sexual rights. This new approach implies allowing individuals more responsibility and freedom to make their own decisions about reproduction and sexuality, without being subject to restraint, discrimination or violence. It also implies the need to encourage self-care, and increase the coverage and quality of health care.

This has proven to be some challenge for health service providers, for they often need special training to be able to incorporate a gender perspective in their work and provide services that are culturally acceptable and of sufficiently high quality. Furthermore, the discussion about reproductive and sexual health now goes beyond direct health issues to include consideration of men and women's rights. Nevertheless, there has been significant progress made in Bolivia in health and in other sectors that are relevant to gender relations.

Progress in health services

- ~ An integrated approach to, and priority for, women's reproductive and sexual health has been incorporated into national health national plans, namely the 1994 Life Plan and the 1997 Strategic Health Plan. In Bolivia, there are no exclusive family planning centres, as in other countries, but integrated health centers for women.
- ~ The need to incorporate the gender perspective into policies, programs and public activities has been recognized by government. Inter-sectoral coordination mechanisms have been created, with the participation of gender issues staff. The current government has established a Board of Directors, which includes the Ministers of Health, Sustainable Development and

- Education and their respective experts, to make decisions about health policy.
- ~ Reproductive and sexual health services have been improved, by including Depo-Provera and voluntary surgical sterilisation in order to widen the range of contraceptives available, and by incorporating other services such as anti-tetanus vaccination and early detection of mammary and uterine cancer.
 - ~ There has been a marked increase in the use of hospital services. The number of births in hospitals rose from 70,927 in 1995, to 83,165 in 1996. The number of pap-smear screenings has doubled since 1994. The State provision of contraceptive services increased six-fold over three years, from 12,000 contraceptive users in 1993 to 88,000 in 1996.¹
 - ~ New Government and NGO-run services have been created for adolescents and youngsters in La Paz, Santa Cruz, Tarija and Sucre.
 - ~ New training strategies incorporating the new approach in reproductive and sexual health are being used to train health workers, through the nine training centres of the Ministry of Health.
 - ~ New standards and protocols have been developed by the Ministry of Health.
 - ~ Studies involving NGOs have been conducted on health service quality, including assessments of quality by service users, in order to identify strengths and weaknesses.
 - ~ A national Infant and Maternity Insurance Scheme was established in 1996-97 and Basic Health Insurance in 1997. These schemes have significantly reduced economic barriers to health service use.
 - ~ Health service workers have been trained in post-abortion family planning, and this has improved their attitudes towards women with abortion complications.
 - ~ Led by the September 28 Campaign Group, various campaigns have been conducted to encourage public discussion about abortion and promote the legalisation of abortion in the interest of social justice. Catholics for the Right to Decide have given important support to this

- campaign - demonstrating that Catholics do not have a singular position on this issue.
- ~ Government has worked with NGOs to design indicators of health service quality and the incorporation of a gender perspective, as well as guidelines for training.
 - ~ Health service users are surveyed in order to identify possible shortcomings in service quality.
 - ~ International aid agencies, such as the European Union (EU) and the bilateral programs of the German Government (GTZ) and the British Government (DFID) are joining the UNFPA and USAID initiatives, and thereby better coordinating their support for reproductive health services.
 - ~ The Health Reform Program has been initiated. Before the 1997 national elections, civil society meetings were organized in the main cities with representatives from the political parties, to explain reproductive and sexual health issues and the commitments that were assumed by the Bolivian State at Cairo and Beijing.

Progress in education

- ~ An Education Program on Population has been created, and encourages non-sexist education from the first school classes.
- ~ A training program has been created with the School of Medicine, to increase students' understanding of gender and reproductive and sexual rights.

Progress in gender equity

- ~ The Equal Opportunities Plan for Women has been developed by the National Gender Secretariat, and makes special reference to health. This plan is now being executed.
- ~ The co-responsibility of men in the reproductive process and their need to participate in reproductive and sexual health programs is being promoted. A taskforce on

- aspects of masculinity has been organized, and related research is being carried out.
- ~ Integrated legal services and family protection units have been created.
- ~ Pilot projects are being conducted to identify the best ways to assist women victims of violence.
- ~ A process of formulating municipal Annual Operative Plans (AOP) has been initiated and incorporates a gender perspective, along with the participation of community and women's organisations and government agencies.
- ~ An Equal Opportunities Resolution, N° 24864 of 1998, has been enacted.

Progress in law reform

- ~ A law against violence inside the family was enacted in 1995.
- ~ The Quotas Law was enacted in 1997.
- ~ A First Pan-American Conference of Parliamentary Doctors in Medicine has been held. This meeting was motivated by the political commitment to take legislative actions to support health reforms, and recognise reproductive and sexual rights. It discussed ways to address the obstacles of gender and generation inequality, and the poor recognition of abortion as a public health issue.
- ~ The September 28 Campaign Group has proposed an amendment of the Criminal Proceeding Code on unpunished abortion (article 266). The group has stated that, "Although the legislation considers some cases where women need to interrupt their pregnancies, the procedure through which women could have legal access to abortion simply does not exist." Although the amendment proposed by the Group does not fully meet women's demands, it is a useful step forward at the stage of consensus building.
- ~ A Sexual Harassment Act and a Protection Act for victims of offences against sexual freedom have been presented for discussion, and may soon be enacted, despite

- resistance from some members of Parliament. A Domestic Servants Act is in the same condition.
- ~ The Political Parties Act, which ensures the more equal participation of women in party decision-making posts, has been enacted.
 - ~ The Electoral Code Reform has been enacted. This encourages the alternate listing of men and women candidates on ballots for municipal elections.

Progress in understanding population dynamics

- ~ A Population Policies Unit has been established in the Ministry of Sustainable Development.
- ~ The Institute of Statistics and Census is helping provide gender-disaggregated statistics at municipal level, in order to assist decision-making and encourage the participation of Surveillance Committees.
- ~ Health and Demographic Surveys are conducted every four years, and provide important information for assessing progress in health and the effectiveness of health programs.

4. Remaining difficulties

Since the ICPD and the Beijing Conference, Bolivia has had two governments, and this has hampered the process of change in several aspects. From one government to another, authorities tend to adopt different positions on national policies, and this can weaken the fragile state of progress on reproductive and sexual rights. The pattern of advances and retreats interferes with the sustained development of the programs. For example, the change in government caused a temporary suspension in financing that put at risk the Integral Legal Services (which reduced from 37 to 31) and the transfer of Family Protection Units to the responsibility of prefectures and municipalities.

Although the Infant and Maternity Insurance Scheme instituted by the previous government was an achievement, it did not provide any subsidy for abortion complications, even though this is the third most common cause of maternal death. The insurance scheme has been

successful in the main cities, but less so in the smaller cities and rural areas. An important shortcoming was that the scheme was not accompanied by sufficient training or infrastructure development. The increased number of clients that the scheme encouraged thereby caused the quality of services to deteriorate, a complaint reported by a number of women users. By comparison, the Basic Health Insurance Scheme initiated in January 1999 takes into account any bleeding during the first quarter in the reproductive and sexual health service coverage. It also plans to give more attention to service quality, the training of service staff, and more sensitivity about intercultural and gender issues, but this is yet to be implemented.

Despite the recognition that has been given to progressive policies in line with the Cairo and Beijing frameworks, they have not yet been made operational at the various levels. The organisation of services still reproduces elements of gender, generation, and ethnic discrimination. Reproductive and sexual rights and service quality issues have not become incorporated into institutional practices, nor truly figure among political priorities of local authorities. There has not been effective coordination with the executors of the Health Reform Program.

Despite its recent advances in the field of health, Bolivia can not satisfy the needs of all of its population. In rural areas, the demand for reproductive and sexual health is still mostly low, but generally unmet, due to the shortage of human and financial resources. Although a great deal of effort has been put towards incorporating reproductive and sexual health services into primary health services, some sections of the population are still under-served, especially rural communities and adolescents. More trained health workers and more consideration of gender are needed in order to attain the necessary quality of health services.

In the field of education, coordination between the Government and NGOs is precarious. There are contradictory positions about equity proposals and the incorporation of reproductive and sexual rights into school curricula. The Education Reform Act states that it will “promote the practice of human values and worldwide known ethic rules, as well as those of our own culture.” Yet it disregards the fact that those universal values and everyday practices include several forms of discrimination.

A backward step in gender relations has been the replacement of the Gender Affairs Secretariat by the General Bureau of Gender Affairs. Over the last two years, this institution has lost its political power and this has hindered the incorporation of gender considerations into public policies. It is difficult to command coordination and execution capacity from a lower level of authority. A consequence of this has been the dispersion of gender-related proposals and their poor integration into sectoral institutions.

There is little civil awareness in Bolivian society or understanding about law, or how rights are derived from laws, despite efforts by NGOs to democratize this knowledge. The public interpretation of laws thereby can be distorted - as they have been in the case of the Quotas Law, which did not allow, as it should have, a 30 per cent participation by women in the 1997 national elections. Instead, only 13 per cent was achieved.

5. Participation in the five-year review of ICPD implementation

While a great deal of effort has been made to comply with the Programme of Action, there is a lot still to do in order to enable men and women to fully exercise their reproductive and sexual rights. The process of evaluating this progress concluded with the presentation by Bolivia of their national report to the Twenty-first Extraordinary Session of the United Nations General Assembly, in New York during July 1999. This report stated that, "Within the framework of respect for human rights and strengthening of democracy, the Bolivian State plans to keep searching for alternative models to confront the issue of reproductive and sexual rights, within the context of the social, economical, political and cultural agents taking part in the integral health." This statement reiterated the national commitment to the agreement reached at Cairo, and signaled Bolivia's intention to progress further on implementing the ICPD Programme.

This statement by the Government has further encouraged the cooperation of civil society organisations, especially women's organisations, and others working on reproductive and sexual health. The Catholic Church did not, however, actively participate in this process, and nor did community groups or labour unions. At the United Nations, given the difficulty of reaching consensus within the Group of Seventy-seven

(G77) about sexual rights, family types, sexual education, adolescent programs, or respect for diversity, the Bolivian Delegation allied itself with governments and women's NGO networks that fully supported the Programme of Action.

6. Coordination mechanisms and organisations

Bolivia is a country with quite a tradition of coordination between its various sectors. Collaboration between the Government and NGOs became possible by the late 1980s, and has strengthened during the 1990s. Preparations for the Cairo and Beijing conferences encouraged this cooperation.

Even so, no specific institution has been created in Bolivia, and no real indicators defined, to thoroughly scrutinize the progress being made on the international agreements. While the organisations mentioned here have not been specifically mandated to review this progress, they have some interest in it, for their agendas include the promotion of reproductive and sexual health and gender equity.

The Government has recognized that issues such as reproductive and sexual health, gender, and community participation have been addressed by the NGOs for years, and that they have valuable experience and methods to offer. Nevertheless, little by little, the Government has begun to replace NGOs, or compete with them on various activities. Redefinition of the functions of both parties is required.

The same international cooperation that once mainly financed the activities of NGOs now directs more of its assistance through the government, which by virtue of its infrastructure, offers a wider scope of activity. While NGOs have had to make some adjustment in their relationship with Government, most have positioned themselves to monitor the follow-up of the international agreements, implement sustainable methodologies, lead action on contentious issues, and cooperate with all parties working to improve reproductive and sexual health.

With the implementation of the Decentralisation and Popular Participation Act, the prefectures and municipalities have become the

new strategic partners of NGOs, encouraging them to work more at the local level. The level at which NGOs work, however, depends most on the politics of the moment and the issues under discussion, and on the individuals in public office. Better coordination with NGOs is not only a State Policy, but also reflects the will of prominent individuals to work together. This cooperation saves effort as well as resources.

Government mechanisms for coordination include the National Reproductive and Sexual Health Committee and the National Safe Maternity Committee. The National Reproductive and Sexual Health Committee encourages women's organisations to participate in its work, as well as other government and international organisations working in the fields of education and gender and generation equity.

In 1996, the Catholic Church began a campaign against the promotion of condoms and the reproductive and sexual health policy of the Life Plan. The Minister of Health was personally committed to legalising abortion, and this sparked a national controversy. Although the outcome of this was that the State took a step backwards in its policies on abortion, the debate overall had a positive effect, for it consolidated a space for opinion exchange and collaboration.

The National Safe Maternity Committee involves the health sector, NGOs, and central government institutions such as the Ministries of Finance, Education and Sustainable Development. This committee monitors maternity throughout the country.

In May 1999, the National Sexual and Reproductive Health Forum was formed to unify the various committees and organisations. This body brings together 87 institutions and organisations, including government bodies and international cooperation agencies. There are inherent difficulties in coordinating such a wide body of interests, especially to achieve any consensus on controversial issues such as abortion within the framework of reproductive and sexual rights.

Among NGOs, there are several coordination organisations. These include the Unwanted Pregnancy Group, which educates the public about abortion, and the September 28 Campaign Group, which promotes the legalisation of abortion. While various organisations aim to follow up on the Cairo and Beijing commitments, they do so in a somewhat

disconnected manner, because of political and organisational differences within the women's movement, and the different currents of feminism.

The Political Forum, which involves women parliamentarians from diverse political parties, aims to increase women's participation in politics. The Citizenship Forum has assumed the defence of citizen rights as their contribution to the women's movement. These organisations are playing leading roles in influencing public opinion for women's rights.

International cooperation agencies support the activities of both the Government and NGOs. Their coordination mechanism, the Inter-agency Committee, aims to avoid duplication and over-lapping of projects.

Institutions participating in reproductive and reproductive and sexual health policies, from a gender perspective

Government	Civil society organisations
Ministry of Education	Citizenship Forum
Ministry of Health	Political Forum
Ministry of Sustainable Development	Women's Platform
Vice-Ministry of Gender, Generation and Family Affairs	Women's Coordinator
National Connection Committee of Beijing	Reproductive and Sexual Health National Forum
	Follow-up
Safe Maternity National Committee	Unwanted Pregnancy Group
	September 28
	Campaign Group
	Women's NGOs
	Health NGOs
	RED-ADA
	Network Against Violence

7. Financing ICPD implementation

There is no information available to systematically analyze health sector spending, least of all on reproductive and sexual health. The six sources of finance for health services are the central government budget; municipal government budgets; public health insurance; private insurance; international aid, and fees paid by users.

Since 1994, municipal governments have been responsible for most health investment and administration. An estimated 3.3 per cent of municipal government budgets have been allocated to health. Fees paid by users, or expenses that accrue directly to households, represent 24 per cent of the total financing for health services.² The 1990 Family Budget Survey estimated health expenses averaged US\$14 per month per household, or around four per cent of all expenditure.³ The present policy of most health service providers is to charge users for services.

Between 1995 and 1997, public investment in health averaged about six per cent of all public investment. Investment in education was more than double this figure.

In committing to the ICPD Programme of Action, governments promised to assign 20 per cent of official development assistance, as well as 20 per cent of its national budget, to improving health. According to official information from the Ministry of Finance, Bolivia has met this goal, and even exceeded it. Public investment in the social sector has been growing since 1994. In 1995, investment in social sectors totaled 35 per cent of all investment; in 1997 it reached 45 per cent. These public investments, however, depend heavily on external resources, and this puts their sustainability into some question.

During 1995-1997, bilateral and multilateral donor agencies invested approximately US\$30 million a year in reproductive and sexual health, to support the programs of the Ministry of Health and NGOs, and the national health insurance schemes. The main aid agencies working in Bolivia include USAID, which provides almost 40 per cent of all development assistance, and UNFPA, DFID, HOLLANDA, GTZ, and WHO. Together these agencies provide almost 70 per cent of reproductive and sexual health programs, which therefore are heavily dependent on them.

8. Obstacles to ICPD implementation

A principal obstacle to implementation of both the ICPD and the Beijing action plans is the strong influence of culture and religion throughout Bolivian society, including its laws, which often propose respect for “uses and customs,” and “prevalent attitudes.”

Despite the efforts made to widely publicise the agreements made at Cairo and Beijing, the information remains largely confined to a social elite. Little has percolated out to grassroots NGOs.

In the health services, the standards of care that were proposed by the ICPD Programme of Action have not been incorporated into usual practice, and this prevents many people from fully exercising their reproductive and sexual rights.

Institutional instability and changes in government affect the continuity of programs and weaken their development. Although various coordination mechanisms exist, they generally do not function well in linking national level activity with that at departmental levels.

Another barrier is the pressure of international organisations for specific targets to be complied with. This sometimes encourages organisations to sacrifice service quality for broader coverage. Financial dependency on these organisations influences policies on reproductive and sexual health and gender, yet these agencies, too, conform to national constraints in defining these policies. For example, national organisations working on reproductive and sexual health must be certified, to ensure they do not incorporate abortion into their agendas.

Finally, the political will of the government to implement the ICPD Programme is expressed through its allocation of financial and human resources to the necessary activities. In this respect, Bolivia has not managed to comply with the proposed standards.


9. Looking forward: a proposed agenda

Bolivia has responded to the challenge of implementing the ICPD Programme of Action, as well as the Beijing Platform of Action. This is despite the difficulties posed by the prevalence of poverty in the country, low levels of education and income, and insufficient financial and human resources and infrastructure. The process has begun, although there still are gaps to be filled.

Women's and feminist movements and other NGOs play an important role in explaining reproductive and sexual health issues and gender rights to the community. Women constantly draw attention to the dissociation between the discourse and practice of state organisations. Their organisations provide an avenue for diffusion of information about the international agreements. Women's groups and other NGOs have been catalysts for decision-making, in both technical and political aspects.

The future agenda could include these priority actions:

- ~ Incorporate reproductive and sexual rights into both the discourse and practice of human rights, and give them equal priority. At present, gender concepts and reproductive and sexual rights often get lip service, rather than real attention.
- ~ Define reproductive and sexual health beyond biomedical aspects, to take into account its cultural, social and economic dimensions.
- ~ Encourage more consideration to be given to aspects of sexuality in health and education programs, as integral to the development of a person.
- ~ Give more attention to violence in reproductive and sexual health programs, particularly to assist child and adolescent victims.
- ~ Design services that meet the real needs of users. Service providers necessarily involve themselves with concepts and value judgements regarding the construction of gender identity and power relationships between men and women. These constructions need to be identified and equality of the sexes be promoted in all fields of life, including family and community life, by encouraging men to be

- responsible for their reproductive and sexual behavior, and their role in the family.
- ~ Support the continued progress on the ICPD and Beijing action plans, by encouraging coordinated actions between the government, the community, international cooperation agencies, and NGOs.
 - ~ Develop indicators to measure progress on national goals.
 - ~ Assist NGOs and grassroots organisations to participate in processes of health and educational reform.
 - ~ Provide information and legal education to women, and the public generally, about their reproductive and sexual rights, to empower them to exercise and defend these rights.
 - ~ Conduct research that allows better understanding of ethnic, social, generational and gender differences within reproductive and sexual health issues. Women have been at the centre of attention on reproductive and sexual rights, but achieving gender equality will be impossible if men are not also involved.
 - ~ Promote and design sexual health policies for adolescents and integrated services where information, education and medical services are available.
 - ~ Promote formal and informal sex education programs which include a gender approach.
 - ~ Train education and health workers in the new concepts of health and reproductive and sexual rights.
 - ~ Support the structural organisation of the Vice-Ministry of Gender, Generation and Family Affairs, in order to more fully incorporate a gender perspective in its policies and programs.
 - ~ Encourage the Bolivia Government to move ahead on its commitments by allocating more resources to sexual and reproductive health, within the framework of a greater economic independence and national sovereignty. 

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¹ MSPPS, 1998.

² Cárdenas, 1997.

³ Urquiola, 1994.

Nicaragua

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1. The national context

After the Nicaraguan census of 1971, political and economic circumstances made it impossible to hold another census until April 1995. Over that period, the population more than doubled, reaching approximately 4.7 million in the late 1990s. Situated at the centre of the Americas, with a total area of 133,000 sq. km, Nicaragua is the least populated country in the sub-region. Its history has been marked by violent political changes.

Many Nicaraguans live in extreme poverty, on a daily income of less than one dollar.² Approximately two-thirds of the population is unemployed. In 1998, per capita GNP was US\$404, giving Nicaragua the worst ranking in Central America.³ UNDP's 1998 Human Development Report described Nicaragua as having good natural resource potential: 46 per cent of its area is covered in forests and woodlands, and its reforestation index stands at 27 per cent. Without effective regulation to govern their exploitation, however, the country's natural resources are at great risk. So is the society generally, for resource degradation aggravates and triggers the cycle of poverty.

Development indicators for Nicaragua

	1970s	1990s
Population size	2.5 mill	4.7 mill
Population growth rate (1975-1997)	-	2.9% ann. av.
Total fertility rate	6.5	4.4
Life expectancy at birth	53.6 yrs	67.9 yrs
Maternal mortality rate	-	-
Infant mortality rate	107	42
Under 5 mortality rate	168	57
Contraceptive prevalence	-	49%
	1990s gender gap	
	Female	Male
Life expectancy at birth	70.6 yrs	65.8 yrs
Net primary enrolment (6-15 yrs)	80%	76%
Adult literacy	66.0%	64.3%

Sources: UNDP Human Development Report, 1999; Nicaragua Human Development Report, 1997

The 1995 national census indicated that life expectancy at birth in Nicaragua was 67.5 years—but this statistic is unreliable, for the National Vital Statistics System has acknowledged that only around 60 per cent of deaths are counted. The official mortality rate in 1996 for infants and children under five years was 57 per 1,000 live births. Other sources, however, report that infant mortality averaged 92 per 1,000 live births during the last five years in the western provinces, a region particularly hard hit by poverty.

The official literacy rate reveals a gender gap that favors women: 66.0 per cent for women and 64.3 per cent for men.⁴ Total enrolment in primary, secondary, and tertiary education is also slightly higher for women (63 per cent) than for men (61 per cent). Women's participation in the work force is relatively low but has slowly increased, from 24 per cent in

1970 to 34 per cent in 1995. The income generated by women has now reached 29.5 per cent, although private research centres put this figure a little higher, at 35 per cent, and note that urban women participate most in the work force.⁵

Research done by the International Conference on Population and Development (ICPD) Follow-up Project has revealed other dimensions of the gender gap in Nicaragua, particularly in relation to health:⁶

- ~ A lack of preventive, care, and rehabilitation programs for girls victimised by violence, and their families;
- ~ An absence of policies and programs in the area of male responsibility in sexual and reproductive health;
- ~ Lack of legal norms specifically dealing with adolescents' health and reproductive health;
- ~ The existence of outdated laws that penalise abortion. Although therapeutic abortion exists, it is not recognised;
- ~ The exclusion of women from the design of legislation so that their rights are not adequately promoted; and
- ~ Inadequate legislation and regulations regarding access to quality health services that cannot avoid discrimination by social class, age, ethnicity, sexual orientation, social status, or geographic area.

The Minister of Health has announced that the health system can provide medical care to only 2.8 million of its 4.5 million people. This situation, whereby one third of the population receives no medical attention, violates the basic rights of Nicaraguans and contradicts the Cairo mandate. Other factors that affect the general level of health in Nicaragua include limited access to safe water (39 per cent) and sanitation (69 per cent). Twelve per cent of children under five years of age are underweight and 46 per cent do not reach fifth grade.

Structural adjustment policies were adopted in Nicaragua from 1993. These policies have adversely affected health services, especially reproductive health services. Many rural health posts have been shut down. Many others are staffed by nurses that cannot meet routine demands, let alone any complications of pregnancy, labour or abortion. The reform program presupposed that administrative and financial management would be decentralised. It is evident that responsibilities were decentralised, but not resources.

2. Policies in place before the 1994 Cairo Conference

Despite important sociopolitical and economic changes in recent years, pro-natalism has prevailed in Nicaragua. In the 1980s, women were urged to give birth to replace the people killed in the Liberation War and the War of Aggression. This responsibility, while quite unrealistic, hampered any acknowledgment or advance in the defence of women's reproductive rights. In the early 1990s, the new Government had another message, one which emphasised the value of maternity, family, household care, and women's return to domestic chores.

The situation before the ICPD was characterised by:

- ~ Great confusion regarding reproductive health and rights, resulting from the Government's tendency to support the most conservative views and, as well, affirm the need to reduce the population-growth rate.
- ~ The absence of any discernible integration of development objectives to preserve the environment, establish more equitable economic relations, and improve material conditions for disadvantaged groups.
- ~ The absence of any mention in Government plans of any special concern to improve the status of women or redress the power imbalance between men and women; and
- ~ Excessive interference and influence by the Catholic Church in health and educational issues.

After the Latin American and the Caribbean Regional Conference on Population and Development in Mexico in 1993, the Autonomous Women's Movement organised in Nicaragua a National Women's Gathering on Population and Development Policies. Participants at the meeting included 131 women who represented 65 separate organisations of the women's movement, 15 Government institutions, two autonomous agencies, and four international aid agencies. Among the prior conditions for the meeting was that there would be total autonomy by the Movement in terms of the agenda, people invited, the organisation of the debates, and the drafting of documents and the official record. The objectives of the Gathering were to:

- ~ Understand the elements that determine population policies worldwide, and their variables;
- ~ Assess the health status of women, based on factors that impact on their quality of life;
- ~ Discuss population policies and programs in Nicaragua; and
- ~ Formulate strategies based on gender recommendations and agreements.

The Gathering approved proposals by the Autonomous Women's Movement and made recommendations about population policies, health, education, adolescents and youth, women's economic, legal and political situation, and the media. The Government of President Violeta Chamorro took none of these proposals into account.

From April 1993, when preparations for the Cairo Conference began, several women's movement organisations put forward proposals on population and development policies. The Social Action Ministry has never incorporated these contributions, nor any of those contained in the official record of the Gathering, thereby blocking any collaboration prior to the Cairo Conference.⁷

3. The activities of NGOs working on human rights and reproductive health

In their struggle for autonomy and the right to decide on matters that affect their lives, women have been involved in many initiatives and strategies. While they have gained important ground, the dogmatic attitudes of policy designers have eroded some of the progress they have made. In regard to education and health services, the current administration has further restricted women's influence and participation. The National Commission of Struggle against Maternal Mortality and the National Health Council, two multi-sectoral and multidisciplinary coordinating organisations that worked hard to succeed in the early 1990s, have had their connections with the Health Ministry severed.

Civil society and women's organisations have nevertheless disseminated important information about the state of reproductive rights.

They have continued to demand improvements in the quality of medical care, that reproductive health be an integral part of women's health services, and that these services must extend beyond family planning. Alternative Women's centres have promoted the idea that reproductive and sexual rights are intrinsically human rights, and have conducted public education programs on women's health and sexual autonomy.

In their defense of reproductive rights, these organisations have presented the results from the ICPD research at a number of gatherings. Participants in these discussions have included Government officials, researchers, university and high-school students, parliamentarians, health promoters from rural communities, physicians, staff from women's centres and collectives, and various other individuals. Discussions have ranged from the quality of health services; the access of youth and adolescents to reproductive health information and services; abortion and unsafe abortion care; male responsibility; and women's participation in decision-making. These debates have involved 27 women's centres and collectives, 22 NGOs, 21 national and international cooperation agencies, 11 study and research centres, three unions, three national networks, and 22 media organisations.

Women's organisations have also encouraged better understanding and discussion about population and development policies. SI MUJER, for example, has conducted study circles on sexual and reproductive health for medical students and health workers, and on population policies and the Cairo agreements. Some women's organisations and other NGOs have been involved in community work, including organised talks, group discussions, and home visits, to distribute information and promote alternative sexual and reproductive services. Some communities have organised protest marches and circulated petitions to protest against the setting up the Family Ministry, the premises of which have been rejected by the women's movement. Unfortunately only one woman Deputy voted against the proposal to create this ministry.

The demands of the women's health movement were brought into focus by the Cairo Conference, and priority issues and strategies to achieve significant changes were identified. Nicaragua participated in the ICPD Follow-up Project, which has been implemented in five Latin American countries by the Latin American and Caribbean Women's Health Network since 1996, and in Nicaragua by the SI MUJER Centre. This project focuses on six key issues:

- ~ The situation of girls victimised by sexual abuse;
- ~ Male responsibility in sexual and reproductive health;
- ~ Women's organised participation at all levels of decision-making;
- ~ The quality of reproductive services especially for vulnerable areas and people;
- ~ Adolescents' access to reproductive health information and services; and
- ~ Humane abortion and unsafe abortion care.

The six research studies conducted on these issues together provide a situational analysis of the national state of reproductive health.⁸ This research has found that the Government of Nicaragua has lacked the political will to incorporate the ICPD recommendations into its population and development policies.

4. The presence and role of ICPD opponents

In Nicaragua, some sectors consider population growth to be the cause of the prevailing extreme poverty. They promote population control based on controlling women's bodies. Among many education and health officials, religious and personal criteria take precedence over international agreements on sexual and reproductive rights. The Catholic Church also actively campaigns against sexual education, condom use, and modern contraceptive methods and instead with the Education and Family Ministries promotes natural methods, sexual abstinence, self-control, and fidelity. The 'natural law' argument has been incorporated into the Sexual Education Policy, prepared by the Education Ministry. This policy promotes and recognises only heterosexuality, sexuality for procreation, and family stability as manifested, for example, in Law 150, under which any act deemed as promotion or exercise of homosexuality carries a prison sentence. It states that:

"The human sexual act is natural when performed between man and woman...within the stable and permanent community of man and woman, sex encounters its natural place and fulfilment. Sexual abstinence on the part of singles, up to their marriage, that is, up to the establishment of a

stable relationship, total fidelity, a fundamental value in people's lives..."

The Sexual Education Policy has been used by the Supreme Court of Justice to reject a claim of unconstitutionality against Law 150, under which any act deemed as promotion or exercise of homosexuality carries a prison sentence.

The official education system associates any reference to sexual education as being against 'moral values,' and blocks NGOs from participating in promoting or defending sexual and reproductive rights in the schools.

5. Evaluating the implementation of the ICPD Programme

An improved environment for policy discussion

The ICPD made it possible to have a public debate on reproductive and sexual health and rights in Nicaragua. Government representatives and Catholic Church leaders summed up their understanding of the ICPD Programme as that the ICPD intended to legalize abortion, destroy the family, and impose homosexuality. Civil society organisations, on the other hand, have defended sexual and reproductive rights and promoted male responsibility in sexual and reproductive health. Conservative sectors organised marches and pastoral sermons, and delivered manifestos against abortion and the 'sin' of scientific information. In turn, civil society organisations have seized the opportunity to abandon the demographic approach and focus on women as the linch-pin of development.

Paradoxically, Nicaragua - a country characterised by extreme poverty and underdevelopment - has two versions of its national population policy. The Chamorro Government published one in June 1996. Another was presented by the current administration in May 1998. The latter incorporated some aspects or concepts of the Cairo Programme of Action, such as the right of couples to decide, freely and responsibly, the number and spacing of their children. However, despite this significant acknowledgment of reproductive rights, other parts of the document refer

to the 'defence of the right to life since conception,' an obvious rejection of the possibility of abortion, and even therapeutic abortion, which currently is allowed.

From its research, the ICPD Follow-up Project has collected important information about the state of reproductive health and rights in Nicaragua, demonstrating that the current administration has not fulfilled the agreements that were signed in Cairo.

Poor recognition of health and reproductive rights

The Ministry of Health, through its Integrated Women and Child Care Program, proposed that women's reproductive health services would be provided 'from a gender perspective.' Yet this has not been implemented in terms of actual services, or in staff training. Male responsibility in sexuality and reproduction has been virtually ignored. The Ministry recently introduced sexual and reproductive services for adolescents and youths in Managua and some other main cities, such as Matagalpa and Chinandega, where high rates of adolescent pregnancy are recorded. Their adult-oriented approach, however, often entails rebuking female adolescents. This does not make government services attractive to a population that already suffers from insufficient information and services, and the consequences of a traditionalist education that omits any reference to sexual education.

Regarding reproductive rights, the national population policy recognises the freedom of people to decide about the number and spacing of their children, but it also specifies that sexual education must be provided in the framework of *moral values* and in exercising sexuality with fidelity and responsibility. The Government thus assumes that women's reproductive rights are part of the culture of moral and sexual values, under the guidance of the Administration's religious ethos. The lack of recognition for women's sexual and reproductive rights affects the quality of life of women and their families and communities.

National strategies and programs regarding abortion and unsafe abortion do not fulfill Cairo's agreements. The Bertha Calderón National Referral Hospital recorded the following maternal death rates caused by unsafe (induced) abortion: 19.23 per cent in 1993, 7.14 per cent in 1994, 12.50 per cent in 1995, and 20 per cent in 1996. When the causes of

maternal mortality are ranked, induced abortion contributes to 34.4 per cent of all maternal deaths. For the 1990-91 period, government documents revealed that abortion was the principal cause for 24 per cent of maternal deaths in Nicaragua.

6. The role of NGOs and their relations with Government

Relations between Government and civil society organisations—particularly women’s centres and collectives—are often marked by tension. There evidently is little commitment by Government to relate harmoniously to different social sectors. The leadership of the Catholic Church has an negative influence on the Government, self-dubbed as liberal. The Government indeed acts as an unconditional ally of the Catholic Church, despite the fact that Nicaragua has been a lay state ever since the Constitution of 1893. Catholic Church and Government attacks on women’s organisations have gained momentum since 1994—an ongoing assault that is closely followed by the media. For example, in his August 1996 Pastoral Letter, Cardinal Obando y Bravo commented on women’s centres and collectives. Clearly referring to the efforts of feminist groups, he criticized what he called ‘contraceptive colonialism’ and condemned the use of modern family planning methods and the concepts of reproductive rights, reproductive health, and safe sex, because, he claimed, they were pro-abortion and promoted sexual promiscuity and arbitrary use of sex.

In 1994, Deputy Lombardo Martínez, later a Health Minister and member of the Population and Development Committee of the National Assembly, declared he would introduce in the Assembly a petition to close down centres that defended women’s sexual and reproductive rights. He argued that Nicaragua had zero population growth because the use of contraceptives was decimating the country’s population, along with the abortions allegedly performed by women’s centres.

Other actions by the Catholic Church and Government against civil society have included:

- ~ In 1994, the Education Ministry sent letters to secondary schools urging them to block NGO from participating in any activity related to sexual and reproductive health,

- whether that involves education programs or distributing condoms to young people. This violated the Cairo Agreement regarding the right of NGOs to work on these issues with Nicaragua's young population.
- ~ An advertising campaign was conducted against the use of condoms, affirming that they were unsafe and did not protect against HIV. The Minister of Health went so far as to declare that condoms were not for Catholics.
 - ~ Official opposition to NGOs working with health workers and public school teachers on education and capacity-building activities.
 - ~ In 1995, the Anprovida group managed to suspend the national immunisation campaign against tetanus, alleging that the vaccine included a sterilising substance for Nicaraguan girls. The allegation was proved to be false and the immunisation campaign was resumed, despite the reluctance of Cardinal Obando y Bravo, but the number of girls presenting themselves for immunisation declined, especially in rural areas.

In addition to these disinformation campaigns, the Government, through its Minister of Health, Mr. Quiñones and his allies, has directly threatened to close down women's collectives. The Minister has refused to convene the National Health Council, an advisory body to the Ministry that includes representatives from 32 civil society organisations. In this body, SI MUJER represented the National Council of Struggle Against Maternal Mortality. The Council dates back as a legal entity to 1992 when it was set up to coordinate women's organisations and health authorities. The current Minister, however, refuses to acknowledge its existence, thus neglecting the Government's commitment to Chapter 15 of the Cairo Programme of Action, which supports women's participation in reproductive health actions.

Women's collectives have also been under attack from civil organisations created by the Catholic Church, such as Anprovida and Coprosa, which in 1995 held a Central American Congress of natural family planning organisations. At this Congress, they openly accused SI MUJER and other organisations of receiving large sums from international agencies to perform illegal abortions and promote an ideology that goes against

family values. These charges were made by Rafael Cabrera from Anprovida, leader of disinformation campaigns against the use of contraceptive methods and the decriminalisation of abortion.

The strategy adopted by women's centres and collectives has been to avoid direct confrontation with these forces. Despite their scarce resources, they have run publicity campaigns to inform people about their true mission and the work they do on behalf of women, adolescents, and youth. They have found support from international agencies, women's networks, and aid organisations. They have also become closer to autonomous public agencies such as the Nicaraguan Women's Institute.

Government recently created a Family Ministry, which has been a matter of controversy with civil society since its inception. This new ministry has eliminated or transferred to its responsibility a number of previously autonomous institutions, such as the Nicaraguan Children's Fund and the National Commission to Promote and Defend Children's Rights. It has maintained the Nicaraguan Women's Institute under its jurisdiction. The Family Minister, Humberto Belli, formerly a Minister of Education, has proposed to resolve what he describes as one of Nicaraguan society's serious problems, namely the loss of moral values, by changing legislation—such as abolishing the law of unilateral divorce, which dates back to the Sandinista Revolution, because it “disintegrates the family.” Another of his policies is to promote natural contraceptive methods, on the grounds that these will reinforce moral instead of mechanical conduct and promote self-control and sexual self-discipline.

7. Funding reproductive health

From its outset it was evident that the ICPD Programme of Action required a sufficient allocation of human and financial resources to support reproductive health services. All six of the research studies undertaken under the ICPD Follow-up Project reveal that the Nicaraguan Government has not allocated the necessary funds to implement the ICPD Programme, making it impossible to fulfill the ICPD agreement to promote sexual and reproductive health.

The various Government bodies that assist girls who have been victimized by sexual abuse are constrained in many ways. They have been unable to improve their procedures or facilities. The police have had their budget reduced, and thereby their access to fuel and vehicles, as well as their capacity to arrest suspected aggressors. The courts are also hampered by their minimal level of staffing, which leaves them unable to handle their case-loads.⁹

Although the budget of the Health Ministry had a nominal increase in recent years, it has actually shrunk by 4 per cent due to currency devaluation.¹⁰ Cooperation agreements with sympathetic countries, international development banks, and UN specialised agencies have helped to meet the shortfall in resources, in order to help reduce maternal morbidity and mortality in Nicaragua.¹¹ Annual per capita health expenditure decreased from US\$35 in 1989, to US\$16 in 1993, and to US\$14.5 in 1996, contributing to the general deterioration of public health services.¹² In interviews, senior officials of the Ministry of Health revealed that they do not keep separate expenditure statistics for women's health, let alone their sexual and reproductive health. For abortion-related care, patients must meet most costs, particularly when complications occur.

The Ministry of Health claims that it lacks sufficient funds to develop programs to encourage male responsibility in sexual and reproductive health, but this argument has proved to be invalid. Official information refutes Ministry of Health claims about a lack of funding.¹³ According to documents from the Ministry of External Cooperation regarding official aid for health sector development, the Ministry of Health received US\$220.6 million in grants and loans over the 1993-96 period. These funds did not include funds allocated to health in the Government's national budget, which amounted to 519,920,505 córdobas in 1995 and 541,951,686 córdobas in 1996.

8. Five years after the ICPD

There is very little visible progress in improving reproductive health in Nicaragua. There is some evidence that maternal mortality has actually increased. A study by UNICEF cited the rate in Nicaragua to be 200 maternal deaths per 100,000 live births during the period 1994-1998, higher than the officially reported rate in 1994 of 160/100,000. Government

reports claim 73 per cent of pregnant women received prenatal care in 1998, but all other evidence points to this being lower. According to official reports, in 1998 only 47 per cent of births were delivered in health facilities, and that contraceptives and other family planning services are provided to only 18 per cent of women of fertile age. There has been no increase in services for adolescents, other than one centre that opened in 1996.

Government policies and practices have not changed for the better, either. There are still no national plans and programs that explicitly interpret population policies, especially sexual and reproductive rights, and this allows the personal view of civil servants to often prevail, reflecting their own prejudices and values. Civil servants often do not make commitments because they lack the authority to make decisions. This problem is compounded by high staff turnover and the low professional standing of many civil servants appointed to take decisions on issues about which women's organisations are better acquainted.

In 1999, the Government tried to change the Constitution to acknowledge 'the right to life as from conception.' This is a more explicit statement of the current Constitutional provision that states that 'the State must protect the process of human reproduction,' but does not specify from what time.

There is still strong opposition to sexual education for adolescents and young people in state institutions. The official argument is that parents should not transfer to the State an issue that is the exclusive concern of the family. There is also opposition to adolescents and young people having access to sexual and reproductive health services because this would 'violate paternal authority,' on the grounds that parents must know the kind of questions posed and the answers received. Even for adults, there is opposition to providing sexual and reproductive health services, other than those for 'basic health.' Conservatives believe that any reference to reproductive health services implies the intention to perform abortions, therefore, services must be basic, and address the 'true' problems of health suffered by the population, namely epidemics such as dengue and malaria.

In 1999, the Government made some attempt at reforming the Criminal Code in regard to abortion. It proposed to reduce the penalty to three to six years. Abortion will however remain illegal and unsafe for poor

women, and illegal and safe only for the small minority who have the resources to get proper medical attention. The proposed change will remove the requirement for women to get their husbands' or close relatives' consent. The Ministry of Health specialists will instead make the decision. That will usually mean a flat refusal for women. It also threatens the position of private medical practitioners and the Women's Centres, for the official position is that anyone who causes physical or psychological damage to the unborn child will be sentenced to prison. This argument will also be used to support the refusal of those doctors who do not accept abortion. The changes mirror the aspirations of the Vatican, which were also behind the creation of the 'Day of the Unborn Child.'

NGOs have nevertheless made some progress. They were able to participate in the formulation of a National Plan of HIV/AIDS Prevention, where they made specific proposals regarding human rights, prevention, sexual education and therapeutic abortion. In December 1999, the Ministry of Health approved this plan.

On World Population Day in 1999, as part of the Cairo+5 Review, 65 NGOs in Nicaragua presented a declaration on Civil Society and Population Policies to the Government, requesting that the Government:

- ~ Explain which of its agencies is responsible for coordinating population and development affairs and implementing the National Policy of Population and Development;
- ~ Establish within three months, a mechanism of mediation and coordination between Government institutions and NGOs, especially those working on population and development issues; possibly a Tripartite Steering Committee on Population and Development, composed of representatives of the Government, NGOs and the UN.
- ~ Fully monitor its compliance to the ICPD Programme of Action, and ensure that these commitments were clearly addressed in its policies, programs and activities.

This request was officially repeated in October 1999, but by April 2000 the Government had not yet responded.

In some other respects, NGOs have barely held or lost ground. Reference is regularly made to the Government's 'reservations' at the Cairo and Beijing Conferences, but officials refuse to discuss these issues. Before elections, all kinds of promises are made, but afterwards revoked on the grounds of conflicting commitments or technical difficulties. When required to summon NGOs, Government mostly selects those that keep a low profile and put up little opposition, or those that will not present many arguments. Often the organisations summoned to deal with specific issues have no experience or interest in those issues.

In March 2000, the President appointed his wife as President of the National Commission on Population, thereby establishing nepotism and the marginalisation of social organisations as an official policy. A month later, a Presidential decree created a National Commission to Fight against Maternal and Perinatal Mortality. The President granted himself the power to choose a 'representative' of civil society for this Commission, thereby excluding the participation of those women's organisations which would not agree to be represented by a person appointed in this way.

Also in April 2000, the Catholic Church mounted a campaign against the proposal about Therapeutic Abortion in the new Criminal Code then under discussion. This was the first time in twenty years that such a large campaign against abortion had been conducted. The Church was advocating for the removal of any legal grounds for therapeutic abortion; to make it completely illegal, as was done in El Salvador in 1997.

The Government of Nicaragua participated in the Cairo+5 Review process, but did not encourage NGO participation. In March 1999, the President of the National Commission of Population requested information and advice from NGOs, but although they regularly sent him information, he never developed further contact with them. In March 1999, the Ministry of Family was appointed to lead Nicaragua's official delegation to the ICPD meetings, and took as his counsellor a well-known supporter of conservative groups allied with the Vatican. At the Preparatory Conference for the ICPD, they were directed by a document drafted by the Vatican, together with Argentina, Guatemala and some Arab States. They expressly refused to accept any NGOs' participation, the Minister saying that he did recognise their autonomy, and that civil society must have no influence because the family must be strengthened. At the Cairo+5 discussions in New York,

the Government of Nicaragua was the only Latin American country that adhered to all the positions of the Vatican.

In September, 1999, all population issues were assigned to the Ministry of Family, which then published a document with the Government's seal that required all Government bodies to comply with particular definitions of gender concepts. These had to be read in a loud voice whenever training activities on these issues took place.

The implementation of the ICPD Programme of Action in Nicaragua has been determined by political, ideological, economic, religious, social, and cultural circumstances that have not favoured integrated human development or the realisation of the central role of women, as conceived and conceptualised at Cairo or in other recent international conventions. There are many challenges still unmet, although neither civil society nor state bodies can deny their duty to uphold the commitments. These commitments can not be subject merely to the will of those in power. They are mandatory, according to international law and universally held standards of human rights. ✎

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²From 1989 to 1994, an estimated 43.8 per cent of the population lived in poverty.

³*Comportamiento de nuestra deuda externa*. La Tribuna, Nov. 23, 1998.

⁴UNDP, 1997.

⁵This project was coordinated by SI MUJER within the framework of the Latin American Cairo Agreements Follow-up Project of the Latin American and the Caribbean

⁶ Women's Health Network, 1997-1997.

⁷ Pizarro, 1998

⁸ This research was conducted by nine civil society organisations, and study and research centres. Each research theme was analyzed according to nine categories: 1) its legal framework, 2.) the existence of policies and programs, 3) objectives and targets of programs and plans, 4) forms of program application, 5) human and 6) financial resources to implement programs, 7) statistical records, figures and their analysis, 8) media coverage, and 9) society participation in political and program decisions.

⁹ Summary. September 1998, P. 15. Condition of girls victimized by sexual abuse.

¹⁰ Summary. September 1997, P. 17. Quality of reproductive health services, focusing on vulnerable areas and sectors.

¹¹ Summary. September 1997, P. 33. Access of adolescents to reproductive health information and services.

¹² Summary. September 1997. P. 31. Humane abortion and unsafe abortion care.

¹³ Summary. September 1997. P. 17. Male responsibility in sexual and reproductive health.

Peru

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1. The national situation

Peru's first explicit population policy was articulated in the Law of National Population Policy of 1985. Previously, policy principles had existed in a scattered fashion and were being implemented through various family planning and infant and maternal health programs. The 1985 law, however, marked the first time that a number of related issues were dealt with in an explicit and integrated manner. These include the right of people and couples to decide freely and responsibly about their fertility, the equal rights of men and women over their reproduction, and the prohibition of abortion and sterilisation as family planning methods.

At that time, the Ministry of Health's use of the term 'reproductive health' almost exclusively referred to the capacity to produce healthy children. In the laws of Peru, abortion was, and still is, considered to be an offence against body and health, and is prohibited except for therapeutic abortion, which is conducted by a doctor with the woman's consent when her life or health is in serious jeopardy.

Development indicators for Peru

	1970s	1990s
Population size	15.2 mill	24.4 mill
Population growth rate (1975-1997)	-	2.2% ann. av.
Total fertility rate	5.6	3.0
Life expectancy at birth	53.5 yrs	68.3 yrs
Maternal mortality rate	-	280
Infant mortality rate	115	44
Under 5 mortality rate	178	56
Contraceptive prevalence	-	64%
1990s gender gap		
	Female	Male
Life expectancy at birth	70.9 yrs	65.9 yrs
Net primary enrolment (6-15 yrs)	93.3%	94.3%
Adult literacy	84%	94%

Source: UNDP Human Development Report, 1999

2. Preparations for the Cairo Conference

The build-up to the Cairo Conference was the first time in the history of the women's and feminist movements in Peru that such a national process had taken place, involving people from different sectors of the country in talking about reproductive and sexual health and rights. Working together with Government agencies, women's organisations found that they could lobby for and defend the women's cause in various ways. Not only did they find themselves part of a national and international process, but their continuing role in monitoring this process was affirmed and empowered.

Before the 1994 Conference in Cairo and the 1995 World Conference for Women in Beijing, NGOs were little involved in public policy in Peru. Afterwards, however, they found new opportunities opening for them to be more involved not only in national and local policies, but also in implementing programs. They had to adjust themselves to this new situation, yet maintain their key role as observers of the ways in which the commitments made in Cairo and Beijing were to be met.

3. The presence and role of opponents to the ICPD agenda

Preparations for the Cairo Conference drew open opposition from the most conservative elements of Peruvian society, in particular the Catholic Church. Opus Dei, which holds an important position in the hierarchy of the Catholic Church and in the National Congress, was the standard-bearer for this opposition. It publicly stated that the purpose of the ICPD was to legalise abortion. This strategy had some success in diverting public attention from some core issues and their significance. The concerted opposition raised against the ICPD was unprecedented in recent decades. It was promoted in mass sermons, youth festivals, seminaries, spiritual retreats and lay movements working in different sectors of society, including amongst young people and entrepreneurs.

4. Assessing the impacts of the ICPD

The facilitation of change

The impetus created by Cairo Conference encouraged the Government of Peru to give more importance to population issues in national development, particularly those that relate most to poverty alleviation and improved living standards. The Government has given priority attention to family planning, sexual education and the improvement of women's situation as important components of human development.

Peru's population policy aims to counter the concentration of population in the main cities, by assisting the return of people who moved to the cities to avoid terrorist violence, and by improving the security and quality of rural life. The population policy also promotes the full exercise

of women's rights and requires development projects to encourage equal opportunities for women. In order to facilitate the implementation of the Law of National Population Policy, a Special Commission was created in 1997 to elaborate a 1998-2000 National Population Plan.

In furthering its population and development policies, the Government has also agreed to, or set up, new institutional arrangements, such as:

- ~ The proposal by Peruvian feminists in 1997 to create a Tripartite Table of Follow-up to the ICPD Programme of Action. This body comprises Government representatives from various agencies including the Vice-Ministry of Women's Promotion and Human Development; the Ministries of Health, Education, and Foreign Affairs; and the Presidency; as well as NGOs, universities, and international aid agencies. This body facilitates the exchange of information between sectors and interest groups, identifies priorities or gaps in national programs, helps monitor progress towards the ICPD goals by designing appropriate indicators, and disseminates information about these achievements.
- ~ The creation of a National Commission for the Coordination of the Family Planning and Reproductive Health Policy (Coordiplan). This body is presided over by the Vice-Ministry of Women's Promotion and Human Development and consists of the Vice-Ministers of Health and Education and the President of the Peruvian Institute of Social Security. This body aims to optimise the quality of family planning and reproductive health care services.

After Cairo, UNFPA reformulated its programs in line with the spirit of the ICPD Programme of Action. Accordingly, the core of any population policy should be human rights, in particular women's sexual and reproductive rights and gender equity. UNFPA has given considerable technical and financial support to the Government of Peru to implement the Programme of Action. UNFPA and WHO together have assisted the mediation between the Government and NGO by helping create mechanisms of collaboration between them, and between other sectors,

universities and international organisations, and sustain the Tripartite Table of Follow-up to the Cairo Programme of Action.

The 1995 World Conference for Women in Beijing added further momentum to the changes encouraged by the ICPD. For example:

- ~ In September, 1995, while the Beijing Conference was in progress, Peru's National Congress legalised surgical sterilisation as a method of birth-control method, thereby modifying article 6 of the Law of National Population Policy and emphasising that the choice of a birth control method depends on the free will of individuals.
- ~ The Ministry of Health formulated a National Program of Reproductive Health and Family Planning for 1996-2000. This program is an important advance because it acknowledges that gender inequality creates problems for women, and that reproductive health is a basic right and essential to the exercise of other rights.

Despite this important progress, action on the basic premises of the ICPD Programme faces serious constraints:

- ~ The Government's economic policy, while urging a reduction of the fiscal gap, is causing a significant increase in poverty, particularly in the interior of the country and in rural areas.
- ~ The State Modernisation Policy, and the health sector reforms it entails, gives priority to attaining maximum efficiency and productivity, even though this damages other aspects of health policy, particularly the attainment of equity and quality.
- ~ More generally, there is a large gap between the discourse and principles of the Population Policy, and its application. There is an absence of real political will to implement the policy to fully respect women's rights, and there is a lack of specific mechanisms to make the policy operative. These are big hurdles to the true implementation of the Cairo Programme.

Progress in gender equality

In Peru, as in other countries, most of the progress on gender equity and women's empowerment has come about through the efforts of organised groups of women. They have been assisted by international progress in the recognition of human rights and women's rights. International events, such as the ICPD, have helped to incorporate some basic premises of gender equity into national legislation and the structure of Government.

- ~ In 1996 the Vice-Ministry of Women's Promotion and Human Development was created in order to:
- ~ Promote gender equity in access to education, health and employment for special target groups;
- ~ Foster the participation of women in society and in programs to benefit their development and alleviate poverty; and
- ~ Develop and implement programs to assist children and adolescents in situations of risk.
- ~ In October 1996, the People's Defence Council gained a special branch to defend women's rights. Also created was the Commission of Women, Human Development and Sports of the Congress of the Republic.
- ~ In 1997, in order to encourage women's equal participation in politics, Congress approved the Electoral Organic Law, which, for the first time in Peru, required that any political group must include at least 25 per cent of women or men, as appropriate, in their electoral rolls. The same provision is included in the Law of Municipal Elections.
- ~ Encouraged by the World Health Organisation, a National Committee has been created to work against violence towards women and girls, and includes state sectors and women's NGOs as its members.

Progress against gender violence

Gender violence has long had some recognition in Peru; the first Police Station for women was created in 1889. Until the 1980s,

however, gender violence and family violence in Peru was mostly considered to be a private domestic issue.

Violence as a public health issue, and one related to sexual and reproductive health, has recently become a concern in academic, professional and political circles. It has also gained more public prominence. This has largely come about through the sensitisation efforts of the feminist movement, including the 'No More Violence Against Women' Campaign that is mounted by women's organisations each year around November 25th. The women's movement is working to deal with violence and its impact on women's health in more conceptual and systematic ways, and international aid donor organisations are assisting this through their support for special projects.

- ~ The Law of Family Violence, enacted in December 1993, was a landmark in the recognition of women's rights.
- ~ Legislative resolution N° 26583 of March 1996, approved the 'Convention to prevent, penalise and eradicate all forms of violence against women.' As a result, police delegations led by police-women have been expanded nationwide. There are now eight delegations in the interior of the country, and trained departments in five other cities.
- ~ The Sole Text of Law 26260 was approved in June 1997. In February 1998, the powers and functions of justice personnel participating in this process were defined.
- ~ Law N° 26770 of April 1997 repealed Article 178 of the Penal Code of 1991, which had allowed rapists and their collaborators the possibility of being freed from the corresponding penalty if one of them married the victim.
- ~ The General Law of Health, issued this year, grants free attention in state health care centres to victims of violence, upon the request of the police, and doctors' certificates being given full value as evidence in the Courts.
- ~ Municipal Defence Councils of Children and Adolescents (DEMUNAS), organised by municipalities, NGOs, grassroots organisations and parish churches, have been established to defend the rights of all children and

- adolescents. The Organic Law of Municipalities has been modified to incorporate responsibility for the DEMUNAS, of which 983 are currently operating throughout Peru.
- ~ The Ministry of Health, with assistance from UNICEF, is setting up special units in hospitals and health centres to prevent and deal with abuse against children and adolescents. The Ministry of Education is similarly executing a pilot program against child abuse in primary and secondary schools.
 - ~ In 1997, the Vice-Ministry of Women's Promotion and Human Development, working together with NGOs and universities, has trained policemen, civil servants and Court employees in the treatment and prevention of family and child sexual abuse.

Progress in sexual education and gender equity for adolescents

Since 1995, the Ministry of Education has re-incorporated population education, with an emphasis on sexual education, into the national school system. A training program has been approved for primary and secondary students and their teachers. Family and sexual education guidelines have been drawn up to direct the work of NGOs, particularly women's organisations, which have been sub-contracted to conduct this education throughout the country. In 1996, 2,410 primary teachers and 12,300 secondary teachers received this special training.

The Ministry of Health conducts a special health program for school students and adolescents. It aims to reduce the most frequent causes of illness and death in these age groups: principally accidents, unwanted pregnancies and infections.

In April, 1998, Law 26941 was approved, through the initiative of the Women's Commission of the Congress. This law modified the Code of Children and Adolescents to state that pregnant adolescents and mothers must be allowed to start or continue their studies without any discrimination, and that children and adolescents cannot be tortured or treated in a cruel or degrading way.

5. Moving ahead on reproductive health and rights

Reproductive health

Changes in health policies in Peru are directly related to the political commitments of the Government and current development theories and perspectives. They are also linked to Peru's new relationship with international markets and its compliance with the requirements of the International Monetary Fund (IMF).

In 1990, at the beginning of his first term in office, President Fujimori announced the start of the 'Family Planning Decade,' and that the Government would provide family planning services in all clinics operated by the Ministry of Health. Family planning has been a key strategy in the Government's so-called 'war against poverty.' Yet the connection between family planning and poverty alleviation is not so obvious. Firstly, it sits very poorly with the new reproductive health approach and focus on women's reproductive rights. Secondly, poverty alleviation requires development and equity policies. Fewer births in poor areas will not alone change social and economic inequality.

Through the processes leading up to and from the Cairo and Beijing Conferences, women's organisations have been key actors in securing a greater role for civil society in directing legislative, institutional and public policy changes, especially for women's health. Feminist NGOs have played an important role in the analysis and debate of reproductive health policies and programs.

Progress in reproductive health includes:

- ~ Since 1995, health policy in Peru, particularly consideration of reproductive health, has been in line with the ICPD Programme of Action.
- ~ In August 1995, the National Population Policy was modified to allow voluntary surgical contraception as an approved birth-control method. In the same month, the Ministry of Health introduced free family planning services in all of its health care centres.

- ~ Since 1995, allocations from the national budget have increased for family planning, from US\$10 million in 1996, and US\$13.7 million in 1997, to an estimated US\$15.2 million in 1998. In this year, the Treasury also allocated US\$6.7 million to the national Maternal and Peri-natal Health Program; US\$714,000 to the Health Program for Students and Adolescents; and US\$4.5 million for a national program to prevent sexually transmitted diseases (STDs) and AIDS.
- ~ In February 1996, the 1996-2000 Program of Reproductive Health and Family Planning was approved, in line with the concepts of reproductive health agreed to at Cairo.
- ~ The 1996-2000 Program of Reproductive Health and Family Planning recognises that abortion is a public health problem in Peru. Its plan to reduce maternal mortality includes reducing the number of deaths caused by abortion complications and unwanted pregnancies. Obstetric emergency protocols and procedures have been established to assist with cases of incomplete abortions in hospitals; and a training program now under-way will improve the medical attention given to incomplete abortions.

The concept of reproductive health nevertheless has different meanings when it is put into operation. Most activities of the Ministry of Health are still centred on family planning. They emphasise fertility decline rather than good reproductive health or the exercise of reproductive rights.

While abortion remains an occasional issue of public debate, no progress has been made on decriminalising it. The new General Law of Health has instead provided that doctors should inform the director of a health care centre whenever there are signs of 'criminal' abortion, and that they are compelled to denounce it to the relevant authorities.

Very few studies have been conducted to ascertain the quality of health care from the perspective of service clients. There nevertheless is sufficient information to identify some main problems in service quality. Research conducted by Consorcio Mujer (the Women's Consortium) into public-run health services, found that many women expressed deep dissatisfaction with the services provided, although they had little or no

awareness of their rights as individuals and beneficiaries of these services. The relationship of the service provider to the user has traditionally been paternalistic and authoritarian, and gives little consideration to neither the users' needs and expectations, nor the exercise of their rights. The results of this research have helped address this problem by improving communication between the various interest groups and the Ministry of Health. The information provided by the research about the treatment of the rights of clients, and the discussion these findings provoked, contributed to the drafting of the new General Law of Health enacted in 1998.

Other issues with the quality of health services include the need to improve the sanitary infrastructure, establish accreditation standards for hospitals, provide training in quality care for health workers, and improve the understanding about the ways in which service users experience the services provided. Criticism and disputes over the practice of voluntary surgical contraception has encouraged the Program of Reproductive Health and Family Planning to change its practices, so to better acknowledge reproductive rights and improve the quality of its services, in line with the Cairo Programme.

Although most of the changes described here have been introduced at the national level, they are not necessarily implemented in an even way across the country. Furthermore, the initial political will for change does not necessarily entail a sufficient financial commitment to fully implement the change. Some of these programs operate in a parallel fashion, and there is little integration between them. International aid also is often poorly coordinated, with different agencies independently supporting their own projects on various aspects of reproductive health.

Apart from inadequate coordination, another factor that hinders progress on reproductive health is the continuing opposition of some conservative forces. According to the National Promoting Group of Women for Real Equality, however, the most progressive element in the Government's population policy has been the re-definition of the relationship between the Church and the State. This has helped reduce interference by the conservative Catholic hierarchy on population and reproductive health issues.

The agenda for rights

The incorporation of reproductive health as a right into policy documents is an important achievement. The concept of reproductive and sexual rights has not been equally acknowledged. Some steps have been taken to incorporate sexual and reproductive rights into the work of some NGOs, particularly those involved in family planning, and onto the agenda of international aid agencies, unions, professional associations and grassroots social organisations.

State institutions such as the Vice-Ministry of Women's Promotion and Human Development have made some acknowledgment of sexual and reproductive rights in their plans and programs. Their understanding of these rights, however, is strongly conditioned by their preoccupation with family planning. Their policy statements, therefore, are reduced to references to, for example, 'men's and women's capacity and freedom to decide in a responsible way, the number of children they want to have, and to have access to information so as to choose freely between all the contraceptive methods available.'

Because of the confused understanding about rights, even some government delegations to the Cairo Conference spoke in support of quite different objectives. For example, while President Fujimori spoke in favour of women's self-determination of their reproductive capacity and life, at the same conference the Peruvian delegation was reserved about the concepts of reproductive and sexual health and rights, for fear this might be against the sanctity of the family and marriage.

The understanding of reproductive and sexual rights that is being promoted by the general discussion on human rights in the international domain nevertheless is slowly dissolving barriers and stereotypes about sexuality. These rights are becoming more recognised in relation to health, but still are less recognised in respect of women's autonomy and empowerment.

Apart from the legislative changes already described, other changes relevant to women's sexual and reproductive rights are:

- ~ In March 1996, the Convention to Prevent, Penalise and Eradicate All Forms of Violence Against Women was

- approved. It defines violence against women as any form of physical, psychological or sexual abuse that occurs within families or in any interpersonal relationship.
- ~ Law N° 26644, dated June 1996, states that a pregnant worker has the right to 45 days of leave before and after childbirth. Decree Law N° 887 of November 1997, the Law of Social Security Modernisation, restored the right to maternity and lactation allowances for ninety days.
 - ~ The Sole Ordered Text of the Legislative Decree N° 728 of June 1997, considers sexual harassment to be an act of hostility that may lead to dismissal.
 - ~ Law N° 26941, which changed the Children's and Adolescents' Code, states that teachers can not harass their pupils.
 - ~ The Ministerial Resolution 0654-92-SA/DM approves the Normative Guide for the care of pregnant adolescents at health care centres.

6. Relationships between NGOs and Government

The social movement of women, particularly the feminist movement, has gained valuable experience from the Cairo and Beijing processes, by conducting research, providing alternative services, making legal and political proposals, conducting education and sensitisation programs for key agents in the community and Government, and mobilising women's health campaigns. This experience has had an impact on the way in which various sections of the Government and the community relates to sexual and reproductive rights.

The legitimacy that has been attained by women organisations and other NGOs was gained through their work to benefit women, for years before the international conferences promoted by the United Nations. According to a recent report by Peruvian NGOs, apart from defending their own interests, these movements have significantly contributed to the solution or alleviation of those national problems that have been made more acute by the structural adjustment policies. Poverty, infant malnutrition and cholera are among many issues confronted by women's organisations, although this work is not necessarily acknowledged in official spheres of power.

Since the Cairo and Beijing Conferences, NGOs and the Government have found themselves increasingly in competition to execute aid-funded projects on health and education. This change has been part of the process of economic reform whereby some government functions are being subcontracted to civil society institutions. This process is also being promoted by international aid agencies giving direct support to NGOs. The Cairo Programme makes explicit the need for civil society to participate more directly in development processes. NGOs are believed to make more efficient use of resources and have more direct contact with the community. This situation nevertheless calls for the development of new mechanisms for cooperation between NGOs and Government.

The new association between the State and civil society has also been marked by women's greater participation as citizens in elaborating national and international policies, including participating in the International Conferences promoted by the United Nations.

The assumption by NGOs of these social and economic commitments in areas once considered to be the Government's responsibility is not a new situation in Latin America or Peru. Long periods of economic and political crisis, successive re-adjustment measures, and the absence of state functions this has often entailed, have required NGOs to help communities meet their basic needs. These NGO activities have not, however, been as systematic as the economic reformers propose they will become.

The new situation poses challenges and opportunities for NGOs and civil society generally. The opportunity to exert influence in both formulating and executing policies is attractive. Yet these kinds of commitments may interfere with the autonomy of NGOs and limit their capacity to question Government.

7. The impact of the Cairo+5 review

Well before the Cairo Conference, the Government of Peru gave importance to family planning and this coincided, somewhat, with the agenda of the women's movement. To that extent, the ICPD Programme was only one factor in political decisions to accelerate or postpone measures relating to reproductive health. For example, a maternal-infant

insurance scheme was finally established in the midst of a national election campaign, even though it had been demanded by the women's movement some years before.

On the other hand, the Cairo process has certainly helped develop a dialogue between Government and civil society regarding some of the aspects of the Programme of Action, particularly those relating to the quality of health services. It has also helped expand people's understanding about reproductive and sexual health and rights. During the Cairo+5 negotiations, Peru's official delegation defended the ICPD Programme of Action of Cairo. Representatives of feminist NGOs were included in the official delegation. This collaboration is the outcome of the positive dialogue between Government and NGOs on these issues. This openness of dialogue and interaction between civil society and government marks a great achievement of the ICPD process - although these relationships remain fragile in some respects and negotiation processes must constantly be restarted.

Women's organisations have played a key role in monitoring the compliance to the ICPD Programme, both on their own behalf and as part of other national and international organisations. They have continually reminded Government and state institutions about their responsibility to act on the commitments made at Cairo and Beijing. They have also denounced violations of women's rights, improper professional practices, and serious breaches of health service, such as in the Tubal Ligation Campaign.

The Cairo+5 Review again brought out the conservative sectors of Catholic Church in opposition to the ICPD Programme of Action. The Church and other conservative groups denounced the surgical contraception campaign on the grounds that it threatened the right to maternity and mutilated women. They accused the government of assisting in the depopulation of the countryside, and voiced other opposition to the National Program of Reproductive Health and Family Planning. A particularly contentious issue with the Church is sexual education in schools, which the Church claims to promote licentiousness and threaten the family. Behind the Church's questioning of reproductive and sexual rights, there is evident criticism of homosexuality and abortion.

The Cairo+5 Review report makes useful suggestions as to how to move forward the agenda for reproductive health. In Peru, these priorities should include:

- ~ Actions to further reduce maternal mortality;
- ~ Improved access for adolescents to health care services, including amendment of the General Health Law, which now hinders adolescents' independent access to these services;
- ~ Creation of new coordination mechanisms between the various sectors, and further encouragement of the participation of civil society in controlling the quality of service at health care centres;
- ~ Development of a consensus on what constitutes quality health service;
- ~ Revision of laws that penalise abortion, and better acknowledgment of abortion as a public health problem, in order to reduce the number of related maternal deaths; and
- ~ Involvement of boys and men in reproductive health and family planning programs and actions.

8. Conclusions

Five years after the ICPD in Cairo, the most concrete achievement in Peru is the national Reproductive Health and Family Planning Program, which embraces the principles and premises of the ICPD Programme of Action, and has been responsible for good progress in some aspects of reproductive health in the country. Special attention is being given to improving the access of disadvantaged groups to contraceptive methods. Male and female sterilisation has been legalised.

On the other hand, the continuing emphasis on fertility control, particularly as an anti-poverty strategy, maintains an element of control in the program, and does not properly reflect the precedence that should be given to women's welfare and human development, based on the exercise of their reproductive rights. Furthermore, while considerable resources are being directed to family planning, other important needs, such as reduction of maternal mortality, HIV/AIDS prevention and treatment, and the revision of abortion laws have had much more limited attention.

While a gender perspective is articulated in the policy discourse no intervention strategies have been defined to change the power relationships among genders, or generate equal opportunities in the different aspects considered in the Cairo Programme. No progress has been made in educating boys in responsible sexuality and reproduction and to respect women's sexual and reproductive rights.

Important legislative changes have included a prohibition against expelling pregnant students from school, and the removal of the possibility that a rapist can escape penalty by marrying his victim. Even so, reproductive and sexual rights still lack the legitimacy in law that they require. The issues of abortion and the right of adolescents to have independent access to sexual education and services have not made significant progress in revising the law.

The right of all people to access health care services is acknowledged by the New General Health Law, largely through the efforts of feminist NGOs. On the other hand, current health reforms threaten to reduce, rather than increase, access to quality services. Although women's access to reproductive health services has generally increased, it is not clear what will happen as the user-pays strategy continues and more costs are transferred to the community.

Women's organisations have become much more active in policy formulation, but the mechanisms for this are still weak. The progress attained so far must be strengthened, in order to foster women's role in civil society and their potential political force.

Although there has been a significant increase in the budget for basic and reproductive health from both the Government and international aid donors, family planning activities are most privileged and there are not sufficient resources to meet all other reproductive health needs.

The reforms that are now under-way in the health sector are based on policy guidelines that espouse equity, efficiency and quality as pillars of the new health system. Yet defining service efficiency only in quantitative terms, and not in terms of equity and quality, restricts the possibility of attaining the latter. In this case, political will is being driven by a logic of the market, instead of the logic of fully developing the human potential of men and women. ❦

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Puerto Rico

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1. The national situation

The Island of Puerto Rico is part of the Greater Antilles, and its language, history and culture link it with the Latin American continent. Since the North American invasion of 1898, Puerto Rico has been a colony of the United States. It officially became a Commonwealth with its own local government in 1952, but remains subject to the decisions of the United States Supreme Court and Congress. From the late 1940s, Puerto Rico became a pioneer of economic development strategies based on industrialisation by invitation which were accompanied by populist public health policies, including infant and maternal health as well as Neo-Malthusian policies of population control.¹

In the 1930s, legal restrictions on contraceptives were removed, and methods were offered through state programs related to the US New Deal policies. By the 1940s the opposition of the Catholic Church and groups that supported independence and denounced these programs as genocidal, led the government to reduce its open support for these programs, but they were still promoted tacitly through private organisations.² Sterilisation was so zealously encouraged that in 1965, 34 per cent of women of reproductive age had already been sterilised, one of the highest rates in the world.³ Throughout the 1960s, various contraceptive methods, including pills, intra-uterine devices, and Depo-Provera, were tested on

poor women in Puerto Rico under conditions that did not guarantee their knowledge about possible health risks.⁴ During the 1970s, population control programs were again openly promoted by the Puerto Rican government, following North American guidelines that favoured a worldwide agenda of population control.⁵

From the 1950s, a state practice which Fernós has called 'looking the other way,' opened access to abortion, at least for women with economic means. Although it was illegal, the island became the Mecca of abortion in the Caribbean until abortion was legalised in 1973 as a result of the *Roe vs. Wade* decision by United States Supreme Court.⁶ Ratified by decisions of the Courts in Puerto Rico in 1974 and 1980, elective abortion is now legal in the island but is not offered as a public health service. In principle, it is available within the public system for cases of rape, incest or when a woman's life is at risk, but in practice, it is only available at private clinics.

In the 1970s, groups such as "Mujer Integrate Ahora" (Woman Join Now), the Federación de Mujeres Puertorriqueñas (Federation of Puerto Rican Women), the Governor's Commission for Women's Affairs, and Taller Salud, a women's health collective, denounced the Government's policy of promoting sterilisation and quotas, including the participation of ever-younger women.⁷ The emerging feminist movement attacked the abuses committed in the name of population control, but also defended women's rights to abortion and birth control methods that were safe for their health.⁸

Population control programs were reverted when the Republicans, with their privatisation and welfare state dismantling policies, came into power in the United States in 1979. This affected social and health services, especially regarding birth control, cut back largely because of its association with abortion, by then under attack by the North American right wing sectors. The coming to power of the Democrat Party in the United States in 1992 changed this situation, but the health policies were still affected by pressure from the pre-eminently Republican Congress.

By then, population control programs had become less aggressive due to changes in the government of Puerto Rico and the denunciations of abuse levelled by the Catholic Church and feminist groups. US federal cutbacks in funds reduced the availability of birth control services. Government funded sterilisation became more restricted and available

mainly to high parity women or those at health risk.¹⁰ In 1993, a health reform program began. This privatised services and thereby dismantled the vast system of public health, which despite its limitations had served the entire population. The Government abandoned its traditional role as health service provider and instead became involved in supervising, assessing and regulating health systems.

State health services are now available only to the medically indigent through the system of private health maintenance organisations (HMOs) paid by the government.¹¹ HMO insurance coverage includes gynaecological and cancer prevention services, maternal-infant health services, and some HIV-AIDS treatment. Reproductive health services for fertility regulation and sexually transmitted diseases (STDs) are restricted. Only sterilisation is provided as a fertility control measure and contraceptives are available only for medical reasons unrelated to birth control. Induced abortion or its complications are not covered by the insurance.¹²

The Health Department still provides some health services that are not covered by the new insurance scheme, and services for groups as yet not incorporated to the health reform. These include maternal-infant care, services for pregnant adolescents, family planning, prevention and care of STDs and HIV/AIDS, and care for victims of rape. Funding from the Puerto Rico and US Governments supports these services. Free contraceptives are still provided by programs funded by the US Federal Government and distributed in the remaining state Diagnosis and Treatment Centres, other Federal Government funded family planning programs, and private medical centres and drugstores that agree to provide this service.¹³ The closing of government facilities and further cuts in federal funds however threaten this access.

With regard to gender equity, the transformation in the social situation of women in Puerto Rico has accelerated since the 1970s. The percentage of women over the age of 25 who are university graduates increased from 5 per cent in 1970 to 15 per cent in 1990. Since the 1980s, women have overtaken men in university enrolments and graduates in almost every academic field. During the 1980s and 1990s, women's participation in the work force increased from 26 to over 35 per cent, although this is still a relatively low rate compared to more developed countries. While women have moved forward in all professions and occupations, occupational segregation still persists. Most women still

work in occupations traditionally considered to be feminine: education and health professions, or as clerks or administrative assistants. Income inequality is evident between men and women at each occupational and schooling level.¹⁴

The feminist groups that emerged during the 1970s have contributed to the improvement in the legal and social status of Puerto Rican women. They have encouraged public discussions on women's rights as well as changes to policies and institutions, including the establishment of the Governor's Commission for Women's Affairs in the early 1970s. These efforts were strengthened by initiatives by the United Nations, such as the declaration of an International Women's Year and the Women's Decade in 1975. Family and labour legislation were amended to reduce employment discrimination, increase maternity benefits, and provide equality between spouses in terms such as common property, paternal authority, child custody and the establishment of common residence. Early work to end violence against women included the establishment of the Rape Crisis Center in 1976 and the Julia de Burgos Shelter for Battered Women in 1979, followed by other shelters and service centres. Research and education projects were set up at universities to reduce discrimination in education, employment and mass media. Taller Salud, established in 1979, was a pioneer in the women's health movement in Latin America.

Feminist groups' activity peaked in the 1980s, particularly around the issue of violence against women. They were invited to be advisers in the Legislature. Their relationship with the Government's Commission for Women's Affairs grew closer.¹⁵ At the end of the decade, legislation was approved to address domestic violence and sexual harassment in the workplace. The Peace for Women Coalition, active since the late 1980s, includes a range of feminist groups, shelters, service and research centres, and government institutions working to end violence against women.

Yet as a reaction to these advances, a backlash against women's rights and organisations arose right before the Cairo Conference and has continued to this day. In 1992, with the advent of a new administration, the Governor's Commission for Women's Affairs lost status. Its participation

in NGO activities was drastically reduced. Beyond cuts to reproductive health services, the neo-conservatives attacked the movement for gender equity, particularly targeting abortion rights and efforts to eradicate violence against women. Since its approval in 1989, the law against domestic violence has been threatened by groups that argue domestic violence is a private matter, and that the law discriminates against men.

Neo-conservative groups have attacked the right to abortion, particularly since the US Supreme Court ruling in 1989 that allowed individual states to additionally regulate abortion. Copying US anti-abortion groups' tactics, some groups have repeatedly - but unsuccessfully - lobbied for restrictive legislation, such as a bill to require a 24-hour waiting period for women seeking abortions.¹⁶ During 1992 and 1993, blockades and boycotts were staged against abortion clinics, but fortunately did not escalate to the violence seen in the United States.¹⁷

Anti-abortion legal initiatives have failed. The Courts have reiterated the right to abortion in decisions such as the enforcement of freedom of access to clinics.¹⁸ Yet the controversial nature of the issue has discouraged civic leaders, politicians and the State from engaging in its open discussion. The situation is one of practical tolerance. Yet the social stigma attached to abortion hinders its acknowledgment as a woman's right and the demand for its availability as a public health service. Despite its legal status, officials only tacitly accept abortion, not defend it.¹⁹

Feminist and other progressive groups responded to the anti-abortion offensive by organising the Reproductive Rights Coalition, a network of 17 feminist and human rights organisations, academic researchers, women's service centres, family planning clinics and government agencies. From the early 1990s, the Coalition has provided a different voice in official discussions and public debates on this issue. Although it is not a large or powerful organisation, the Coalition has helped defend the legal status of abortion. Feminist and pro-choice groups have not succeeded in removing the stigma against abortion.

2. Preparations for the Cairo Conference

As a United States colony, Puerto Rico is not represented in international organisations and receives no assistance from the United Nations or its agencies. The International Planned Parenthood Federation (IPPF) is the only international population related organisation present in the island, through Profamilia, the sole private family planning agency. Despite the Island's ties to the United States, Puerto Rican officials were not involved in the US official representation to the ICPD. The Government of Puerto Rico thus disregarded the Cairo Conference and there were no preparatory actions or discussions on its Programme of Action.

Nevertheless, groups in Puerto Rico like Taller Salud have addressed reproductive health issues, central in the development of the international women's health movement, since the 1980s.²⁰ Feminists in the legal field have advanced the recognition of women's rights and reproductive rights as human rights.²¹ The ICPD Programme of Action became a landmark in terms of NGOs involvement and its incorporation of the demands of the women's health and reproductive rights movement. It allowed the discussion of what had been the women's health agenda as official policy of the paramount world organisation, the United Nations. Already part of the women's health movement, the Reproductive Rights Coalition and the Project of Women's Studies of the Cayey Campus of the University of Puerto Rico were able to participate in regional meetings prior to the Conference, as well as the Preparatory Conference in New York and the NGO Forum at Cairo.

3. Developments since the Cairo Conference

Since 1995 the Puerto Rican government has concentrated its efforts on implementing its Health Reform Program, which now covers the whole country. Already reduced by cutbacks in US federal funding, public health services could be further restricted through the privatisation of facilities. For poorer women especially, access to services that are not included in the national insurance scheme, such as contraceptives, have become restricted with the closing of public health centres where they once were available.

As a positive development, in September 1997 the Health Department launched a new Policy on Sexual and Reproductive Health based on conclusions and recommendations from a workshop attended by many NGOs promoting a broad agenda for women's health. The Policy includes some elements of the ICPD Programme of Action, such as an integral definition of reproductive health, attention to STDs, the needs of adolescents, improved quality of care, and the involvement of NGOs. Abortion, however, was not mentioned, and the Policy states the Government's commitment to promote sexual education based only on abstinence, as required by US federal funding.

Puerto Rico has a particular set of needs among those included in the ICPD Programme of Action. The long-standing maternal-infant health program had reduced maternal mortality to a rate of 5.3/100,000 live births by 1979. After the economic crises and cutbacks in health services in recent years, however, this rate had risen again to 21/100,000 live births by the early 1990s, although it has declined again since. Only around three-fourths of women receive prenatal care during the first quarter of their pregnancy, a fairly low figure compared to more developed countries.²²

The ICPD Programme validated the long-standing demands by Puerto Rican NGOs for women's self-determination and the removal of quotas and other state mechanisms pressuring their fertility decisions. Claims of abuse against population control policies, however, have not implied any lessening of the demand for women's effective and safe birth control. Actually, the changes in the social and economic status of women, including the contradictory spaces opened by Neo-Malthusian birth control policies, well before the Cairo Conference brought about widespread use of contraceptives and a steady fertility decline. Despite reduced access to reproductive health services since the 1980s, national fertility surveys in 1982 and 1995 found contraceptive use rose from 69 per cent to 78 per cent of fertile women, and fertility had declined from 2.8 children per woman in 1980 to 2.1 by 1995.²³

The Health Reform Program that began in the early 1990s reduced the quality and access to reproductive health services and decreased the availability of contraceptives. Women face various difficulties. They must travel longer distances and pay more for transportation when services are not available in their locality. They face delays in getting service, the contraceptives they need may not be available, and not enough drugstores

and medical facilities supply free contraceptives from the government. The quality of government and private medical attention may be different.²⁴ Different services often are not available within the same clinic. Contrary to the ICPD's proposal for fertility control to be part of broader and integrated reproductive health programs, the Health Reform Program in Puerto Rico, in fact, has reduced this integration.

The ICPD Programme of Action advocates for more access to a broader range of safe, efficient, and acceptable contraceptive methods. Women should understand the risks and advantages of different methods, and receive assistance to use any method that suits them best, including barrier methods that maintain women's control and do not interfere with their hormonal system. Yet, sterilisation, an irreversible method, remains as the most widely used birth control method. Over 40 per cent of women in unions are sterilised. There has also been a dramatic rise in births by caesarean section, particularly in the private clinics, which doctors are prone to follow by sterilisations at higher parities. In 1995, they accounted for 34 per cent of all deliveries, one of the highest rates in the world, becoming an unintended factor in the rise in sterilisation rates.²⁵ Although voluntary sterilisation is covered by the new insurance scheme, the lack of uniform protocols for the procedure, and the fact that some service providers discourage women or do not respect their decision, may limit access.²⁶

Contrary to the ICPD's emphasis on men's responsibility for their reproductive actions, there is minimal use of male contraceptive methods. Despite widespread use of contraceptives, the rate of unintentional pregnancies is high, and this may encourage the use of abortion and sterilisation to regulate fertility. While, the ICPD Programme emphasises the need for better access to sexual education and birth control for people who are denied them, in Puerto Rico, adolescents have very little access - as reflected in the fact that they account for 20 per cent of all births.²⁷

The definition of sexual and reproductive health accepted at Cairo also included the prevention and treatment of cancers of the breast, cervix or uterus, reproductive tract infections (RTIs), STDs and HIV/AIDS. In Puerto Rico, cervix examinations (pap smears) have been extended and deaths from cervical cancer reduced to 1.3/100,000 women. In the last national fertility survey, 95 per cent of women reported that they had been screened but only 73 per cent had done so in the two previous years, and most

women went to private clinics, not public health services.²⁸ Mortality from breast cancer is high and rising.²⁹ There is little public or epidemiological knowledge about RTIs or STDs in Puerto Rico. While AIDS is more prevalent among men, there is a faster increase in deaths among women, from 193 in 1990 to 299 in 1995.³⁰

Reproductive health also requires the promotion of equitable gender relations beyond medical services. Overall, there has been little promotion of men's responsibility for their sexual, reproductive or family behaviour. Most of the recent programs for men have been in regard to HIV/AIDS transmission.³¹ Since the 1970s, pioneer programs about gender equity and sexual education have been provided through schools and universities in Puerto Rico, but have not been extended throughout the educational system. There is acknowledgment of the various means of coercion and violence against women; Puerto Rico pioneered laws in Latin America to stop violence against women. These laws however remain under attack and the police and courts have problems upholding them.³² Moreover, although the most overt forms of male domination in the family have been challenged, women remain subordinated, and this contributes to the prevalence of violence.

The ICPD Programme reaffirms the need to improve women's unequal status and encourage their participation at all political levels, as well as strengthen the presence of women's groups in designing, monitoring and evaluating policies and programs. Women's still have restricted access to positions of leadership or economic and political decision-making.³³ Although they may have reached higher levels of education than men, persisting stereotypes still limit women's employment opportunities. Although the State has reiterated the need for childcare and infant development services and has established some programs to fulfil this need, but very few families benefit from them.³⁴ Other services to support women's domestic responsibilities have not even been considered.³⁵ More equity in women's opportunities for social and economic development is therefore still a priority, especially because of the persistent unemployment and poverty among women.³⁶

The Puerto Rico Government gave scant attention to the ICPD but instead concentrated on implementing its Health Reform Program throughout the country. Already reduced by cut-backs in US federal funding, public health services were even more restricted through the privatisation

of facilities. For poorer women especially, services that are not included in the national insurance scheme, such as contraceptives, are now quite restricted because the public health centres where they once were available have now closed.

In September, 1997, the Health Department launched a new policy on sexual and reproductive health. This policy was based on conclusions and recommendations reached from a workshop attended by many of the NGOs working to promote an integrated agenda for women's health. The policy therefore includes some elements of the ICPD Programme of Action, such as the definition of reproductive health, the attention to be given to STDs, the needs of adolescents, improved quality of care, and the involvement of NGOs, among others. Abortion, however, was not mentioned, and the policy states the Government's commitment to promote sexual education based on abstinence, for this was a prior condition for US federal funds being used for this purpose.

Development indicators for Puerto Rico

	Total
Population size (1995)	2.9 mill
Families with female heads and absentee husbands	23%
Percentage of families in poverty	55%
Percentage of female-headed households in poverty	70%
Average family income	US\$10,000
Av. income of female-headed households	US\$6,015
Percentage of women aged 25 and over, with higher education or at least 12 yrs of schooling	50%
Percentage of women in the work force	37%

	Female	Male
Life expectancy at birth (1995)	79 yrs	70 yrs
Mortality rate (per 100,000 pop) 1995	6.5	9.8
Infant mortality (per 1,000 live births) 1995	10.4	15.0
Maternal mortality 1995	14.2	
Contraceptive prevalence	77.5%	

Sources: 1990 Population Census; Departamento de Salud (Health Department), 1995, (Annual Report of Vital Statistics; 1995); Dávila (1998), *Puerto Rico. Encuesta de Salud Reproductiva, 1995-1996*, (Puerto Rico Reproductive Health Survey, 1995-1996).

4. The work of organisations that promote reproductive health and rights

Several NGOs in Puerto Rico have incorporated the ICPD Programme into their agenda and work to disseminate public information about it. These groups include Peace for Women, the Health Workshop, the Puerto Rican Pro-Family Welfare Association, and the Pro-Reproductive Rights Group. These organisations and many individuals presented a list of demands about women's health in March 1995 to the Puerto Rican legislature, and discussed these demands with members of parliament and civil servants. Together, the Pro-Reproductive Rights Group and the Puerto Rican Pro-Family Welfare Association developed the Alliance Project in 1995, which uses the media to promote the ICPD Programme to the general public. Since 1994, the Pro-Reproductive Rights Group has designed and conducted women's health workshops, together with the Felisa Rincón de Gautier Foundation. Reports on these workshops have been provided to civil servants and legislators to assist them in designing public policies, especially on reproductive and sexual health.

University researchers have conducted studies on various practices relating to reproductive health. They have also promoted the ideas contained in the ICPD Programme in their training of students in the health professions and other disciplines. Several NGOs assist people with

HIV/AIDS, work to prevent adolescent pregnancies or are active in other areas relevant to the ICPD programme - most through voluntary workers and with limited economic resources.

5. Opponents of the ICPD Programme

Even before the ICPD, conservative groups challenged women's advances in reproductive health and gender equity. The Catholic Church, the Pro-Life Association, Morality in Media and other fundamentalist groups continue to campaign against reproductive health and rights, and against any attempt to further the recognition given to women's rights. In recent years they have opposed the use of condoms, tried to restrict access to abortion, insisted that sexual education must focus on abstinence; and expressed opposition against marriage between people of the same sex. Just as well, some men have attacked the law against domestic violence and attempted to question its constitutionality in the courts. The most recent attacks have aimed to discredit not only the law, but also the organisations that defend it.³⁷

Apart from the actions of these groups, neo-conservative elements in the US Congress exert an influence over developments in Puerto Rico through their power to reduce federal funds for social and health services, and their assignment of funds for sexual education only on condition that this education advocates abstinence.

6. Progress on the ICPD agenda

Some conditions in Puerto Rico favour developments along the lines advocated in the ICPD Programme of Action. These include the high level of contraceptive use, low fertility rates, the legalisation of abortion and legislation against domestic violence, as well as laws that favour gender equity in the family and at the workplace. Women generally are well educated and their participation in the work force continues to grow.

Even when they do not have a big membership, feminist groups and other NGOs have helped to educate the public about gender equity

and reproductive health through research, community mobilisation and service provision. They have encouraged public discussion on health and reproductive rights, and influenced national policies, despite political changes in the island. Some aspects of the Programme of Action, such as the prevention of breast and cervical cancer, prenatal care and maternal health, have been incorporated into the Health Reform Programme.

An important obstacle against the implementation of ICPD agreement, however, appears to be the Government's lack of political will and its acceptance of a development strategy that encourages foreign investment even at the cost of high dependency, poverty, unemployment, and rising health costs. Existing as it does within the sphere of the US economy and policies, Puerto Rico has similar demographic characteristics to some developed countries, such as low levels of mortality and relatively high life expectancy and level of education. Yet the strategies of economic development have not allowed the establishment of a solid internal economy and greater State resources, and have not alleviated the endemic problems of lack of employment, income levels far lower than in the United States and high levels of poverty, particularly in households headed by women.³⁸

Since the 1970s, the contribution of US federal funds has to some extent buffered these limitations. Although many of these funds go towards paying for services rendered, such as military service or for pensions and social security to which employers and workers had contributed, they also support the operation of government departments and social services, especially health and education, and provide welfare benefits to individuals. Still, this dependency on the US makes Puerto Rico vulnerable to changes in US domestic policies, such as the move towards economic neo-liberalism and the consequent reduction in federal funds to programs in Puerto Rico. After the 1992 election of a governor who favoured the country's annexation to the US, the privatisation program has accelerated, including the dismantling of the public health system. The Health Reform has not only limited the availability of services. Through the sale of public medical facilities, it also transferred part of the national wealth into private hands.

A private survey found that people covered by the Reform expressed a high degree of satisfaction compared to people under private plans not endowed by the government. Yet this survey also noted that this satisfaction may stem from their previous lack of access to private health care services and no clear judgement as to whether the service they receive

is the most adequate.⁴⁰ People who use the services least may be the ones who express most satisfaction. People with the greatest need for services may find themselves restricted by the 'capitation' system, whereby there is a maximum payment per user. Information and scientific evaluations have been scant and limited in scope, so that it is difficult for people to judge at present how well the Health Reform Program meets the needs of the public.

Concern about high health costs is widespread. The Department of Health has been forced to reassume the administration of some hospitals and health centres that were privatised. Press reports and private studies also suggest that doctors now spend less time with each patient and there is less access to diagnostic tests, such as mammograms and cancer scans. Drugstores, laboratories and doctors have expressed concern about the number of clients they can properly attend to and quality of the care they can give.³⁹

Worrying social trends connected to the economic situation and neo-liberal policies include a general atmosphere of violence and substance abuse. In this situation, it is difficult to mobilise people to demand better social services and to priorities on women's health needs. The feminist movement remains small, and there is not yet any consistent incorporation of a gender perspective into state policies and programs. The cultural atmosphere in Puerto Rico, furthermore, is one where sexuality and reproduction are not publicly discussed. This situation is encouraged by religious and conservative sectors in Puerto Rico and North America, including the Republican majority in the US Congress, which restricts abortion services and sexual education programs and threatens affirmative action projects. Efforts to reverse abortion laws and discriminate against people with HIV/AIDS and homosexuals and lesbians have increased.

7. Limited recognition of reproductive rights

The ICPD Programme of Action provides an opportunity for the women's health movement to look back on its work and to incorporate it as an integral agenda into the public discussion and policies. Even if not directly related to the ICPD, the integrated vision of sexual and reproductive health has begun to be incorporated into the training of health professionals, increasing their awareness of issues such as adolescents' rights, sexual rights, and men's responsibility for their sexual, family and reproductive

behaviour. The Health Department and the Governor have supported efforts to ensure the rights of adolescents to reproductive and sexual health information and services, and not be discriminated against because of pregnancy, but their access to contraceptives has not been accepted.⁴⁰

There has been no broadening recognition of sexual rights, but there has been some advance in the public discussion of everyone's right to enjoy sexuality. New efforts have been made to secure respect for the rights of homosexuals, lesbians, bisexuals and trans-sexual and trans-gendered persons. A coalition of organisations took a case to court to attempt to amend Article 103 of the Criminal Code, which now prohibits sexual relationships among consenting adults of the same sex.

Some changes have also been made in the language used in Health Department's 1997 Public Policy on Sexual and Reproductive Health. Yet changed policy language has not brought any improvements in health services. The Government and the Department of Health do not use the term 'reproductive rights.' They remain closely focused on family planning and maternal and infant health, and even there access to contraceptives has been reduced rather than expanded. It remains very restricted for adolescents. Efforts to improve this are strongly opposed on the grounds of paternal authority.

Overall, the drive to improve the coverage and quality of reproductive health services is threatened by the reduction in state and social responsibility for these services. Education and information about prevention of unhealthy practices and the promotion of good health needs to be increased. Conservative groups campaign against sexual rights, and sexual relationships among people of the same sex remain penalised. The situation calls for more involvement by women and NGOs working on women's health in designing, monitoring and evaluating policies and services.

8. Relationships between NGOs and the Government

NGOs in Puerto Rico have little power to influence public policy compared to Government. They have not had much success in moving forward the agenda on sexual and reproductive health. They are often left

out of discussions. For example, Government held a workshop with NGOs to discuss the formulation of the public policy on sexual and reproductive health, but never invited them to participate further in its development. Since 1992, when the status of the Commission for Women's Affairs was reduced, NGOs have kept their distance from Government. Members of the Peace for Women Organisation and the Pro-Reproductive Rights Group include some government agencies, but their participation is only nominal.

NGOs have had more influence on public discussions about reproductive and sexual health. The ability of these organisations to mobilise and coordinate the public, as well as their research activities, provide them with an important voice in the community. Even without having a structured relationship with Government, NGOs have been involved in lobbying NGOs, meeting with civil servants and legislators, appearing in public hearings at Court, and calling for public opinion and mass meetings.

NGOs have various forms of access to government funds and other forms of support. Most of them receive scant funds and rely on voluntary workers. Those organisations that do have external support, such as from the US or international agencies, although can be vulnerable to sudden reductions in their funding. One local organisation, for example, that has been affiliated with the International Planned Parenthood Federation (IPPF), has had its funding reduced and been warned that IPPF plans to stop providing support in 2000. Some projects in Puerto Rico have been supported by US federal funds, such as those granted through the Violence Against Women Act and distributed by the Commission for Women's Affairs. North American foundations and private bodies have also supported projects that defend the legal status of abortion or work to combat diseases of the reproductive system and HIV/AIDS. ❦

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Uruguay

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1. The national context

Relative to other parts of Latin America, Uruguay often is considered to be a country without major health problems. Yet there is considerable inequality in access to health care; scarce services for reproductive health and none for adolescents; increased birth rates among disadvantaged groups; strong penalties against abortion; no sexual education in the school system; and insufficient training in reproductive health for health professionals. This calls into question the image of Uruguay as a developed country in terms of its health situation and policies.

The early demographic transition in Uruguay - from high levels of maternal mortality and fertility to low levels of both indicators - has contributed to the supposition that Uruguay has no population problems. Consequently, little thought has been given to population policies there. The earliest birth control programs in third world countries aimed to restrict fertility in order to reduce poverty. Although a third world country in some respects, Uruguay's development has been somewhat atypical. This has been attributed to the early influence of European immigrants, the relatively good standard of living assisted by the welfare state, and massive support for education, particularly women's early access to higher education. On average, fertility is low in Uruguay, but with high variation in different areas of the country. Over the last 30 years, reproductive behaviour has also

changed in respect of the age distribution of fertility. There has been a significant increase in adolescent fertility, and a high percentage of children are now born outside legal marriage.¹ Many unintended pregnancies among adolescents result in no birth, indicating abortion, but there are no reliable registers of either the number or consequences of abortions. More abortion-related deaths appear to happen in regions where abortion is restricted, where there are few reproductive health services, and where women have less control over their fertility.

Uruguay has belatedly begun to take interest in collecting information about reproductive health. Specific questions were first asked in the 1975 census. In 1985, the World Health Organization and the Ministry of Public Health conducted a national fertility study. Uruguay has not participated in other international studies of reproductive behaviour.² Information about fertility behaviour and reproductive health in Uruguay is partial and fragmentary, and the multitude of sources makes data articulation difficult.³ There is little or no information about:

- ~ The number of abortions performed;
- ~ Deaths caused by induced abortions;
- ~ The number and kind of gynaecological examinations performed;
- ~ The use of contraceptives; and
- ~ Pregnancies and childbirth.

Meanwhile, the indicators that are available on reproductive health in Uruguay point to some issues of concern.⁴ One is social inequality in access to prenatal care. Around ten per cent of pregnant women do not have prenatal examinations. This percentage rises to 17 per cent for women who receive medical attention at the Pereira Rossell Hospital operated by the Ministry of Public Health. Eighty per cent of women who give birth at this hospital have less than nine examinations during their pregnancy. Only 31 per cent of pregnant women are examined during their first quarter; most women start prenatal examinations late. The extent of prenatal care varies by the age of the woman. At the Pereira Rossell Hospital 14.5 per cent of women aged between 15 and 19 had no prenatal examinations and 19 per cent had three or fewer, which is not adequate. The largest group of women who gave birth at this hospital without prenatal examination, however, was aged from 30 to 34 (19.6 per cent).

Development indicators for Uruguay

	1970s	1990s
Population size	2.8 mill	3.3 mill
Population growth rate (1975-1997)	-	0.7% av. Ann.
Total fertility rate	3.0	2.4
Life expectancy at birth	68.5 yrs	73.9 yrs
Maternal mortality rate*	-	85
Infant mortality rate	48	18
Under 5 mortality rate	57	21
Contraceptive prevalence*	-	84%
1990s gender gap		
	Female	Male
Life expectancy at birth	78 yrs	70.5 yrs
Net primary enrolment (6-15 yrs)	95%	94%
Adult literacy	98%	97%

Source: UNDP Human Development Report, 1999

*Note: *Given the poor state of health data in Uruguay, these statistics can not be considered reliable. The only national survey data on contraceptive use comes from a survey in 1985. In the fifteen years since, access to contraceptives may have deteriorated.*

Another concern is adolescent pregnancy and childbirth. During the last thirty years the number of births to adolescent women has considerably increased. In 1996, 16.5 per cent of all deliveries were to women aged between 10 and 19. Of the births that occurred between January and August 1998 at the Pereira Rossell Hospital, 25.1 per cent were to women aged between 10 and 19 years, and 31.4 per cent were to women aged between 20 and 24 years. The highest percentage of low-birth weight babies was to women aged less than 20 or over 35 years, but the largest actual number of these births was to the younger age group. Adolescent pregnancy poses a risk to both baby and mother. Data from

the Pereira Rossell Hospital for January to August 1998 furthermore show that 27 per cent of the births to adolescents were not first pregnancies.

The increase in births to adolescent women is just the tip of the iceberg, for there is no record of the number of these pregnancies that do not result in a live birth. Most of these pregnancies apparently are unintentional; 63.2 per cent of the known cases were outside legal marriage, compared to 26.5 per cent in 1961. There appear to be two related trends: changes to family structures, and a growing absence of responsible paternity.

Maternal mortality is another concern, but again very little is known about it. The erroneous and ambiguous content of death registers - and equally poor records of causes of death - pose an enormous difficulty to studying maternal mortality in Uruguay. Maternal death is only registered as such when the death occurs in a Maternity Unit in a Health Care Centre.

There is no official information about abortions that are performed. Since 1938, abortion has been illegal. There probably is, however, a remarkable sub-register regarding deaths caused by abortion. Several attempts have been made to change the law, the most remarkable being an amendment presented in 1993 by a group of legislators from the 'Frente Amplio' (left-wing) Party, with the support of some legislators of the National (right-wing) Party and the Red Party. Despite this broad support, the amendment was not passed. A new bill to regulate the voluntary interruption of pregnancy was presented in 1998 to the Health Commission of the House of Representatives, but it has not yet been dealt with.

There is no up-to-date information about the use of contraceptives, other than the national fertility survey of 1985. Uruguay has not participated in any recent international surveys of reproductive behaviour, the argument usually being that Uruguay has no particular concern as its fertility rate is already low. Yet qualitative studies show that poor women, especially, ignore contraceptives even though they may regularly attend the Ministry of Public Health's maternal-child health clinics. The failure to use contraceptives is particularly marked in adolescent women.

Genito-mammary cancer is another concern. In 1996, 6.3 per cent of deaths to women were related to reproductive health, breast cancer being the most frequent. Uruguay leads Latin America in the breast cancer

deaths as a percentage of all cancer deaths (35.5 per cent in 1996). This percentage has risen in recent years. The only information available about gynaecological examinations for the early detection of cancer and other diseases comes from the National Cancer Program, and is insufficient to explain the growing increase of these deaths. In-depth study is called for.

HIV/AIDS appears to be more prevalent in men than women. According to the Ministry of Public Health, around 73 per cent of HIV cases and 80 per cent of AIDS cases are men, but there is a slow yet constant increase in the number of female cases.⁵ The ratio of infected men to women fell from 8.5:1 in 1989 to 3.3:1 in 1996. The Ministry of Public Health also reports that the main means of transmission is sexual intercourse, predominantly (56 per cent) heterosexual. Although HIV occurs in all age groups, the main incidence in Uruguay is in the 15 to 34 age group, whereas for AIDS it is slightly older, in the 25 to 34 age group. HIV/AIDS therefore predominantly affects young people, the most sexually and economically active group in the population.

2. The political situation before Cairo

Uruguay was under a military dictatorship from 1972 to 1985. During the period of transition towards democracy, women's and feminist organisations began to emerge. They consolidated themselves within the reconstruction process of other social movements and the emergence of new social currents.

The Cairo Conference in 1994 came at the end of the first decade in which women's groups and other NGOs in Uruguay worked on health, sexuality and reproductive rights. From much earlier, however, beginning in 1956, the Uruguay Association of Family Planning and Research on Human Reproduction (AUPFIRH), had struggled to introduce modern contraception methods. From its outset, AUPFIRH met considerable resistance from various left-wing groups, as well as reticence from conservative groups that feared the stagnation of population growth in Uruguay. During the dictatorship period, there even was a proposal to provide grants to couples with more than three children. Nevertheless, women's groups began to raise public awareness that the right of access to contraception belonged to women and men of all social groups.

The decade before Cairo also coincided with the second

democratic period and the government of the National Party (1989-1994), one of the most conservative national parties, and Catholic traditionalist in nature. During this period the International Planned Parenthood Federation (IPPF), a principal donor for AUPFIRH, cut back its funds for low cost contraception, because it believed other countries in Latin America were more needing of assistance.

NGOs understood that this posed something of an emergency, especially for low-income women and families living in urban centres. The Network of Uruguayan Women's Health conducted a Seminar on Gender and Population Policies, in which representatives of Government agencies and NGOs participated. Several NGOs were eager to exert pressure on the government to get it to recognise that reproductive health and access to quality health services were important human rights.

The Government was not very clear about its stance or policies. NGOs were not well informed about the content of the government report being prepared for the Cairo Conference. The National Board of Statistics and Census circulated a draft report, which had a strong statistical content but no political analysis. Concerned that the Government of Uruguay had been incorrectly influenced by the Vatican to believe that an international meeting on abortion was about to be held, the United Nations summoned a national meeting about the purpose of the ICPD. The UN and the Ministry of Foreign Affairs convened this meeting in September 1994, a week before the Conference began in Cairo.

A Uruguay delegation was sent to the Conference, comprising the president of the Women's Institute, a representative of the National Institute of Statistics and Census, the representative of the Minister of Foreign Affairs, and the President of the Parliamentary Committee on Population Policies as an observer. The official delegation did not include members of any NGOs or political parties, although some attended separately. Although there was some concern that Uruguay would join the most conservative forces of the Conference, the women's organisations in particular hoped the Government would instead agree that sexual and reproductive rights were fundamental human rights. Two Uruguay feminists lobbied in Cairo by keeping the official delegation informed about the progress that could be gained when the concerns of women and girls were taken into good account. On the final day of the Conference, Uruguay took the floor. The Minister described the situation in the country, the low

rate of population growth, and confirmed the right of people to decide when, how, with whom, and how many children they wished to have. He also spoke about concern over the rapid ageing of the population and the impact that growing numbers of old people would have on labour availability and social security.

3. The situation after Cairo

After the Conference, women's NGOs in Uruguay called a meeting to inform people about what had transpired there. An immediate concern was the amount of funds that would be available to provide the necessary reproductive health services and sexual health education programs. AUPFIRH was already experiencing a shortage of resources. Negotiations began with the United Nations Population Fund (UNFPA) about funding government's development of reproductive health programs. UNFPA agreed to this, on the understanding that these funds would act as a starting point in Uruguay working towards the commitments it had made in Cairo, and that the government would bear all the costs of the programs after three years.

At the end of 1994 national elections were held. The National Party was not re-elected. The winning Red Party formed a more liberal government. Some of the opposition to birth control faded. By the end of 1995, the Ministry of Public Health presented its 'Elected Maternity and Paternity Program,' which revealed a firm intention to reduce maternal and infant mortality, as well as the incidence of abortion. Meanwhile, the Municipal Government of Montevideo, governed by 'Frente Amplio'- 'Encuentro Progresista,' a left-wing coalition, with UNFPA support, adopted the Program of Integrated Services for Women. The institutional arrangements for this program involved coordination between the Health Department and the Women's Commission, and representation from women's NGOs. Both the national and the municipal programs began implementation in February 1996.

Still concerned about the real commitment of the Government to these priorities, after the Fourth World Women's Conference in 1995, NGOs involved in the National Commission for the Follow-up of Commitments, held an interview with the President of the Republic, Att. Julio María Sanguinetti. They expressed their concern about insufficient

attention to sexual and reproductive health. The President said he was not aware that the Ministry of Public Health was not responsible for providing family planning services; he himself had taken people to these centres to receive attention. He also said, "We have to provide services by ourselves," evidently referring to the Uruguay Government.

Three years have however passed since this interview. There has not yet been any such explicit commitment by the Government. The continuation of the Ministry of Public Health's current program for reproductive health is in jeopardy if, according to the timetable agreed to at the outset, UNFPA ceases its financial support. For its part, the Program for Integrated Services for Women has developed a financial plan to ensure its continuance after UNFPA's funding support ends. This strategy is to provide contraceptives at a minimum cost, sufficient to support a Replacement Fund under the administration of district Health Commissions, composed of neighbors, in coordination with local health centres.

4. Public policies for reproductive health

From 1996, various programs to support reproductive health have begun to be implemented. The concept of reproductive health has historically been linked to birth control, and birth control never seemed very necessary in Uruguay's low fertility regime. As well as with family planning, reproductive health was also connected with reducing maternal mortality and morbidity. It was seen principally as a biomedical problem concerning women, rather than a matter that touched on a range of social issues.

In 1996, policies to address reproductive health began to be implemented by the national government and by the Municipal Government of Montevideo. The United Nations conferences in Cairo and Beijing promoted this type of program and gave legitimacy, especially from the Government's perspective. As in other Latin American countries, the women's movement - including feminists elected to Government after the restoration of democracy - have played a vital role in raising the public profile of health and reproductive rights issues. Furthermore, in areas where Government has been more reluctant to act, for example, sexual education in the schools, NGOs have been key in improving public understanding about sexuality and reproductive health, especially among adolescents,

girls, and educators.

Apart from the programs already described, good progress has been made in developing other national and local public policies in support of reproductive health. The Ministry of Public Health is addressing the problem of cancer through its National Cancer Program (PRONACAN) and AIDS through its National Aids Program. The Women's Health Area and the Women's Committee, formed in 1998, report that better consideration is being given to reproductive health within the national government. The ministerial charter of the Women's Committee is itself based upon the commitments assumed by Uruguay at the ICPD in Cairo - although it does have its weaknesses. There is little coordination within the institution and with other sectors, and the human and financial resources for its sustainability have not yet been clearly visualized.

In April 1999, an Honorary Commission of Reproductive and Sexual Health Counseling was established, composed of representatives of the Ministry of Public Health, the School of Medicine, the Women and Family Institute of the Ministry of Education and Culture, the Medical Union of Uruguay, and representatives of women's NGOs. Its purpose is to develop protocols for counselling. Although its formation represents some progress, so far it has not been fully implemented.

Within the Government of Montevideo's Program of Integrated Services for Women, three sub-programs have been developed, namely: Informed and Voluntary Maternity; Genito-mammary Cancer Prevention; and Pregnancy and Puerperal Integral Care. The program promotes the concept of good health through three key strategies:

- ~ Encouraging community participation through Health Commissions that comprise people from different districts of the Department;
- ~ Coordinating institutions such as the Municipality, NGOs, the Ministry of Public Health, and other relevant government ministries; and
- ~ Training professional and community actors in issues related to health and gender.

5. The continuing role of NGOs

A National Commission for the Follow-up of the Commitments assumed at the Conferences of Cairo and Beijing was created after the Beijing Conference in 1995. It comprises 52 national and local NGOs. As well as monitoring the commitments assumed by the Government, it lobbies for attention to be given to special issues, conducts activities to increase community awareness about the situation of women in Uruguay, and conducts training activities. Its activities have focused most on reproductive health, labour, poverty, violence, political participation, education and the mass media. The outcome of its first round of monitoring will be a diagnosis of the national situation of women and the formulation of indicators of political will. This monitoring activity helps to produce new information about women in Uruguay and also creates a tool to exert pressure, where necessary, on the central and local governments. One issue that has already drawn its attention is the lack of a national plan to ensure equal opportunities for men and women in Uruguay.

A number of individuals, NGOs and private institutions are working on gender issues and women's health. Together they participate in various international campaigns, such as the International Day of Action for Women's Health, the International Day for the Legalisation of Abortion, and the International Women's Day. The past ten years of NGO action has achieved some far-reaching results. Areas of special concern have been the legalisation of abortion, improvement of the quality of health care, and denunciation of improper practices in the health care services. For example, at the First Tribunal for Women's Sexual and Reproductive Rights, held at the Legislative Palace, women gave testimony against domestic and sexual violence, improper practices in childbirth and in the puerperal stage, clandestine abortion, the transmission of HIV/AIDS and factors contributing to adolescent pregnancy.

Since the Cairo and Beijing conferences, women's organisations have more openly shared their accumulated experience. An NGO Training Network in Gender Issues has been registered in some states. NGOs have helped develop gender training courses for health workers, especially those working in sexual and reproductive care services.

In 1999, the Medical Union of Uruguay established the Commission of Gender and Public Health Policies, in an attempt to

incorporate health and reproductive rights into the dialogue among medical professionals. The Health Organisation has made a financial commitment to run permanent medical training courses on these issues.

All of this work of NGOs in Uruguay has been maintained through strong social and political commitment, and usually with scarce financial resources.

6. The Cairo+5 review process

In summing up overall progress in Uruguay on the ICPD Programme of Action, it is evident that the Government has responded to the Programme, but in a docile rather than active manner. For example, although sex education has not been introduced in the formal school system, the Government has allowed WHO to participate in the programs of the Ministry of Public Health, including a possible program on Children's, Adolescents' and Reproductive Health. Similarly, after the Cairo+5 Meetings in New York in 2000, the Minister of Public Health signed a commitment to support a national Selected Maternity and Paternity Program. A similar program being run in Uruguay, with support from UNFPA, currently only services the poor sectors of Montevideo and ten cities in the interior of the country.

Some progress is now being made on the abortion issue. After the Cairo+5 Review, the School of Law held meetings on this issue, inviting some women's health activists and researchers to attend as participants and lecturers. At these meetings, the need to find a humanitarian solution to this problem was recognised. Even one of the most celebrated and conservative professors expressed the opinion that legislation in Uruguay was outdated and should be revised to allow abortion in some circumstances, as some neighbouring countries have done.

With a recent change in government, the future of this activity is not certain, especially as the incoming Civic Party is Catholic and has firm views on the legality of abortion. In the past, this party succeeded in penalising abortion by means of budget negotiations. It now has promised, however, that if Parliament reconsiders legalising abortion, the final decision will be taken by a national plebiscite. Women's organisations are working nationwide to promote an Agenda for Women which includes the legalisation

of abortion and the need of a National Commission of Population and Development, in which women's NGOs can participate.

During the recent elections, 16 women legislators entered Parliament, double the previous number. They are committed to incorporating gender into all issues, to creating a Commission of Gender Equity, and to promoting legislation to improve gender equity, such as the Law of Domestic Violence, and other legislation that deals with working women, lactation and abortion.

The path forward, however, is not clear. For example the Catholic Church recently and unexpectedly decreed March 25th to be the Day of the Unborn Child. On that day the Church conducted a liturgy and a special mass at the Cathedral, in the presence of the bishop, and also organised the distribution of pamphlets near clinics where clandestine abortions take place. The press response to this included other points of view, but the Pro-life Movement broke out strongly and abruptly in the media and on the streets. ❧

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Fiji Islands

❧ Margaret Chung ❧

1. The national situation

Fiji Islands is a small island state in the South Pacific Ocean. The multi-ethnic character of its population is the product of a century of British colonial rule, which ended in 1970. Just over half of Fiji's population are ethnic Fijians, people of Melanesian and Polynesian ancestry who are indigenous to these islands. Most others are Indo-Fijians, descendants of the indentured labourers who came to Fiji in the late nineteenth and early twentieth centuries.

Fiji's family planning program is often cited as a success. Fertility rates have been halved since the early 1960s. Yet this success is overstated, for while the availability of contraceptives undoubtedly helped to lower fertility, more pervasive agents have been economic and social changes, particularly the upsurge in women's employment. These have transformed the life-experiences of women and complicated their decisions about child bearing.¹ In Fiji's multiethnic society, fertility rates have also had particular political significance, and this has flavoured policy and program design.² As the indigenous Fijian population has grown to become a majority, the national preoccupation with differences in fertility between Fijians and Indo-Fijians has faded.

This has opened the field for more authentic concerns to be aired; ones that more directly touch the lives of women. These include concerns

with teenage reproductive health, the responsibilities of men, the problems faced by many families with growing costs of child rearing, and the wider realm of reproductive rights. This changed direction is partly attributable to the ICPD and donor agency priorities, but the politics of population in Fiji have also played their part.

Development indicators for Fiji

	1970s	1990s
Population size	0.6 mill	0.8 mill
Population growth rate (1975-1997)	-	1.5% ann. av.
Total fertility rate	4.0	2.7
Life expectancy at birth	63.9 yrs	72.7 yrs
Maternal mortality rate	-	31
Infant mortality rate	50	20
Under 5 mortality rate	61	24
Contraceptive prevalence	-	32%
	1990s gender gap	
	Female	Male
Life expectancy at birth	74.9 yrs	70.6 yrs
Net primary enrolment (6-15 yrs)	99%	99%
Adult literacy	89%	94%

Sources: UNDP Human Development Report, 1999; UNDP Pacific Human Development Report, 1999

Family planning services and information have been widely available in Fiji for the past thirty years. They began through support from the International Planned Parenthood Federation (IPPF) to a national Fiji Family Planning Association (FFPA) and, from the mid-1960s, through the Ministry of Health. The promotion of family planning involved a close partnership between Government and non-government organisations (NGOs) from the outset. The FFPA worked mainly as an advocacy group, while Government provided most services free or at minimal cost through public

clinics. The Catholic Church ran a clinic that advised women on the rhythm method; this was little used and eventually closed. Until recently, there were few other players in the field.

Also until recently, 'population issues' in Fiji meant 'family planning' and family planning simply meant contraceptive use by married women. Public information materials have stressed the health and economic benefits of well-spaced births, and the range of effective contraceptive methods available. In practice, the choice for women - especially rural women - has been somewhat circumscribed by what is locally available and the clinic doctors' evident preference for long-acting methods - pills, inter-uterine devices (IUDs), Depo-Provera, or sterilisation - because of their ease of application and their quantitatively better results.

Ministry of Health assessments of the program's success have rested largely on their definition of the contraceptive prevalence rate (CPR), namely the proportion of women of child-bearing age who use their clinics.³ Official statements about improving the service have traditionally been expressed in terms of raising the CPR. Yet this statistic is notably unreliable in evaluating whether the program meets women's needs. It is statistically weak in that it counts only part of the women population and poorly reflects the frequent changes women make in their contraceptive strategies or the mix of traditional and modern methods these may entail. More seriously, rather than look to the quality of the service provided, as defined by users, health authorities have instead focused on the CPR. They have attributed its slow rise to cultural barriers and, in particular, the traditional mindset of Fijian women, a stereotype then used to justify not providing more appropriate services.

Other reproductive health issues, such as infertility or the needs of unmarried or childless people, received little attention in the family planning program. Medical staff contacted only mothers on their home visits, and saw or counselled only mothers at pre- and antenatal clinics. In urban areas, women can get wider services through private doctors, but in most rural areas, contraceptive services, including information, have been almost entirely the domain of the Ministry of Health. Fertility control has been largely seen as the responsibility of women in Fiji, although this is now changing to some extent. Population issues generally remained the responsibility of the Ministry of Health for, despite sporadic talk of

integrating broader population issues into development planning, there was little direction as to what this entailed and little practical action was taken.

2. Preparations for Cairo

The Fiji Government was an active participant in the ICPD Conference in Cairo and its preliminary meetings. In 1993, before the ICPD, health officials from Pacific island countries met in Port Vila, Vanuatu, to decide upon common concerns and positions in regard to the proposed Cairo Programme of Action. These decisions were formalised in a subsequent meeting of health ministers, in the Port Vila Declaration on Population and Sustainable Development. While the statement focused on broad relationships between population, development, social and cultural factors and the environment, it noted as special concerns: inadequate health facilities and services, teenage pregnancy, the erosion of traditional culture and kinship systems, and the spread of sexually transmitted diseases (STDs).

Although reproductive health conditions vary enormously across the very diverse Pacific island region, it was thought that a regional strategy would best enable Pacific island views to be heard at Cairo, for while individual small countries might be possible to overlook, a consortium of 15 countries represented a significant advocacy group.

While several countries in the region still struggle to provide even basic reproductive health services, Cairo marked a watershed in attitudes across the region. This is largely because of the active involvement of major donor organisations such as the United Nations Population Fund (UNFPA), the World Health Organization (WHO) and the bilateral aid programs of Australia and New Zealand, in regional and national discussions leading up to Cairo and, since then, in funding family planning, sexual health and reproductive health programs in the region.

3. Commitments in Cairo

At the Cairo Conference, the Fiji Government promised to address the Programme of Action 'seriously and urgently' and commit more financial and other resources to doing so. The Government referred

to the support it had received from international donors and its expectations that this assistance would continue, yet this rather vague statement made no reference to any priority concerns within these programs.⁴ The Government's population policy emphasises the need to maintain population growth at below 2 per cent a year and equip the population with the necessary skills to advance social and economic development.⁵ This involves:

- ~ Providing safe and effective methods of contraception and public education about family planning;
- ~ Establishing programs to raise the status of women through education and employment, so as to raise the age of marriage and contribute to fertility reduction; and
- ~ Improving labour force and education planning and development.

The proportion of government resources allocated to social services has increased slightly, but only marginally for health. The Ministry of Health has revamped its family planning program, including renaming it Reproductive Health. Its intention to broaden the traditional emphasis on women's contraception and address other reproductive and sexual health issues was demonstrated at a national workshop on health strategies in March 1996. At this meeting, representatives of Government, NGO and international agencies working in the field of health together discussed sexual and other health issues. The Government also launched a brief campaign to promote vasectomies and men's responsibility in family planning, but perhaps too readily decided that few men would be interested.

The Government is also working outside of the health field. A new Human Resource Development Plan, formulated with assistance from UNFPA, the International Labour Organization (ILO) and the United Nations Development Programme (UNDP), reflects the central prominence given population and labour force growth in the national economic development strategy and in education and health plans. While formulation of the project preceded the ICPD, its implementation reflects the ICPD recommendations, particularly in better reflecting gender balance in its activities and plans. The Fiji Government's decision to ratify the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was in important respects an outcome of the Cairo and Beijing meetings, as were their

requests for donor assistance in developing gender planning and analysing poverty trends in Fiji. The Ministry of Women and Culture launched a national strategy to fulfil commitments made at in Beijing and at the World Social Summit in 1995 in Copenhagen. This included a Plan of Action Against Violence Against Women and Children.

These developments are in the spirit of the ICPD Programme of Action and advance it, but were not necessarily initiated by it. A general view among Fiji delegates at the Cairo Conference was that the principal recommendations of the ICPD were already being implemented in Fiji:

- ~ Demographic indicators showed a steady decline in fertility and mortality;
- ~ The Ministry of Health had a well-developed network of family planning clinics; and
- ~ Moves were already afoot to address some of the more obvious gender disparities, such as through the Government's then recent ratification of CEDAW.

4. Presence and role of the reproductive health and rights advocacy community

NGOs and donor agencies have nevertheless been instrumental in driving the agenda along. Major donors in the reproductive health and rights area - UNFPA, WHO, the bilateral aid programs of Australia (AusAID) and New Zealand (NZODA), and IPPF - have taken strong cognisance of the ICPD Programme of Action in formulating and funding their programs. This is perhaps the most effective form of advocacy of all.

Previously existing women's NGOs in Fiji have taken up aspects of the Cairo and Beijing agendas as central parts of their programs. New NGOs have also emerged in these areas. One new group is the Family Support and Education Group, which formed in 1994, and provides information and training in life skills. The organisation is involved in addressing emotional and physical abuse. A survey they conducted of secondary school students found that almost half had at one time or another been abused. Another new group is the Women's Health Forum. This group is planning to set up a Women's Health Information Centre and stimulate public discussion on health policies relating to women.

There is no overt opposition to the ICPD recommendations; the main adversaries being perhaps:

- ~ Complacency, in that the concept of reproductive health is still somewhat tied to family planning and female use of contraceptives; and
- ~ The absence of strong, collective advocacy, particularly on issues of reproductive rights on which there has been little public discussion, but this seems set to change soon.

5. The enabling environment for ICPD Implementation

There is a positive environment for implementing the Programme of Action in Fiji. The Government has expressed its commitment to the plans of action devised at Cairo, Beijing and Copenhagen and is acting on these commitments. The major donor organisations are actively supporting and expanding these activities. Increasingly, activist women's NGOs are pushing the public agenda into new fields of reproductive health and rights.

The economic environment is less certain, for external funding of many activities remains critical to their existence. On the one hand, while the Fiji Government espouses economic reform, implementation of these policies - in particular any reduction of government spending - has occurred very slowly. As operating costs have risen faster than overall government spending, capital investment in social services has been reduced to the point where the quality of these services may soon deteriorate, and thereby negate some of the progress in reproductive health and population planning discussed here.

On the other hand, the Government depends substantially on donor support, especially in the field of health. As most of this is attached to programs, donors have significant impact on the direction and resource levels of these programs. The down side of aid dependency, of course, is that the continuation of donor assistance is not inevitable. The spending of donor agencies is coming under increasing scrutiny from their own public. The abject need for assistance in some countries makes Fiji and much of the Pacific island region appear less requiring of aid. Donors are

therefore viewing with concern the insufficient political will that they can discern among some Pacific island governments to instigate real change or to commit their own resources to improving reproductive health.

The Asian economic crisis also squeezed donor funding. IPPF, for example, received major contributions from Japan. This was cut back for some time.

Finding secure funding is a perennial problem for NGOs, and often a drain on the energy of these organisations. The Fiji AIDS Task Force, for example, which educates mainly young people about safe sex, has several times been on the verge of closing because its major funding support was uncertain. The emphasis that donor organisations now give to sustainability is difficult for NGOs to come to terms with, particularly in small, economically-stagnant countries like Fiji.

In May 2000, the Government of Fiji was overthrown in a coup that resulted in the take-over by power by a so-called Interim Government, whose claims of legitimacy have been rebuffed by the international community. Several major donor agencies have suspended their aid programs. Other economic sanctions are threatened. If they are applied, Fiji's economy and society will nose dive into a quite uncertain future.

6. Changing perspectives on reproductive health

A principal change in the Ministry of Health's program is a change of name from Family Planning to the Reproductive Health Programme. The focus remains fairly closely on providing high quality contraceptive services and maternal and child health services. The goal is described as providing:

'High quality comprehensive health services ... to promote and maintain the development of a healthy family, reduce maternal and perinatal infant morbidity and mortality, and raise the standard of living for mothers and children. The system will continuously monitor and improve its services in order to produce the most effective and efficient delivery of services; and produce and retain a high quality workforce.'⁶

Fiji Government spending on social priorities, 1985-2000
[Figures in F\$ million]

	1985	1990	1995	2000
Total govt expenditure	412.5	597.2	801.9	1097.9
Public expenditure ratio ¹	35.0	33.0	30.9	n.a
Social allocation ratio ²	32.5	29.5	28.7	30.9
Total social priority exp.	44.2	55.5	--	104.6
Primary education	39.6	50.1	--	100.3
Rural & public health	3.9	3.5	--	2.3
Rural water supply	0.8	1.8	--	2.0
Total social expenditure	134.3	175.9	223.0	339.9
Water supply	1.7	16.8	--	21.4
Education	83.4	109.1	103.6	198.0
Social welfare	2.1	2.5	5.6	10.7
Health	33.3	45.3	62.7	81.7
Housing	2.1	0.6	--	3.8
Poverty Alleviation Fund	0	0	4.0	1.4 ³

Source: Fiji Government budget estimates, various years.

Other changes are in process. The UNFPA program of assistance to Fiji 1998-2001 has assisted the Ministry of Health to:

- ~ Widen access to and use of reproductive and sexual health and family planning services, particularly for under-served communities, youths and adolescents;
- ~ Train health workers;
- ~ Incorporate adequate midwifery content and education in human sexuality in the Fiji School of Nursing curriculum,
- ~ Assist operational research and data gathering on reproductive health, and

- ~ Promote public education on family planning and reproductive and sexual health issues.

Other UNFPA assistance has included the establishment of a Reproductive Health Training Program at the Fiji School of Medicine (a Pacific regional training centre) and resources for research in reproductive health at the University of the South Pacific, also based in Fiji. Two Pacific regional research projects are underway, one on adolescent fertility and the other on domestic violence

The Governments of Australia, Japan and Fiji are supporting the Health Promotion Centre, which develops public information material on a range of health issues.

A number of NGOs are active in this field. The Fiji Reproductive and Family Health Association is actively promoting knowledge and understanding about contraceptives and sexual health throughout the country. The AIDS Task Force provides education and counselling to young people and sex workers to encourage safe sex practices.

The planned development of a Women's Health Information Centre however reflects wider needs for reproductive health that are not being met. A survey by the Women's Health Forum found that many organisations were working in the field of reproductive and sexual health. Even so, women felt there were few places where they could discuss these issues, ask questions, or have access to medical personnel with attitudes sympathetic to their needs. Other health concerns were inadequate facilities for pap smears (cervical cancer being exceptionally high in Fiji); the need for breast self examination and mammograms, better protection against STDs (also common in Fiji), better antenatal care, and more accessible information about women's sexuality, reproduction, menstruation and menopause. A feasibility study for the proposed centre was been conducted. The proposal has the support of the Ministry of Health - in principle, not funds.

7. Attention to reproductive rights

The main advocacy groups for reproductive rights in Fiji are the Women's Crisis Centre and the Fiji Women's Rights Movement. The

Women's Crisis Centre, which has branches in four urban centres, provides counselling on domestic violence, sexual assault and other issues. The Fiji Women's Rights Movement actively promotes all forms of women's rights and is closely involved in the planned establishment of a Women's Health Information Centre. DAWN, which has its secretariat in Fiji, is also active in promoting women's rights and monitoring this progress.

Discussion of reproductive rights in Fiji has not moved much past the right to reproductive health and for protection against violence. The right often discussed in relation to reproductive health is for young and unmarried people to have access to contraceptive information and methods. This move has gained impetus as concern about STDs and HIV/AIDS grows.

Protection against discrimination on the basis of sex was first included in the 1990 Constitution. The 1997 Constitution (Amendment) Act further widened the specific definition of fundamental rights and freedoms to include various categories, including sexual orientation. This set off a flurry of public debate, mostly negative. One of the first actions of the Interim Government in 2000 was to abrogate the 1997 Constitution and replace by Decree the Bill of Rights - with the explicit exception of protection against discrimination on grounds of sexual orientation.

Since the ratification of CEDAW and other international conventions, the Government is committed to reviewing legislation to protect the interests of women. The goal is to remove overt or covert discrimination against women on the grounds of sex, pregnancy, marital status, child birth and family responsibilities in respect of hiring, terms and conditions of work, training and education, promotion and termination of employment. The main agencies are the Fiji Human Rights Commission and the Ministry of Women. Little of this has yet been debated in the public domain.

There has been surprisingly little discussion about abortion, especially as it is widely, if mostly clandestinely, practised. Abortion is illegal in Fiji, except in cases where therapeutic abortion is necessary to protect the mother's physical or mental health. Sections 172-174 of the Penal Code defines abortion as follows:

Any person who with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully

administers to her or causes her to take any poison or noxious thing, or uses any force of any kind, or uses any other means whatsoever, is guilty of a felony, and is liable to imprisonment for fourteen years.

In practice, safe abortion is available to women who can pay the high cost of private practitioners. Others, who cannot afford professional care, resort to 'back street' abortions or various traditional methods, mostly unsafe.

8. The role of NGOs and their relations with Government

Fiji NGOs have tended to have narrow and conservative concerns. For many years, NGOs have operated most schools in Fiji, provided almost all facilities for disabled persons and operated most other social welfare services. These were for a long time seen as the legitimate area of NGO activity. An early advocacy group was the YCWA. Otherwise it has been only in the past decade or so that activist women NGOs have had considerable influence on human rights and women's rights in Fiji.

These organisations have succeeded best where they have been able to secure international donor support or that of other NGOs. The Fiji Women's Rights Movement successfully spearheaded the demand for the ratification of CEDAW in Fiji, with support from a wide consortium of NGOs. The Women's Crisis Centre survived and now flourishes, despite initially no government support and local opposition or apathy, largely because of funding support from AusAID.

Particularly since the mid-1990s, there has been increased donor and Government support for partnerships with NGOs. Assistance from funding agencies is mostly conditional upon the NGOs complying with their agendas. Yet there is little sense of conflict here but rather enthusiasm on the part of the NGOs to move in the direction that the ICPD Programme of Action points to, at least in regard to reproductive health rather than the wider range of reproductive rights and gender empowerment issues. Many donor organisations now believe that NGOs more effectively deliver aid, particularly to target groups such as youth. They want to direct more of their funds through them but often this is foiled by bureaucracy.

There are fewer NGOs that qualify for assistance than donors ready to supply it. There can also be problems with accountability. Some donors in the Pacific have withdrawn their support because of quite blatant abuse of their funds, only to find that another donor soon after steps in to provide other assistance. This ultimately works against the interests of all parties: donors, NGOs and the public.

The main difficulty donor organisations have in working directly with NGOs is that all requests must be approved by the Government Aid Coordinating Committee. This system has some merit for it scrutinises the funding obligations of various organisations and reduces the duplication of activities and funding. But it also causes delays and effectively ensures that some NGOs get the lion's share of resources while others, less favoured by government, are cut out of the action. For example, the Fiji Reproductive and Family Health Association (the successor to the Fiji Family Planning Association), has been appointed by the Ministry of Health as their NGO focal point. This decision cannot be questioned in that the association is doing excellent work, but the process of selection was not transparent or ever explained to other NGOs working in this area. Some donor organisations have found ways around the required government channel; for AusAID, this enabled their early support of the Women's Crisis Centre. This issue needs to be resolved, for it works against the necessary autonomy of NGOs.

There has been some discussion about government subcontracting some services to NGOs. This already happens in some areas, such as social welfare. Much of the current discussion, however, regards the government cutting its costs and responsibilities and expecting that NGOs will provide these services more cheaply and effectively. Some ambulance services, for example, have been subcontracted to St John's Ambulance. Otherwise in the field of health, it has not been a clear transference of responsibilities, rather a stronger working partnership between government and NGOs. ^{١٤٥}

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India

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1. The national situation

India was one of the first countries to launch an official family planning program. Soon after Independence in 1947, family planning - or family welfare as it was later called - became the program arm of India's population policies. For most of the last fifty years, the official approach to population has been to attempt a form of demographic control: to reduce birth rates as rapidly as possible in order to complete the demographic transition. In its early years, India's family planning program was also considerably influenced by external pressure to do something about the 'population bomb.' Ever since its inception in the early 1950s, therefore, the principal goal of India's population policy has been to reduce population growth.

Beginning with mainly urban, clinic-based services, by the end of the first decade the program had switched to more active promotion of contraceptives and a focus on rural communities. By the late 1960s, growing anxiety about rapid population growth led to specific targets being set for each contraceptive method: sterilisation, inter-uterine devices (IUDs), pills, and condoms. Annual targets were set by the central Government for each state. Much of the entire government machinery was pressed into meeting these targets, but lower level workers had little say in determining them. Various incentives and disincentives for government functionaries

at different levels were linked to the achievement of the targets. Lower-rank workers viewed these as a system of rewards and punishments. Evidence from auxiliary nurse midwives - the field level workers with most responsibility for meeting the targets - corroborates this view. During this time, the family planning program emphasised permanent contraceptive methods. The experience of forced vasectomies during the period of National Emergency (1975-77) led to a backlash, which shifted the program focus to female sterilisation.

This rigid target-based approach diverted the health services away from providing health care towards meeting contraceptive targets, and, as a result, caused falsified reporting and human rights violations. The pressure on women to use contraception aggravated existing gender biases. Despite euphemistic titles like Family Planning and Family Welfare, the goal was simply to get as many women as possible sterilised before they could bear many children. Women's health groups became concerned about the introduction of surgical and hormonal methods of birth control, and the weak regulatory and monitoring mechanisms and scant regard for their effects on women's health. By the 1980s, it was evident that the contraceptive targets had become an end in themselves and increasingly disconnected from the original goal of fertility reduction. The decline in fertility was also very uneven across the country. The connection between couple protection rates and fertility decline was increasingly tenuous.

In the early 1990s, the Government acknowledged that the family planning program lacked innovation or dynamism. The Eighth Five Year Plan (1992-97) noted that:

The Family Welfare program has essentially remained a uni-sector program with centralised target-setting, lack of pre-service and in-service training, and a monitoring mechanism that is incapable of identifying roadblocks or applying timely correctives. The IEC strategy has been directed more to national issues rather than to issues of personal choice and decision, which govern the adoption of birth control measures. This incongruity of perception between the people and providers of the service has cost the program dearly.¹

2. Preparations for and outcomes of the Cairo Conference

Preparations for the International Conference on Population and Development (ICPD) at Cairo in 1994 boosted efforts to bring about significant change. A high-level expert committee constituted by the Government delivered its recommendations for a new National Population Policy in June 1994. These called for the focus to shift away from fertility reduction to a more human development-centred approach that would be 'pro-nature, pro-poor, and pro-women.' The committee suggested this change would require a new independent body to implement the program, instead of the Ministry of Health and Family Welfare. This recommendation was itself enough to ensure the report was never supported or implemented by the bureaucracy. Yet it also sparked a nation-wide debate on population policy just before the ICPD Conference. For two years before the Conference, regional workshops were held in different states where NGOs gave their views on the desired direction of change. The Ford Foundation and the United Nations Population Fund (UNFPA) supported these workshops.² Women's groups also managed to dialogue directly with the Government. At the ICPD Conference, there was a more open climate of interaction between Government and NGO representatives than either side had known for a long time.

The ICPD Programme of Action echoed the critique of women's groups and others within India in its endorsement of reproductive rights, in particular, the right of all individuals and couples to make decisions concerning reproduction, free of discrimination and coercion. Paragraph 7.12 noted that:

"...Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients."

Paragraph 7.22 encouraged governments to replace systems based on incentives and disincentives by programs based on voluntary decisions and education. Having ratified this document, the Government of India, in collaboration with the World Bank, undertook a review of its Family Welfare Programme.³ The report urged changes in policies to:

- Move from targets or incentives to client-centred program management;
- Provide wider consumer choices in reproductive health services; and
- Build partnerships with Panchayats (local government bodies) and NGOs, to strengthen the program's client focus.

The World Bank report recommended a Reproductive and Child Health (RCH) approach that would modify and combine the Family Welfare Program, the Child Survival and Safe Motherhood Program. It would also incorporate new services to manage reproductive tract infections and sexually transmitted diseases (STDs), increase the safety of abortion services, and improve the quality of care in a phased manner.⁴

Some donor agencies, notably UNFPA and the Swedish aid agency SIDA, began to make their programming more inclusive of communities, lower level health workers, and women activists and advocates. The most noteworthy effort was that of SIDA's support for the Reproductive and Child Health program in the State of Rajasthan through intensive micro-level planning.⁵

A small but radical experiment had meanwhile been underway since 1992 in two districts of Tamil Nadu State. There, ANMs (Government auxiliary nurse midwives based in the community) had asked for contraceptive targets to be waived for non-health government workers, as they created unhealthy competition among lower-level workers. The ANMs also asked for incentive payments for 'motivators' of contraceptive users to be abolished because they bred corruption. This reform worked well. The Tamil Nadu Government responded by supporting, training and consulting with the ANMs.

In 1995, after the ICPD, all contraceptive targets were abolished in Tamil Nadu and Kerala, two large states where fertility rates were already below replacement level. The central Government asked other states to also experiment with the target free approach in one or two districts. In early 1996, a Government-run committee recommended some alternative indicators to replace targets in monitoring and evaluating programs. In April 1996, the Government formally launched the target free approach throughout India.

Immediately after the ICPD, a group of NGOs formed HealthWatch, a network to help the Government and international aid agencies implement the ICPD Programme of Action. The members of HealthWatch are NGOs and individuals who are committed to doing this through dialogue, policy advocacy and research. Their work involves various issues: women's health, empowerment, children's health, family planning, health service provision, research, training and advocacy. Between June 1996 and April 1997, HealthWatch held regional workshops throughout India to assess how the new 'target-free' policy was working. The findings were consolidated at a national meeting in which Government and donor representatives also participated, and provided early advice on the program's implementation.⁶ Since then, network members have been tracking the progress of the program in different parts of the country. HealthWatch is conducting systematic evaluations in several states.

3. Assessing ICPD implementation

The enabling environment

The Indian nation is increasingly facing the challenges implicit in governing a pluralistic society and representing the interests of quite different sections of society. At the same time, the economy is adjusting to stabilisation and structural adjustment measures that began in 1991. The dire effects of these policies on the lives of the poor and fixed income earners were becoming evident, even as cracks appeared in the neo-liberal Washington consensus after of the South-east Asian financial debacle of the late 1990s.

These economic measures have been less stringent in India than in some Latin American and African countries, yet they nevertheless have had an adverse impact on the poor.⁷ It is probably true that the process of liberalisation and privatisation could not have proceeded more rapidly because of India's fractious and vocal democracy and unstable political climate. Yet this same instability - and the preoccupation of successive governments with their survival in these difficult economic times - has also been responsible for the neglect of poor people and women.

Table 1 Development indicators for India

	1970s	1990s
Population size	620.7 mill	982.2 mill
Population growth rate (1975-1998)	-	2.0
Total fertility rate	5.4	3.1
Life expectancy at birth	50.3 yrs	62.6 yrs
Maternal mortality rate	-	410
Infant mortality rate	130	69
Under 5 mortality rate	206	105
Contraceptive prevalence	-	41%
1990s gender gap		
	Female	Male
Life expectancy at birth	63.3 yrs	62.5 yrs
Net primary enrolment (6-15 yrs)	71%	83%
Adult literacy	44%	67%

Source: UNDP Human Development Report, 2000

During the 1990s a number of positive steps have been taken in policy, legislative, judicial and program development, towards the goals of the ICPD Programme of Action. These changes have included:⁸

- ~ The steady movement of women into public spaces as members of local government institutions in urban and rural areas, following the 73rd and 74th Amendments to the country's Constitution;
- ~ Interventions by the National Commission for Women (established in 1992) against violations of women's human rights;
- ~ The passing of the National Environment Tribunal Act in 1995;

- ~ The formulation of the National Policy on Women in 1996;
- ~ A Supreme Court ruling in 1996 ordering the closure of the aquaculture industry in the Coastal Regulation Zones of India;
- ~ A Supreme Court ruling in 1998 against sexual harassment of women in the work place; and
- ~ The banning of Quinacrine as a chemical method of female sterilisation by the Government in August 1998.

A perceptible change within civil society has been the expansion of social movements of farmers, tribal people, *dalits* (formerly untouchable castes) and women. A significant civil society initiative has been the Right to Information Movement in Rajasthan State in north India. This has mobilised the poor, and poor women particularly, to demand accountability from the Government bureaucracy. Collaboration between Government and civil society is helping improve the lives of the poorest - as, for example, through the Lok Jumbish Program for literacy and the Sonagachi Project for commercial sex workers.

These forward steps, however, have met with disheartening economic and social cross-currents. Progressive civil society increasingly must contend with an upsurge in upper-caste Hindu fundamentalism, and growing use of violence in public contests of communal, caste and ethnic identity. As women have become more visible in public society and debates, especially in advocating for women's rights, so too have violence and crimes against women increased.⁹ Finding justice is hardest for poor, lower caste women. Their resilience and capacity to take risks in order to assert their rights - including reproductive rights - is under severe strain.

There is now a substantial body of literature about how poverty has grown in India during the post-reform period. Several trends have been identified that indicate a deteriorating situation:¹⁰

- ~ The increased alienation of land that small or marginal farmers used or owned, because of large development projects, deregulation of agricultural land for industrial purposes, and moves to privatise wasteland;
- ~ Rising unemployment over the reform period;
- ~ Declining food security from shifts from subsistence to cash crops, lower annual growth rates for food grain

- ~ production, and increased prices for food grains; and Proportionate decreases in government spending on the social sector, from 7.3 per cent in 1990-91 to 6.7 per cent in 1994-95.¹¹

Among these contradictory trends, however, are visible efforts to re-work the health system, to make services more accessible and useful for women. Yet despite various changes in policy and operations, India's health program is low in quality, and barely responsive or beneficial to women. Concepts such as client-orientation and meeting community needs that abound in the Government rhetoric about reproductive health can hardly be seen in the services that are delivered. Implementing the ICPD Programme is difficult in an environment where privatisation is driving up health costs, social sector budgets are being cut, work opportunities are shrinking, and food insecurity is growing.

General health and reproductive health are not mutually exclusive, and reproductive health can not be improved in isolation. A reproductive rights agenda will empower women only if the interventions improve their access to reproductive rights, and control over productive resources. For poor women struggling with adversity, self-empowerment would mean more if policies and programs worked to change power relations within households, so that women truly could assert their rights.

Epidemics such as plague, malaria, and dengue are on the resurgence. There is an urgent need to restructure the various vertically organised but unintegrated health programs to combat communicable diseases from a social development perspective.¹² Equal priority needs to be given to a healthy environment, adequate nutrition and a higher socio-economic status for women. Research in Punjab, one of the more prosperous states, found that women suffer a high incidence of reproductive tract infections, severe anaemia during pregnancy and a very high risk of abortion-related deaths.¹³ Without accessible and affordable maternal health services, 84 per cent of rural women and 42 per cent of urban women are being assisted in child birth by untrained people - and this contributes to the appallingly high rate of maternal mortality rate in India.¹⁴

A study undertaken by an NGO of the impacts of the structural adjustment program in Rajasthan revealed deteriorating living standards

among the poor.¹⁵ The study surveyed 540 families in nine districts, and found that:

- ~ Poverty had increased since the reforms and added to the burden of ill-health;
- ~ Prices for medicines had increased since implementation of the Drug Decontrol Policy in 1994;
- ~ Spending on health was the single largest reason for indebtedness;
- ~ Economic need was forcing women to enter the work force;
- ~ There were serious problems with water quality and quantity;
- ~ The Public Distribution system could not meet the food needs of the poor;
- ~ Government-run anti-poverty programs were dysfunctional; and
- ~ Girls were being kept from school by gender discrimination and an unresponsive school system, and lagged far behind boys in literacy.

While this is only one study, it is a good illustration of the environment in which the ICPD Programme must be implemented in India, and the combined challenges of structural adjustment programs, growing pressure on the poor, gender discrimination, and poor public services for both health and education. Nonetheless, as pointed out earlier, there is a growing articulation of women's rights. The achievements in this regard combined with the increasing participation of women in politics, have been positive. The environment is complex: some forces enable and others constrain the advancement of women's health and rights.

4. The status of reproductive health and rights

It is difficult to assess how new policies have changed health services in this time in the short period since the ICPD. The changing emphasis within existing programs, as well moves to implement new programs, however, can suggest the directions of change.

Some of the large northern states, where health, human development and women's status indicators are poor, demonstrate the difficulty in implementing radically new policies. Even as the central Government was defining a new reproductive and child health program, these states, fearing their family planning performance would deteriorate, reimposed contraceptive targets. It has been difficult for program managers and health service providers to break away from the entrenched, thirty-year-old system of top-down service provision that has been driven by demographic targets. Their mindset has not yet adapted to the paradigm shift that the ICPD Programme advocates.

Confusion has also emanated from the Ministry. In the height reformulating health policy in 1996, the Minister for Health and Family Welfare coined a slick slogan, 'One is Fun,' in a bid to promote a one-child family norm. The change towards a reproductive health and rights agenda has repeatedly been confused with continuing elements of demographic targeting and population control.

It is difficult to assess the impact of policy change across all 32 states and Union Territories of India. The situation in the various states is very different, especially between southern states such as Kerala and Tamil Nadu, which generally have much better health, social development, family planning success and higher status for women, and northern states such as Rajasthan, Uttar Pradesh, Bihar and Madhya Pradesh. The enabling conditions also differ from one state to the next. In Tamil Nadu and Kerala, literate health workers and clients ensure higher quality demand and supply of health services. Even with outdated modes of teaching and pedagogy, the training of health workers can bring about new ways of working. The situation is very different in the northern states. General conclusions about the impact of policy and program changes in such a large and diverse country must therefore be made with caution. Yet the barriers to change in the northern states must not be exaggerated, least this become an excuse for governmental inertia.

A recent study was conducted on the effects of the shift from contraceptive targets in the two states of Rajasthan and Tamil Nadu.¹⁶ The study examined the perceptions of women in the community and ANMs working in Primary Health Centres and Sub-centres, through focus groups and in-depth interviews. Since 1992 in Tamil Nadu, a wider range of health services has become available to couples. While maternal and

child health and family planning services are in place, however, other planned developments, such as providing services for reproductive morbidity, have yet to be implemented. There are insufficient facilities in the Primary Health Centres for health workers to treat women with gynaecological complaints. Nonetheless, the study found that decentralised planning in Tamil Nadu, with health workers fixing their own targets independently of higher supervision, apparently has improved interactions between women and health workers. However, the more elaborate system of record keeping has increased the workload of ANMs. Monitoring of health workers by their supervisors is more rigorous in Tamil Nadu than in Rajasthan.

In Rajasthan, incentives such as cash payments, free transport or other services, once used to encourage women to be sterilised, have been completely withdrawn. In Tamil Nadu, cash compensation and transport are still being given, on the rationale that the women can use the money to buy nutritious food after the operation. The time saved by the ANMs in not having to drum up family planning acceptors is now spent on improving maternal and childcare. In the words of a health worker in Tamil Nadu,

The pressure is off and we are able to inquire about women's health, their children's health. We are also better accepted in the community. People do not identify us only as family planning workers but consult us about ailments of all family members.

The situation in Rajasthan is worse than in Tamil Nadu. Maternal and child health services there are quite inadequate, and most deliveries take place at home. Health workers have distributed safe-delivery kits to local women and traditional birth attendants. Yet without access to antenatal and postnatal care during obstetric emergencies, maternal morbidity and mortality rates will not decrease. Without commitment and understanding of the paradigm shift in reproductive health, program managers readily slip back into the old top-down, target-based approach to family planning, especially if their own superiors in the state or central Government do not encourage them to change.

A review of the implementation of the target free approach in three other northern states, namely, Uttar Pradesh, Bihar and Delhi, found some positive changes were occurring there.¹⁷ These included:

- ~ Some improvements to the quality of reproductive health services, and a move away from coercion;
- ~ The setting of targets has shifted from being top-down to bottom-up;
- ~ More emphasis on counselling and on creating an environment that will encourage more demand for services;
- ~ Information and education programs are becoming more client-centred; and
- ~ Service providers are being re-oriented and trained in new ways to provide reproductive and child health. This training is also bringing together NGOs and Government workers and helping to better coordinate their services.

Problems and shortcomings nevertheless remain; 'The rhetoric has changed, the mindset has not.'¹⁸ There is still much confusion among both service providers and NGOs about the many new terms and policy directions. There are too few workers at the ANM level and many health workers have poor literacy skills and know little about providing services. Socio-cultural barriers continue to prevent women from working in the villages. Inadequate medical supplies compound these difficulties in improving the quality of services in these northern states.

Abortion was made legal in India in 1972 by the Medical Termination of Pregnancy Act, yet safe abortion services are rarely included in the public health services. A major obstacle is the unwillingness of trained gynaecologists and obstetricians to work in public health services in rural areas and small towns. A powerful medical lobby has also prevented a shift to simpler technologies for menstrual regulation that could be performed by trained paramedics. Because of their lack of access to public services, women seek abortions by private practitioners or quack doctors at high prices and risk. Although India is one country where the enabling clause of para 8.25 of the ICPD Programme of Action would well apply, there has not been much government action in this direction.

5. The agenda for reproductive rights

In India, both civil society and the Government poorly understand the concept of reproductive rights. Even women activists have differences of opinion. Some activist groups are suspicious that this concept is part of

a Northern agenda to dump dangerous contraceptives in India. Others see the evident links between reproductive rights and basic needs, and their relevance for women in all countries. Despite these differences, women from both camps are working to address reproductive rights issues. A recent example is the case of Quinacrine sterilisation.

Quinacrine is a chemical agent used in female sterilisation. It provides a good example of the dangers of unregulated privatisation in India. Long after the controversy over 30,000 or more Vietnamese women being sterilised with this drug - even before its toxicology testing or animal clinical trials had been completed - appeared in the pages of *Lancet*, US distributors were supplying Quinacrine to private doctors throughout India. Both the Indian Council of Medical Research and the Drugs Controller of India were unable to act before the Supreme Court of India in early 2000 banned the drug, in response to public interest litigation. In pushing for this ban, some civil groups initiated legal procedures while others worked to inform the public of the drug's risks.

The poor quality of health services for women in the country denies them an important reproductive right. Yet the emphasis on health services can distract attention from other rights that are more closely linked with changing gender relations, for example, or preventing violence against women. Some new programs are addressing these issues. UNFPA's five year Integrated Population and Development project is working in seven states and 40 districts throughout India to provide comprehensive reproductive health care, including better infrastructure and facilities. For the first time, some states have funds to develop strategies to deal with violence against women - although the amount is minuscule compared to spending on other aspects of reproductive health. Much depends on the political will to implement what has been approved on paper. Government officials must better understand violence as a health issue, and to want to create the conditions for women to take more control over their own lives.

Britain's aid program, DfID, has supported Sexual Health Intervention Projects in several states, particularly by giving special support to vulnerable groups such as commercial sex workers, street children, truckers, and men who have sex with men, including through NGOs and women's groups. NGOs have assisted sex-workers in Calcutta to form a union and discuss their rights to live in dignity and practise their trade without being criminalised. This has raised an important public debate.

Another reproductive rights issue in India is abortion. Abortion was legalised in 1972 but this right on paper did not automatically translate into a right in practice. The lack of qualified trained doctors and other critical facilities in the Public Health Centres to conduct safe abortions make it inaccessible to village women. Various estimates suggest that one quarter of maternal deaths in India is caused by bungled abortions. Even where public services are available in the district hospitals or Community Health Centres, the health workers' obsession with contraceptive targets mean that abortion is provided only on condition that contraceptives or sterilisation being accepted. This raises the question of whether the shift to the target free approach in family planning will help to make abortion services less conditional and more available as a right. There is no obvious answer yet, for even in Kerala State, where abortion services are available at the district and medical college hospitals, young unmarried women and adolescents prefer to go to private practitioners for reasons of confidentiality. In order for this right to become a reality, not only must public services improve, but the attitudes of service providers must also be changed through sensitisation and training.

6. The role of NGOs and their relations with Government

It is quite a task to manage the change from vertical family planning, child survival and maternal health programs to an integrated program that addresses the reproductive health of women and men and links it to child survival. In India, this will require major changes in program design, implementation and delivery mechanisms. NGOs working in the health sector are trying to encourage Government to work together with community organisations and to increase the accountability to the community, especially women. International donor agencies are also encouraging Government to work together with NGOs, so that the new programs can more effectively reach out to women and men. Since 1997, various organisations and networks working in the health sector have tried to engage the Government in dialogue. This has become more urgent as widespread donor-assisted Reproductive and Child Health programs have got under-way.

NGOs and Government could work together on at least three kinds of activity:

- ~ Developing innovative models for service provision in new areas and those that the Government has difficulty in effectively providing;
- ~ Supporting the Government program through training, research, and raising public awareness; and
- ~ Advocacy, program planning, monitoring, evaluation and review, and building accountability by functioning as independent agents and citizens.

NGOs in India have long been recognised as cost effective agents to implement the Government programs. Their ability to provide support services has also been acknowledged. Yet they have not been seen as partners in planning, implementation or monitoring. Despite the recognition that NGOs can mobilise the community, their involvement has been limited to helping Government initiated campaigns such as the immunisation drive. Since the Cairo Conference, NGOs have proposed several ways to become better partners in the Reproductive and Child Health program. They include:

- ~ Undertaking activities such as community mobilisation, micro planning and health mapping, activities for which NGOs are often better equipped than the Government. Other such activities include running public awareness and education programs for adolescent girls and boys, training traditional birth attendants, and sensitising service providers about gender issues. NGOs have emphasised the importance of opportunities for the community to be involved in addressing reproductive health issues, and re-orienting local medical practitioners to understand the new thinking on these topics. The Government could delegate these activities to NGOs.
- ~ Taking more active part in health service planning, especially at the level of Primary Health Centres and the district, and thereby providing a stronger link between the Government and the people. ANMs could particularly benefit by having their concerns about security addressed. Of course, this would only be possible if the target free approach is maintained, for using NGOs to identify people

- to be sterilised would damage the effectiveness of the organisations.
- ~ Coordinating the many village committees on health, education, water, forest protection, common property resources, child nutrition and so on.
 - ~ Being involved in health education and illness prevention.
 - ~ Expanding the circle of people who have a holistic view of reproductive health and reproductive rights. This could include involving appropriate organisations in training, communication and advocacy, including special campaigns such as to prevent teenage pregnancy or encourage safe methods of abortion.
 - ~ Conducting qualitative and quantitative surveys or studies on reproductive health problems and ways people deal with these problems, including access to special services, such as for abortion.
 - ~ Operating some health care centres, especially in areas where the Government has not been able to provide services, with the possible secondment of government workers to assist the operation.
 - ~ Monitoring and reviewing programs.

Despite such recommendations and the evident enthusiasm of NGOs and other organisations to contribute to improving reproductive health, there has been no significant change in the relationship between Government and NGOs since Cairo. The Government has sought the assistance of NGOs in only three kinds of schemes, namely:

- ~ Acting as 'Mother Units' to identify, screen and disburse funds to field-based NGOs for specific schemes of the Government. These nodal units are expected to identify and support smaller groups to manage specific reproductive health projects, mostly for family planning, maternal and child health, and innovative programs for adolescents. They must follow strict financial practices set by the Government. For example, each Mother Unit receives a grant of Rs 25 lakhs and can disburse up to Rs 2 lakhs to the smaller organisations.¹⁹ This is the most important scheme through which the Government

- is reaching out to many grassroots groups.
- ~ National NGOs conducting base-line and facility surveys, and other studies commissioned under the Reproductive and Child Health Program. Recognised population studies institutions, market survey agencies, social science research centres and department of demography and population in Universities have been involved in nationwide surveys. Funds from some multilateral organisations are routed through a government sponsored consulting organisation (RITES).
 - ~ State Governments providing grants-in-aid to NGOs to initiate specific projects. These have included operating Public Health Centres in remote and difficult areas. State committees have been established to screen and approve project requests from NGOs. Different State Governments have different systems, but most do this through a committee of Government and NGO representatives.

A few NGOs have been invited to be members of a national advisory group on Reproductive and Child Health, a body that advises Government on the program. Similar advisory bodies have been established in some states. Where the Government has created autonomous bodies to implement the Reproductive and Child Health Program, the executive body includes a few NGO representatives.

At first glance, India may seem to have institutionalised NGO involvement through grant-in-aid programs and advisory bodies. Government aid is made available to organisations working among the poor. Some people believe that India has done a lot more in this area than many other countries. While recognising the importance of NGOs in filling the gap in development activities, it is also true that Government-NGO relations are based on mutual suspicion.

The Government continues to be wary of the intentions of NGOs and their financial transparency and accountability. NGOs, for their part, are apprehensive about depending on Government for funds. Political and bureaucratic corruption, non-transparent procedures, and the risk of summary withdrawal of funds are often cited as reasons. Yet for some NGOs, Government aid lends them legitimacy, especially in the eyes of the local administration. The fundamental problem is that the relationship

is essentially unequal: the dice are loaded against NGOs and Government circumscribes the meaning of 'partnership' within fairly narrow limits.

Some NGOs have a long history of amicably working with Government on health and family welfare programs in an uncritical manner, evidently having accepted the erstwhile target-oriented approach. The other group of women's organisations and grassroots groups is still kept at arms length by the Government - those that criticised the contraceptive targets and were in the forefront of struggles against coercive female sterilisation, clinical trials of certain contraceptives and deteriorating primary health care services. This division has been quite marked since the Cairo Conference, as women's organisations and health advocates have renewed their dialogue with the Government. Many of them welcomed Government's decision to remove contraceptive targets, yet greeted the Reproductive and Child Health programs with only cautious optimism.

HealthWatch, which was established immediately after the Cairo Conference, attempted some dialogue with Government about the Reproductive and Child Health program, but the latter's initial enthusiasm soon gave way to silence. As senior bureaucrats changed, the message sent by the Department of Family Welfare was that they were open to grassroots organisations involved in delivering services, but not to advocacy networks of social activists and researchers. NGOs today therefore have an ambivalent relationship with the Department of Family Welfare. Some may have a good relationship as service deliverers, and individual researchers and activists are invited by Government to participate in various project formulation or appraisal missions. Yet the network they are part of is kept at a distance. It is not easy to explain this trend, although the vagaries of bureaucratic postings and the enormous power wielded by senior bureaucrats make all programs in India subject to constant uncertainty. Unless the climate of suspicion changes and Government understands NGOs to be independent interlocutors and genuine partners in development, this ambivalent relationship will continue.

7. Conclusion

Assessing the direction and quality of reproductive health policy and program changes in India since the 1994 ICPD is a complicated undertaking. There is no doubt that significant changes are occurring. Yet

the shadow of the top-down, target-driven family planning program still hangs over reproductive health policies, and India's bureaucratic system is as famously affected by inertia as ever. Health activists can be no more than cautiously optimistic. The changes that are under way are still fragile. Senior program managers and service providers have only partly changed their mindsets. NGOs find that Government considers neither women in the community nor civil society organisations as its true partners. The Government's limited sense of accountability to women and the community in the directions of its policies and the scope and quality of its programs remains the weakest link. ¹⁰⁴

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- ¹ Government of India, 1992.
- ² Singh, 1998
- ³ World Bank, 1995.
- ⁴ Abortion has been legal in India since the early 1970s but services are still inaccessible and of poor quality.
- ⁵ Unfortunately, this program stands frozen in the aftermath of India's nuclear explosions.
- ⁶ For details on these workshops, see HealthWatch 1996-97
- ⁷ R. Murthy and N. Rao, 1997.
- ⁸ R. Murthy and N. Rao, 1997.
- ⁹ Vimochana, a forum for women's rights in Bangalore that advocates for legal and judicial changes to eliminate violence against women, is studying an increasing number of cases in Karnataka of 'unnatural deaths' of women, from accidents, stove explosions, suicide and similar causes, where the police found no evidence of crime. Vimochana followed 200 of the 714 cases registered in 1997. It found a very different picture. In most cases, there was some history of harassment or torture leading to the woman's death. Vimochana persuaded the police to reopen 70 of the files. A report on the preliminary findings is available and entitled, 'A movement to defend women's right to life.'
- ¹⁰ R. Murthy and N. Rao, 1997.
- ¹¹ In the 1996-97 budget, allocations for the nutrition program, family planning program and primary education were increased; allocations for employment generation and rural development remained static.
- ¹² The Independent Commission on Health in India, 1997.
- ¹³ V. Pushkarna, 1999.
- ¹⁴ The Independent Commission on Health in India, 1997.
- ¹⁵ ASTHA , 1998.
- ¹⁶ L. Visaria and P. Visaria, 1998.
- ¹⁷ Sahayog and UPVHA, 1998.
- ¹⁸ Sahayog and UPVHA, 1998.
- ¹⁹ 1 lakh equals 100,000 rupees.
- ²⁰ World Bank, 1995:34. The family planning program is part of the larger family welfare program that includes family planning, maternal and child health, and area projects.

Philippines

✧ *Josefa (Gigi) Francisco*¹ ✧

1. Creating an enabling policy environment

It is widely acknowledged in South-east Asia that the Philippines leads the region in undertaking the shift to a reproductive health approach in its population programs, as well as in forging links between government agencies and non-governmental organisations (NGOs) and women's or feminist groups. This paper examines these processes in light of more recent developments that bear on efforts to build upon past achievements. It describes emerging concerns that impinge on the capacity of, and dynamics between, key stakeholders in the consensus around the policies, programs and implementation of the reproductive health approach in the Philippines.

The shift toward a reproductive health approach to population management in the Philippines may be traced to developments well before both the International Conference on Population and Development (ICPD) held in Cairo in 1994 and the Fourth World Conference for Women held in Beijing in 1995. From 1987, a presidential directive lodged the Philippine family planning program with the Department of Health. The Commission on Population, which earlier had been at the forefront of implementing the Philippines' family planning program now functioned as a coordinating agency on population. Its primary concern became limited to policy formulation, information and education. With the re-alignment of agency responsibility over the family planning program, a paradigm shift also occurred. Family planning became a 'health issue with population implications, as opposed to family planning as a population issue with a health aspect.'²

The new health-oriented view of family planning was consistent with the strong social development commitment of the new Philippine Constitution also adopted in 1987. A provision in this new constitution that has a particular impact on Filipino women's reproductive health and rights, and on the country's population policies and programs in particular, is Article II, section 12 which 'prevents Congress from legalising abortion and the Supreme Court from passing any pro-abortion decision.'³

Population became less prominent in the policies and programs of the newly installed Aquino administration (1987-1993). The strong lobby lodged by the Catholic Church and leaders of the Pro-Life movement in the country that had supported the rise to power of a democratic government, was a critical factor in this shift. From this time on, the ideological struggle between feminist groups and conservative backlash to women's reproductive and sexual rights began to be prominently articulated and played out within the population and health arenas of government policy.

Women's groups and individual feminists formed alliances with some population officials and donor agencies in assisting both the Commission on Population and the Department of Health put in place their respective women-oriented programs on population and family planning. This process found convergence with international debates and discourses on population and development, women's rights, and sexuality that had been stimulated by the Cairo and Beijing Conferences. Internally, the debates were stimulated by the election to office of the Ramos government and a new Congress (1993-1998) both of which were more open to population management policies.

The Department of Health adopted the new Philippine Family Planning Program (PFPP), which incorporated three priority projects:

- ~ The Integrated Family Planning and Maternal Health Program;
- ~ The strengthened management and field implementation of the reproductive health and family planning program; and
- ~ The Women's Health and Safe Motherhood Project.⁴

Before the May 1998 election, the Department of Health consolidated its role in family planning by establishing a National Task Force on Women's Health Policy. In December 1999, the Department of Health further strengthened its Reproductive Health Program by adopting a National Reproductive Health Policy, a document that set the guiding principles and broad strategies for program implementation. In this new framework, the empowerment of women was identified as key to reproductive health. A life-span rights-based approach to reproductive services was made the cornerstone strategy. This policy now guides the work of the Inter-Agency Task Force on Reproductive Health Program, whose membership includes representatives of selected women's NGOs.

The Commission on Population, for its part, produced a new population program that sought to achieve a balance among population, economic resources and environment. It also released its 1998-2004 Plan for the Philippine Population Management Program that is also based on a reproductive health approach. The five components of the re-defined population management program are:

- ~ Reproductive health and family planning;
- ~ Population and development planning;
- ~ Adolescent health and youth development;
- ~ Gender and women's empowerment; and
- ~ Migration, population and environment.

The policy commitments and programs of both the Commission on Population and the Department of Health demonstrate a strong commitment to a reproductive health in family planning, population management and women's health. The Cairo and Beijing agendas also had a powerful influence on official thinking. A critical part of this influence has been the sustained advocacy by women's NGOs and individual feminists on the Philippine government, particularly on the Commission on Population that was more active than the Department of Health in linking with women's groups.

A closer definition of the shared responsibilities of the Department of Health and the Commission on Population for the country's population program is being considered within and outside Government. Two legislative proposals, namely, Senate Bill No.2012 and House Bill No. 9409 titled, 'An Act Establishing a New Population Policy,

Strengthening the Commission on Population and for Other Purposes,' are pending in Congress. These bills aim to re-establish a distinct population program and broaden the Commission on Population's currently limited mandate, at a time when responsibility for family planning services has been transferred to the Department of Health. This took place during the Ramos Administration (1993-98) when the policy environment, particularly the elected legislature, had evidently become more concerned about population and development issues. At this time, the Commission on Population had also defined its new policy framework that went substantially beyond the earlier and narrow framework of family planning.

The reproductive health approach has only been partially incorporated in the policy and program frameworks of the Commission on Population and the Department of Health. Nevertheless, a broad agreement around population has been able to accomplish the following: ⁵

- ~ The broadening of the definition and coverage of the question of population - although the paradigm is still being contested by women's and feminist groups;
- ~ The establishment of a target-free approach to contraceptive supplies;
- ~ A tighter focus on improving the quality of care for all and on protecting women's and girls' reproductive and sexual rights; and
- ~ The integration and promotion of the principles of gender equity and women's empowerment in all programs.

There is admission that much more can be done to improve the policy environment for women's health in general and reproductive health, in particular, such as: ⁶

- ~ Defining a common and integrated framework on reproductive health, not only between the Department of Health and the Commission on Population, but also with other stakeholders;
- ~ Further refining the family planning and population management programs and population bills through discussions with all policy advocates, especially women's and feminist groups,

- ~ Assisting new policymakers to recognise and support the ICPD commitments, and
- ~ Increasing opportunities for the meaningful participation of women's NGOs in health policy formulation, particularly in designing programs on reproductive health.

Development indicators for Philippines

	<i>1970s</i>	<i>1990s</i>
Population size	43 mill	71.4 mill
Population growth rate (1975-1997)	-	2.3% ann. av.
Total fertility rate	5.1	3.6
Life expectancy at birth	56.9 yrs	68.3 yrs
Maternal mortality rate	-	280
Infant mortality rate	60	32
Under 5 mortality rate	90	41
Contraceptive prevalence	-	40%
	Female	Male
Life expectancy at birth	70.2 yrs	66.5 yrs
Gross primary enrolment (6-15 yrs)	99.9	99.9
Adult literacy	94.3%	94.8%

Source: UNDP Human Development Report, 1999

2. Ongoing debates & challenges

Although the proposed population bills are considered progressive and in line with the commitments made at the Cairo and Beijing Conferences, they are under negotiation with some stakeholders - including women's and feminist groups opposed to them. Ironically, many of these women's groups had also actively assisted the Commission on Population clarify its reproductive health orientation. In January 1998, these NGOs produced a strong-worded position paper on the Population Bills, attacking the primacy given to the population-resource paradigm and goals.⁷ They instead proposed the adoption of the progressive aspects of the ICPD Programme of Action, particularly that which aimed to eradicate poverty and called for the primacy of women's empowerment and rights. Although they had been considered a priority, partly as a result of this opposition, Congress did not pass the Bills before the 1998 national election and they remain stalled in Congress up to this time.⁸

The election of a new government in May 1998 started a new phase in the development of policies to support a reproductive health approach in the Philippines. The new group of legislators were not fully informed about the ICPD and had to be informed and persuaded all over again. Lobbying by women's groups seemed not to have been as effective this time - possibly because some groups were distracted by 'more pressing' national issues of cronyism, corruption, rising prices, a deficit budget, a sluggish economy and the Muslim rebellion, all of which were blamed on the newly elected President.

New appointments in the leadership of both the National Commission on the Role of Filipino Women, a consistent supporter of reproductive health, and the Department of Health, where the reproductive health/family planning program is lodged, have not been heartening. The appointment of a prominent Pro-Life advocate on the Women's Commission and her active lobbying to be included in the official delegation to the Beijing+5 Review, created another hurdle for feminist health advocates. At the Department of Health, the new President appointed a male doctor who had yet to declare his support for women's reproductive health, over the other candidate for the post, a prominent woman advocate for women's health whose credentials were equally impressive. The use of political appointments as a way to return political favours and balance or hold

together a volatile political coalition was virtually left unchallenged by the women's health groups.

A nationwide campaign by the Catholic Church on ways to conduct sex education, as well as with its invigorated anti-poverty and anti-corruption drives, exert other influences on the policy environment. Buoyed by the Jubilee Mission call, the renewed social activism among the clergy and lay members has encouraged some of them to challenge reproductive health activists in more direct and concerted ways. Confrontation between the two groups has so far been avoided. An uneasy alliance seems to have formed around issues of poverty, sex trafficking, and violence against women. Nevertheless, when the Population Bill is finally tabled in Congress, it is obvious that the Catholic Church will be ready to oppose it.

Advocacy and lobbying have shown that people within the government and national opinion leaders who are responsive to gender concerns have been crucial in ensuring that certain policies and programs were formulated and approved. This is particularly so in the Philippines and in Asian cultures generally, where personal friendships, alliances and personalities still dominate politics and governance.

3. The delivery of reproductive health services

Between the two agencies responsible for population concerns in the Philippines, the Department of Health is primarily responsible for the delivery of reproductive health information and services while the Commission on Population guides policy. A tentative system of coordination between the two bodies has been established. The Bill to re-strengthen the Commission on Population is still awaiting approval by Congress.

This arrangement is further complicated by the devolution of functions to local government units, including responsibility for the delivery and financing of health, population and other social welfare services. This devolution of government services was inspired by the Filipino people's desire for greater democracy and government accountability after 15 years of Martial Law.

Either individually or together, the Commission on Population and the Department of Health have initiated formal cooperation agreements with the local government units.⁹ A boost to this cooperation came in the form of an Executive Order in February 1996 from the then President Ramos that required local government officials to give priority attention to the Philippines Family Planning Program.¹⁰

The Women's Health and Safe Motherhood Project of the Department of Health is the showcase project on reproductive health for 1995-2000. It aims to reach 77 provinces, providing services for:

- ~ Maternal care;
- ~ Family planning;
- ~ The diagnosis and treatment of reproductive tract infections and sexually transmitted diseases (STDs); and
- ~ Detection and treatment of cervical cancer.¹¹

These services encompass women's health problems beyond simply those related to maternal care. There are also innovative pilot areas. In one village in Palawan, the Life Cycle Approach is being tested by an NGO.¹² This is a client-oriented approach to service delivery that especially improves the access of people most in need of health services - a laudable initiative.

Government freely admits that weaknesses remain in the delivery of health services, and that six areas in particular need attention. These are:

- ~ The prevention of abortion and management of its complications;
- ~ Appropriate treatment of infertility and sexual health disorders;
- ~ Counselling and education in sexuality and sexual health;
- ~ Adolescent reproductive health;
- ~ Male reproductive health; and
- ~ Prevention and management of violence against women.

It is also recognised that the standards and accessibility of different reproductive health services varies a great deal between provinces, and that services could be better integrated.¹³

Meanwhile, criticisms from women's health groups are that the project is too much oriented toward obstetrical facilities and structures and gives insufficient attention to women's other health needs.¹⁴ Another is that the project depends heavily on imported contraceptives. Some feminist health activists still recall the contraceptive program of the Marcos Government in these terms, "High dose hormonal formulations and dangerous intra-uterine devices were prescribed under conditions which encouraged health workers to overlook possible contra-indications and the patient's own wishes."¹⁵ NGOs and women's groups also criticise the pressure that donor agencies exert over the project, one example being the practice of donors imposing their own 'experts' on central and local government agencies.¹⁶

Besides improving service delivery, the project helps to strengthen the capacity of public health facilities to incorporate a reproductive health orientation into their services. A Women's Health Training Project is being implemented in several provinces and includes training on gynaecological emergencies, treatment of reproductive tract infections and cancers, family planning, and treatment of sexual assault and abuse.¹⁷ Through NGOs, community groups in the five pilot projects will be invited to plan and implement their own health care and action projects.¹⁸

In the future, the program will pay more attention to operational and policy research and evaluation. This research will include studies on women in the labor force, violence against women, teenage pregnancies, unintended pregnancies, the situation of elderly women, mental illness, single and unwed mothers, and special needs of indigenous groups.¹⁹ These concerns partly converge with those identified as 'specific groups of women' that the Population Program intends to give more attention to in the future.²⁰

4. Financing reproductive health

Over the past three decades, the Philippine Population Program has depended heavily on foreign aid and loans from international finance institutions. Donor-dependency has been coupled with a pattern of public investment characterised as follows:²¹

- ~ A steady improvement in human priority expenditure ratios from 1986 to 1998;
- ~ A significant decrease in the social priority ratio in the latter part of the Ramos Administration, which indicates that despite a greater allocation for social services, the distribution of resources within the social sectors did not favour human priority needs, namely basic education, basic health, and water;
- ~ Heavy debt servicing costs, which drain resources that otherwise could go towards human development investments; and
- ~ Human development spending that still is significantly below internationally accepted standards.

The serious impact of the South-east Asian financial crisis on public spending in the Philippines became evident in December 1997, when President Ramos ordered all government agencies to reduce their spending by 25 percent.²² In his inaugural speech, in-coming President Joseph Estrada bewailed the fact that he was inheriting a bankrupt government and a country reeling from the economic crisis.

Local government units had ten percent of their financial allotments withheld by the Government, over and above the 25 per cent cut in spending. A study nevertheless found that local government units had underspent on health and social welfare, relative to the levels prevailing before devolution.²³ Another study found that local government units that collected more revenue were able to increase spending on social welfare, including reproductive health.²⁴ Those units strapped for cash could then get assistance for their social welfare projects from the Government or donor agencies. For example, the United States Agency for International Development (USAID) is helping 87 local government units implement their reproductive health and population programs. As part of this agreement,

the Department of Health will use government funds to assist the other units. However, the Department of Health has no budget to do this.²⁵ The same study found that the biggest share of the project's budget went to importing contraceptives - confirming what women's and feminist groups had said all along. The Department of Health, furthermore, needed P\$30 million to pay Customs duties and taxes for the 'donated' contraceptives, for which no money was available.

5. Conclusions

Over the last five years, the Philippine Population Program has succeeded in distancing itself from its previously strong family planning orientation. It has put in place policies that follow closely the spirit and language of the ICPD Programme of Action. The consolidation of these various policy pronouncements into a single comprehensive population policy, however, is yet to be achieved.

Through these policies, the Philippine Population Program has been reoriented towards a reproductive health approach. There nevertheless remains the constant need to disseminate information to and lobby policymakers, and educate people generally about gender sensitivity and women's empowerment.

The Department of Health is currently responsible for reproductive health and family planning services. This bodes well for the promotion of services that address women's health needs. The main weaknesses in the Department of Health, however, have been its inadequate consultation and collaboration with women's NGOs, and the general lack of gender awareness among health providers.

The two are inter-related, as experience has shown. In both these respects, the Commission on Population appears to have performed better than the Department of Health. Another major setback is the Department of Health's reproductive health project itself, in which a strong emphasis on contraception continues to characterise the nature of the family planning services.

One weakness that needs to be systematically addressed is the long-term dependence on foreign donors. This would require a re-

orientation of the budget for health and population, but more fundamentally the re-structuring of the entire national budget. Debt servicing continues to siphon finance away from pressing public spending needs. The Philippine Government also needs to increase its budget commitment to human development priority areas.

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South-east Asia

❧ **Rashidah Abdullah** ❧

1. Introduction

This case study aims to analyse the implementation of the recommendations put forward in the ICPD Programme of Action, as part of the Development Alternatives of Women for a New Era (DAWN) assessment for the ICPD+ 5 Meetings in 1999. It primarily focuses on Thailand, Malaysia, Indonesia and the Indochina countries of Cambodia, Lao PDR and Viet Nam with some comparative references to the Philippines on which there is a separate DAWN case study written towards the end of 1998. It has been updated in the year 2000 with some information on the ICPD+5 process.

The main information sources are related to ARROW's regional monitoring work on ICPD and Beijing implementation. These are:

- ~ Country papers and Overview of ARROW's 1996 regional research, *'Changes in Population Policies and Programmes Post-Cairo'* in eight countries - China, Fiji, Indonesia, Malaysia, Pakistan, Singapore, Thailand and Viet Nam - published in 1999;
- ~ South-east Asian country papers on 'Women's Health Needs and Rights' in 1997 from ARROW's monitoring project, *'Strengthening the Capacity of South-east Asian Governments and NGOs to Monitor and Implement the*

- ~ *Beijing Platform For Action*; and
- ~ Papers from the 'Southeast-Asian Regional GO-NGO Policy Dialogue on Monitoring and Implementation of the *Beijing Platform for Action*' which was organised by ARROW and APDC (GAD) in June 1998.

2. Policies before and after Cairo

Government officials interviewed in the 1996 ARROW post-Cairo research did not credit the ICPD as having a significant impact on the direction of population and reproductive health policies and programmes. Rather, they acknowledged it as having 'a booster' or reinforcing effect. Prior to Cairo, population and health policies and programmes in the Philippines, Malaysia, and Thailand were seen to be already moving towards a broader concept of reproductive health services, and in the Philippines, even a gender component was being considered. South-east Asian governments, excluding Indochina, reported in the 1996 research that they were on track with reproductive health programme implementation and that no major changes were required.

In Indochina, the pre-Cairo situation was different. Viet Nam's population programme was being critiqued externally as having some major problems of quality and lack of informed choice regarding contraceptives etc. Cambodia and Lao PDR were in the preparatory stages of designing basic comprehensive health policy and programmes including new family planning services. The ICPD recommendations thus most likely had more influence in these countries.

Since the Cairo Conference, there have been a number of policy and programme changes reported in most countries. These range from renaming and restructuring the maternal and child health care programme in Thailand to reproductive health; a similar programmatic change in Malaysia; a new gender-responsive population policy in the Philippines and brand new policies on birth spacing and reproductive health in Lao PDR and Cambodia. Viet Nam is trying to reform the weaker parts of its family-planning programme in relation to unsafe abortion, contraceptive choice and others.

In all the countries studied except for the Philippines, changes appear to have come about through government initiative and the influence

of international organisations. In these countries, little policy advocacy by NGOs including women NGOs is apparent before and after the 1994 Cairo conference. Only in the Philippines were women NGOs involved in the preparatory process and sending of delegations to the ICPD. In fact, Filipino women NGOs have gained an even stronger foothold after Cairo. In contrast, other South-east Asian countries do not have a large NGO presence. For example in Singapore, Malaysia and Indonesia, NGO advocacy is not only discouraged but even punished legally if it becomes too critical. In these countries and in Indochina, NGO roles in service delivery and research are seen as appropriate, but not in the newer areas of policy and programme advocacy. There are few women's NGOs, and only in the Philippines and Thailand are they focusing mainly on women's health.

Organised opposition to ICPD is apparent only in the Philippines, with the lobbying of the Catholic Church against progressive policies and laws. In Malaysia and Indonesia, in the first few years after Cairo, there was reluctance from the government to talk about the rights aspect of the Plan of Action in related seminars or meetings in areas that were regarded as sensitive and controversial, such as abortion, adolescent sexuality and reproductive rights.

Substantial progress has been made by Malaysia however in that both government and NGO's as part of the ICPD+5 review process and beyond have organised roundtables and seminars which include discussion on reproductive rights.

The National Population and Family Development Board in 1998 invited women NGO's for the first time to a dialogue on contraception, abortion and reproductive rights. The Federation of Family Planning Associations, Malaysia, which was the national focal point for the NGO ICPD+5 process, has organised two national seminars since 1998 on the ICPD agenda. Sisters in Islam in 1998 organised a 'Regional Workshop on Islam, Reproductive Health and Women's Rights' that examined Muslim interpretations of sexual and reproductive rights.

UNFPA has played an important role in funding programmes particularly in Indochina and the Philippines and in monitoring government action and development of national action plans. Officials interviewed in the post-Cairo research, however, saw their role as supporters of government policies, thereby it is unknown to what extent they played an

advocacy role. The 'Asia and Pacific ESCAP/UNFPA Governmental High-level Meeting to Review Implementation of the ICPD Plan of Action' in 1998 generally allowed governments to report on their successes, with no detailed presentation and analysis of problems; partnerships with NGOs, including women NGOs; or guidance on how to tackle obstacles.

While UNFPA may have helped in the more medical aspects of operationalising a reproductive health approach, it was nowhere apparent in the meeting that it was able to promote in a practical way the principles of the ICPD in relation to human rights and gender equality. The effectiveness of UNFPA's wide technical support role in these areas needs to be studied. Also, in terms of UNFPA partnerships regionally and nationally with NGO's and other stakeholders, it is necessary to assess to what extent it has forged new relationships in the different areas of the ICPD or encouraged implementation in these areas. FORD Foundation seems to have played a more important role in sensitive and difficult areas that require creativity and innovation in the Philippines and Indonesia and in South-east Asia in general.

At the programme level of family planning and reproductive health programmes, change is still difficult to evaluate. Claims have been made and generalisations have been given, but governments and NGOs have done little systematic monitoring and evaluation. In terms of operationalising reproductive rights concretely into a number of components such as informed choice, choice of contraceptive methods, access to contraceptives and reproductive health services for all ages, gender roles and male involvement, there has not been much progress.

Governments see these issues as less important in the hierarchy of ICPD recommendations, as attested in the Cambodian Minister of Health's statement that, "We must focus on our basic health needs first before we think about rights or gender issues."¹

3. The 'enabling environment for implementing the ICPD Programme

In South-east Asia, the extent to which socio-economic and political factors create an enabling environment for the implementation of

sexual and reproductive health and rights, is difficult to assess, as there are both positive and negative indicators. To begin positively, the Beijing conference has been a big boost, by eliciting much government interest and support much more than the ICPD; fast development of post-Beijing National Action Plans; closer collaboration of NGOs and government in assessing women's needs; and a more united national and regional women's NGO action. The Beijing Platform for Action has reinforced ICPD principles and recommendations, carried the sexual rights concept forward more clearly, and strongly advocated women's rights to accessible, comprehensive, affordable, high quality sexual and reproductive health services. National agendas for women in South-east Asia, including gender equality and reproductive health and rights are clearer after Beijing and the political will to implement the Platform for Action is higher than for the Plan of Action of the ICPD.

Up until the financial crisis of mid-1997, good growth rates enabled more of government budgets to be spent on increasing access to reproductive health services and the quality of services. This allowed South-east Asia to go ahead with social development plans that involve the reduction of poverty and expansion of health services. Women's literacy and access to education and employment in the formal sector had been improving as part of this social development.

Legal reformation of discriminatory laws and new legislation on violence against women to protect women's rights have been slowly increasing due to women NGOs' policy advocacy and increased government commitment. All South-east Asian countries had ratified the Women's Convention by 1995 and most governments claim to be in the implementation stage of gender equality strategies.

The findings of the post Cairo research indicated that in 1996, governments in Indonesia, Malaysia, Thailand and Singapore believed that much had already been done in terms of gender equality, women's empowerment, social and economic equity and accessibility of health care services. However, clarity of the concepts of reproductive rights, women's rights, gender, even accessibility of services was not there and the positive assessment was made based on conventional indicators rather than the new framework of Cairo and Beijing. At the High-level ESCAP/UNFPA ICPD Implementation Meeting in March 1998, it was apparent

that governments were still unclear on these concepts, especially in assessing the success of implementing them.

The 1996 post-Cairo research also found that governments in these countries were defensive about and resistant to the ICPD's emphasis on adhering to universal human rights principles including women's human rights.

The rationale given for lack of focus on human rights by the Malaysian government, for example, was that economic development requires political stability, which in turn necessitates absence of civil or labour protests and unrest. The exercise of human rights in terms of civil and political rights is therefore put on hold until economic development is achieved. Combined with the existence of national security laws that allow arrest without trial, the environment is hostile towards the exercise of human rights. In 1998, a further step backward was taken by the Malaysian government in charging the ex- Deputy Prime Minister with sodomy under a civil act prohibiting unnatural sex, that is, oral and anal intercourse. Within a climate of government hostility to human rights, negativity towards and confusion over reproductive and sexual rights, and a lack of a strong NGO advocacy community, it is not surprising that there is no real public debate on human rights issues. However, the new trend in Asia to establish an independent human rights commission is encouraging. The Malaysian Human Rights Commission, for instance, was formed in 1999 and includes two women activists among the ten members.

The only country in South-east Asia that has a policy-enabling environment is the Philippines. This was developed over the last 15 years due to the hard work of NGOs, particularly women NGOs, who included a reproductive rights agenda into reform efforts in the Marcos era.

Nevertheless, despite restraints in most countries, with the persistence of both national and regional NGOs and the predominant enabling factors, it appears as though progress is being made towards acceptance of a development framework that includes rights. It is critical that this process be understood and strategically monitored and nurtured at all levels. The importance of ongoing regional and international support in building enabling national policy environments as well as capacity building of NGOs has to be recognised.²

4. Reproductive Health

Health policy shifts

The most obvious change since the Cairo conference has been reported at the programme level, involving conceptual and structural changes in programme organisation, range of services, and the target approach. Based on the main sources of this case study, it can be said that there has been a definite shift from a family planning focus to a broader reproductive health emphasis.

In Indonesia, Thailand and Malaysia, this has been expressed in a shift in emphasis in government family planning programmes to reproductive health programmes that now articulate the importance of reproductive health services for the individual woman. Demographic targets in Thailand and Malaysia for family planning acceptance are no longer used and the Indonesian government claims to have made the same change. In Indonesia, a family welfare or family-centred approach to reproductive health is now followed. For Thailand, a focus on unmet needs throughout the life cycle is a priority particularly for adolescents, hill tribes and the Muslim population in the south. Generally, one of the main aims expressed by these countries is to move from a focus on quantity to quality of programmes.

For Cambodia and Lao PDR, it is good to see that new post-Cairo policies are not population policies per se but birth spacing or safe motherhood policies that focus on reproductive health. They also include some statements on rights, which is very encouraging. Cambodia has a progressive birth spacing policy, which was implemented in 1995, that gives women wide access to contraceptives. The Cambodian country paper researcher concluded that based on this policy, all women regardless of age, marital status, ethnic or religious background, have the right to a full range of birth spacing services. Unfortunately, contraceptives are too expensive for most women and less than one per cent of the population use them.³

Only Indo-China countries however, would partly attribute these policies directly to ICPD influence, which coincided with health policy development and reform. Other South-east Asian countries claim to have been already moving in the direction of quality reproductive health

services prior to ICPD. In countries such as Indonesia, however, in which maternal mortality rates have remained at a high of 450 deaths per 100,000 live births, showing that basic reproductive health services are not yet in place, this claim needs to be examined closely.

The provision of health services

Thailand and Malaysia have definitely continued to improve their reproductive health services since the Cairo Conference, by offering a wider range of services including information and counselling for adolescents, more accessible reproductive cancer screening and better quality maternal health services. In 1997, Thailand's Ministry of Health restructured its health services with the guide of its reproductive health policy that was put forward in 1996, offering an integrated programme with ten components. Malaysia's programme is now named Family Health and reaches out to all age groups, high-risk women and marginalised groups such as indigenous communities. Thailand also has extended outreach more to groups in need. Both countries aim to provide information services to adolescents and unmarried youth, but have yet to design and implement a sexual and reproductive health education programme for this age group, let alone provide services that are still categorised as controversial and sensitive.

Similarly, neither country has yet incorporated the views of users, particularly women, in assessing the quality of their programmes. In this area, Thailand's Ministry of Health has made a good start recently by linking up with the Women's Health Advocacy Network (WHAN) and the Centre for Health Policy Studies in Mahidol University in obtaining rural women's views on what they want from gynaecological care.⁴ This pilot action-research involves consultative policy dialogue between the NGOs and government on implications of the findings for current Ministry of Health reproductive health programmes.

The Philippines has progressed by leaps and bounds and user perspectives input is already a feature of their health service. One significant contribution was from the Philippines International Reproductive Rights Research Action Group (IRRRAG) study conducted by WomanHealth Philippines,⁵ from which women's voices on their health and rights have been reported to and acted on by policy makers.

Less change is reported in Indonesia. The 'Mother-Friendly Movement' initiated by the Ministry of Health and the Ministry of Women's Development in 1997 to reduce maternal mortality is innovative and serious in design. Unfortunately, its promising and critical outcomes have been delayed due to shortage of government funds to implement it as planned due to the Asian financial crisis.

The assessment of women's health advocates in the 1996 and 1998 country monitoring papers commissioned by ARROW is that there has not been as much real change as claimed by governments, and some of this change was just semantics. Women's NGOs in Thailand, Malaysia and Indonesia still find that reproductive rights are ignored in health services; views of users about their needs are not sought; violence as a health issue is not sufficiently addressed; the quality of care is described more in terms of supply than demand factors; and health is still viewed from a medical rather than a socio-cultural context.

Government claims in these countries that informed choice predominates and that there is no coercion or problems in contraceptive services needs evaluation. Malaysian women NGOs in 1998 have pointed out problems of accessibility, evident by the low to moderate contraceptive use in Malaysia, particularly for rural Muslim Malays.⁶ The results of the Malaysian IRRRAG research also showed programme and cultural barriers to contraception.⁷

Adolescent women

No country paper, either by the government or NGOs, has reported an additional emphasis on female adolescents within the adolescent health area. The Malaysian Adolescent Reproductive Health Policy formed in 1998 does not address specific physical health needs of young women or gender issues. Nor did the 1996 National Adolescent Reproductive Health Survey, on which this policy was based, take gender needs into account.

Male responsibility

Male responsibility is the area where the least action appears to have been taken. The need for more attention to this area may have been included by some countries in their reproductive health programme

objectives. But the post-Cairo research found a lack of ideas and interest in implementation in all the countries, in both government and NGO services. The ESCAP/UNFPA governmental meeting in 1998 reported a similar trend.

Some confusion also exists around the concept, as initiatives such as reproductive health clinics and services for men are sometimes seen as a strategy to implement the male responsibility concept. In fact, male responsibility towards the objectives of women's empowerment and gender equality is the meaning intended by the ICPD concept.

Influences on program shifts

As stated earlier, for countries outside Indochina and excluding the Philippines, changes have been incremental, apparently as an outcome of government initiatives, global and regional influences of WHO, and perhaps, UNFPA to a lesser extent. NGO advocacy impact has not been strong for reasons given earlier.

There is evidence, however, that well-planned and strategic advocacy by women NGOs is influential in health policy and programme re-orientation as seen in the Philippines, and more recently in Thailand and Malaysia. Women NGOs in these countries have focused advocacy efforts at national policy level as well as in local service delivery and through pilot projects. Gaining the interest and commitment of programme managers has been an important strategy to begin effective advocacy.

For Indochina, which is more dependent on donor funds and external technical assistance, the perspectives and directions of international organisations and donors appears more critical with UNFPA reportedly playing a key role. Innovative research in Viet Nam in the mid 1990's on women's perspectives on abortion and contraception has also been influential as a basis for advocacy by NGOs such as Centre for Gender, Family and Environment in Development (CGFED) in partnership with International Health Care Research (IHCR) of Sweden.

Overall, there remains a huge need for the provision of accessible, affordable, quality and comprehensive reproductive health

services in South-east Asia. Contraceptive services remain the most dominant and accessible reproductive health service in all countries excluding Lao PDR and Cambodia. Maternal mortality rates are still moderate to high everywhere except in Malaysia and Thailand. Only few women are screened for reproductive cancer, reproductive tract infections, STDs, HIV/AIDS or the health effects of violence. In Malaysia, a country regarded in Asia as having model reproductive health services, only 25 per cent of women have ever had a Pap smear.

Surprisingly, there is hardly any report of an evaluation or research study to assess programme changes in line with ICPD implementation. Some countries like Malaysia have had quality assurance activities but the concepts and criteria did not necessarily capture the Cairo ethos. The most comprehensive regional overview of reproductive health programmes seen was by the UNFPA Country Support Team for East and South-east Asia in 1998. However, this analysis relied on secondary reports rather than a special study; thereby, there are gaps.

Interpretations of the impact of the ICPD:

The reproductive rights concept has been problematic in South-east Asia for government, family planning and health NGOs. The post-Cairo study found in each of the countries a lack of conceptual and operational clarity, and confusion with the link between reproductive health and reproductive rights. In Indonesia, Malaysia and Thailand, government agencies at first associated reproductive rights with sexual rights, rights to abortion, and the right to freely decide on contraceptive use irrespective of marital status.

For most government personnel interviewed, sexual and abortion rights were regarded as controversial western agendas contravening religious and cultural principles - the same arguments put forward by conservative groups during the ICPD. Governments interpreted the concept of reproductive rights as meaning rights for married couples only. Regarding contraception, governments like those of Malaysia and Thailand assessed that since there was no overt coercion or incentives related to contraceptive use, as was the case in the past in some South-east Asian countries, the principles of reproductive rights have not been contravened.

Asian governments apart from the Philippines and maybe India have generally expressed little interest in the concept of reproductive rights. This is reflected in the country reports to the ESCAP/UNFPA 1998 High-level Meeting in which no mention is made of the concept. Granted, the country report framework prepared does not have reproductive rights as a heading. Reproductive rights in these reports of government progress is subsumed under quality of care and operationalised as to whether or not targets have been set in the family planning programme.

IPPF has a deeper understanding of reproductive rights and has developed conceptual materials including the IPPF Chapter on Sexual and Reproductive Rights. But this does not seem to have led to a discussion at country level in South-east Asia between NGOs and government on the theme, nor to a public debate. It has thus been left to government to define a narrow meaning of reproductive rights.

Women NGOs have the broadest understanding of reproductive rights because of their long-term commitment to a human rights framework. They were able in their country monitoring reports on 'Women's Health Needs and Rights' to point out a number of problems of access to contraception, to legal abortion, to reproductive health information and to reproductive health services which contravene reproductive rights principles. Their influence and capacity to articulate this perspective strongly however, has been limited as explained earlier.

5. Sexual Rights

Governments regard the concept of sexual rights put forward at the Beijing Conference as similarly controversial and inappropriate. The post-Cairo research noted that the researchers' reports rarely included any reference to sexuality or sexual health. Women NGOs and NGOs working on HIV/AIDS have had discussions on women's marital sexual rights to safe sex and to sex free from coercion or rape. Homosexuality, however, has not been openly discussed as a sexual right.

The impact of these concepts on legislation and on the judiciary system has not been well documented. No abortion law has been reformed in South-east Asia since the ICPD in 1994. Nevertheless, Cambodia did come up with a new liberal Abortion Act in 1998 that included women's rights language. The Cambodian reproductive health policy also includes

the concept of reproductive rights. In 1997, the Muslim law administration in the Malaysian state of Selangor agreed to women's right to refuse marital sex if the husband was thought to have HIV/AIDS. This legal interpretation came about through the advocacy efforts of the Malaysian AIDS Council, which is a health NGO.

There seems to have been little progress made in the area of abortion by countries besides Cambodia and Viet Nam. In Viet Nam, the Health Ministry has taken steps to reduce unsafe abortions. In other countries, even basic information on the prevalence of safe and unsafe abortion, and women's own experiences and needs has not surfaced. The IRRRAG project in the Philippines and Malaysia made some important findings on what women do and want in relation to abortion. Muslim theological interpretations about the permissibility of abortion in certain circumstances helped clarify different, less conservative views to policy makers and service providers of South-east Asia in the workshop on 'Islam, Reproductive Rights and Women's Rights' organised by the Malaysian women's NGO, Sisters in Islam, in 1998.

The post-Cairo Indonesian report commented that abortion is still viewed as a moral issue rather than a public health concern, although many Indonesian women are known to have abortions each year. In most South-east Asian countries, women survivors of rape or incest are not entitled to legal abortion. Women's groups have raised this issue but no change has yet been made to the existing laws on abortion.

ARROW has noted however, that when there is an opportunity to fully explain and discuss the concepts of reproductive rights and sexual rights with government policy makers, there is less resistance than expected. In the regional GO-NGO Dialogue on 'Women's Health Needs and Rights: Monitoring and Implementing the Beijing Platform For Action' co-organised by ARROW and APDC in mid-1998, sexual and reproductive health and rights was one of the main themes. A number of governments used this language in developing their country action plans at the end of the Dialogue. Besides the Philippines, this was the first time that these policy makers said they were exposed in depth to these concepts, which were also practically operationalised.

UNFPA itself may not be so clear as to how to operationalise the new rights concepts. At the ESCAP/UNFPA 1998 Asia and Pacific meeting, the draft indicators put forward by the UNFPA to assess ICPD

implementation did not include a reproductive rights component but focused on the medical aspects of reproductive health.

6. Government and NGO relations

In nearly all of South-east Asia including the Philippines, family planning and health workers in the population and development and health sectors, have primarily taken on the role of service delivery personnel. Described among Family Planning Associations (FPAs) as a complementary and supplementary role, this means the FPAs help to implement the national population policy and programme. In the post-Cairo study, one national FPA explained that this role does not allow advocating issues that would challenge or contradict the policy, such as adolescent contraceptive services and access to abortion. Similar family planning organisations in Thailand said, 'We are pleased with our currently cooperative role with the government. We do not try to criticise or act as inspector of government policy and programmes. We will not do anything that would oppose the government.'⁸

Family planning NGOs have a long history in a number of countries in South-east Asia, beginning from the 1950's and 1960's. This current role of complementing not challenging government has been played for 20 to 30 years since the advent of national family planning programmes and thus has been difficult to expand to include the monitoring and advocacy orientation as required by the ICPD. IPPF has helped to provide the vision on roles and action in its 'Vision 2000' and 'Charter on Sexual and Reproductive Rights', but to what extent national FPAs have been able to put this into practice in their relationships with the government, the UNFPA and other international organisations is not known.

For women NGOs that were generally unconcerned with or involved in the population and development sector prior to ICPD preparations, the task has been to gain a foothold and voice in influencing policy. Apart from the Philippines, this has largely not happened. Women NGOs reported they have not been consulted prior to or after the Cairo conference on government policies and plans. They have not been invited to sit on government committees developing the National Plan after ICPD. Whilst there have been one-off successes in inviting government policy makers to seminars on women's health in Thailand by the Women's Health

Advocacy Network, women NGOs have largely been unable to mount and sustain strong advocacy campaigns after the Cairo conference.

There are several major reasons for this situation. The political space for NGO policy advocacy is limited in South-east Asia. Criticism of government action is not tolerated; the rights and needs of NGOs as part of civil society to monitor and critique are not considered, and laws related to public association, internal security, and sedition or libel are sometimes used against NGOs, especially in Indonesia and Malaysia. The NGO advocacy sector as a whole is small and undeveloped, including the women's movement.

The post-Cairo study found that in Thailand, Malaysia, Indonesia and Singapore, there was no women's NGO that focused solely on women and health, including reproductive health and rights. Some women's NGOs had this issue on their agenda but not as a prime focus and thus advocacy capacity was limited. Women NGOs did not feel technically competent in the area to put forward convincing arguments. They were also unskilled in policy and programme analysis and advocacy due to their focus on violence against women services and legislation or other crisis work. By the end of 1998, however, although women NGOs' political position did not appear to have changed, they evidently had become more influential with the government and better acknowledged. Groups such as WHAN in Thailand, WomanHealth Philippines and Sisters in Islam in Malaysia have collaborated with the government in policy-oriented seminars and appear to be gaining credibility and competence.

International and regional organisations have played a role in developing national NGO capacity. The Commonwealth Medical Association has strongly encouraged medical associations globally to link up with women's NGOs on reproductive health and rights. This has happened in Malaysia. ARROW's several regional projects on monitoring Cairo and women's health needs and rights after Beijing have assisted capacity building. The work of regional women's groups such as ARROW and the East and South-east Asian (ESEA) women's health network however was hampered by funding cuts around 1998 and faced the inability to raise funds quickly enough to meet new needs expressed.

A general constraint for NGOs involved in planning, monitoring, implementation and evaluation of the ICPD Plan of Action is that national

mechanisms for the ICPD implementation haven't been set up. Malaysia and Thailand as at 1998 did not have a plan or mechanism for ICPD planning, monitoring and evaluation. Country progress reports such as those prepared for the 1998 ESCAP/UNFPA high-level meeting were presumably government perspective reports rather than national reports reflecting GOs and NGOs working in the population and development sector. (The Philippines report however appeared to have covered both perspectives).

In terms of accountability in 1998, it is not known if there has been a sharing of experiences among national NGOs or between NGOs and GOs on programme implementation aspects of the ICPD. It appears as though both NGO and government agencies have kept to themselves and not developed a joint national agenda. If this is the case, then accountability issues of users have not been addressed. In planning a post-ICPD agenda, it is crucial that all stakeholders come together and aim for a consensus on the main issues of concern and the relevance of the ICPD agenda for the country. Without a forum to exchange perspectives, little real dialogue can occur. The post-Cairo study found that in all the countries, government agencies described programmes as changing, but women NGOs felt these were not the required types of change. Areas they saw as crucial to the spirit of Cairo were ignored.

Fortunately, the ICPD+5 process has been positive for many of the countries. The Philippines and Malaysia for example, have had a number of GO-NGO seminars as well as an NGO meeting held at the end of 1998. ARROW's follow-up project to the post-Cairo research has enabled national seminars in Thailand, Viet Nam, Malaysia and Indonesia to bring together NGO and government stakeholders to assess progress and plan a national action agenda.

More discussions are needed on the roles of NGOs and civil society in national policy making. The post-Cairo study found that government agencies saw only a government role in deciding on population and development policy, and that this was in fact regarded as a top policy role. Areas such as adolescent sexuality, reproductive rights, and family planning were regarded as sensitive subjects that should not be widely discussed and debated by government or NGOs due to the political implications of issues such as morality, religion and ethnic relations. This has been the thinking behind social development policy in much of South-east Asia for the last 25 years and it is an obstacle that needs to be

addressed. Unfortunately, such thinking was reinforced by the national sovereignty principle of the ICPD that recognised these political needs but cleverly described the rationale in terms of “respect for religious and ethical values and cultural backgrounds of its people.”⁹

7. Financing reproductive health

Countries differ in their public health financing arrangements. In the more well off South-east Asian countries of Thailand, Malaysia and Indonesia, until 1997 public health services were almost totally financed through government sources. In 1996, only ten per cent of the total Thai health budget came from international financial assistance, compared to 78 per cent in 1981.¹⁰ In contrast, Viet Nam, Cambodia, Lao PDR and the Philippines are dependent on external assistance for financing family planning and reproductive health services.¹¹

Until 1997 or 1998, government health budgets were evidently increasing in Malaysia and Lao PDR. Viet Nam increased its government budget for family planning in 1996 and 1997. In the Philippines, the total government health budget had increased yearly between 1994 and 1997.¹²

National expenditure figures for 1996 for Asian countries suggest that family planning services account for most reproductive health funds. It is clear, therefore, why maternal mortality rates are still high in Indonesia and moderately high in Viet Nam and the Philippines, because more money is spent on family planning than on maternal health services. In Thailand, 80 per cent of the family planning budget goes to contraceptives provided free by the government.¹³

The financial crisis

The trend in the last two decades of South-east Asian governments including that of Indochina increasingly spending more on social investments such as on health was reversed in 1997 due to the emerging financial crisis and new structural adjustment programmes in Thailand and Indonesia. Indonesia’s health sector was hard hit with the Rupiah losing 70 per cent of its value against the US dollar.

Consequently, there were reports of seriously inadequate stocks of medicine and contraceptives and the inability to provide emergency treatments.¹⁴

The deterioration of the general health of people due to inadequate nutrition and food consumption as an outcome of increasing poverty and rising food prices in Indonesia in particular and in Thailand and the Philippines, further compounded the problem. Government budget cuts across the board including health care was expected to happen in mid-1997. In Malaysia in 1998, there was an 18 per cent cut to all government ministries including the health ministry. However, this cut was recently reduced to 12 per cent for the health ministry because of needs related to the rising costs of drugs.

Prior to the crisis, there was already a growing trend towards privatisation of health care services including primary health care, as part of the expanding effects of globalisation. Most South-east Asian countries appear to have been spending a lower percentage of their total national budget and Gross National Product on health, although the actual expenditure may have risen. User fees for public health services have been increasingly introduced in Malaysia, Indonesia and Viet Nam. Less government spending has resulted in a shortage of health personnel, insufficient hospital beds and inadequate medical equipment such as labs and radiotherapy to meet the demand.

While this situation does not necessarily result in more deaths, which for example could be indicated by an increase in the maternal mortality rate, it does affect people's health in terms of access, quality, convenience, suffering and hardship. These aspects of health and well being are not measured by mortality rates but are just as important. In Viet Nam for example, the abolition of the state health subsidy system has meant that the good infrastructure of village clinics and maternity houses is slowly being eroded. Now only 75 per cent of villages have their own clinics compared to 93.1 per cent during the period of state subsidies.¹⁵

By mid 1998, the already strained public health care system was beginning to buckle under an increased number of patients. Some of the middle class can no longer afford private care and have turned to government facilities. Malaysia has reported a significant drop in private

health care clients since September 1997. It is expecting a similar increase of at least 15 per cent in the workload of the public health sector, as happened during the last recession in 1989.

Management bottlenecks

During ARROW's field visits to Cambodia in 1998 and Indonesia in 1996, NGOs reported that it was commonly known that some resources for primary health services were siphoned off by health providers who offered private health services after working hours in their houses. These services comprised medication, contraceptives and other supplies. In Cambodia, this resulted in a shortage of such commodities in the health centre itself. The meagre salaries of government health providers and the overall condition of poverty were the contributing factors.

In the better off countries, urban centres still provide more treatment opportunities. Although Malaysia's primary health care system is extensive, it is the urban areas that are more equipped with adequate basic emergency equipment and services such as X-rays, mammograms, radio-therapy and cytology labs. These services are much less available outside the cities. The Ministry of Health is trying to distribute services more equitably.

International assistance

Financial assistance from within the Asia and Pacific region increased from the primary sources of Japan, Australia and New Zealand in 1995 and 1996.¹⁶ Indonesia reported a post-ICPD increase in funds from a variety of international sources including US\$43 million in a World Bank Loan.¹⁷ The Asian Development Bank has increased funding to Indochina and other poor countries until the economic crisis emerged.

At the ESCAP/UNFPA Asia and Pacific High-level Meeting in 1998, most Asia-Pacific countries reported monetary constraints that were made more serious by the financial crisis. This became a huge barrier to expanding and improving reproductive health services. It is obvious that resource-poor South-east Asian countries and those hit by structural

adjustment and the economic crisis will have to generate or re-allocate more of their own finances or receive more development aid. All countries have huge needs for the provision of comprehensive, accessible, and affordable reproductive health services such as reproductive cancer screening, STDs, HIV/AIDS, domestic violence screening/treatment, infertility services, and in many (excluding Thailand, and Malaysia), vastly improved childbirth services. This is even before addressing quality of care and rights/perspective issues, which require additional personnel, training and materials.

IPPF, its affiliated FPAs and some regional NGOs had budget cuts in 1997 and 1998, mainly due to cuts in SIDA's health budget. Regional NGOs like ARROW and the East, South-east Asia Women's Health Network, had to reduce core programme activities in 1998 and search elsewhere for short-term funds for some project activities. This was an extra burden for already busy NGO's and hampered their sustainability and effectiveness. Funding to mainstream and established regional and international NGOs may have been less affected, as they were more obviously population-related, and therefore could access a wider range of funding sources.

Country level government and NGO funding may have been more secure with an increase in national level UNFPA funds post-ICPD, and funding from foundations such as FORD Foundation available in Indonesia, Philippines, Thailand and Viet Nam.

8. Conclusions

The way forward for women NGO's was outlined in the Consultation for Asia and Pacific Region which took place in Malaysia in 1998 and the report of the NGO Forum on ICPD+5 in the Hague, which showed the effectiveness of the ICPD+5 review process for NGOs. Continued monitoring and advocacy is critical, as is the development and agreement on indicators to measure progress in operationalising new concepts. Women NGOs need to win a permanent place on national decision-making committees that influence policy and programme directions. Strengthening strategic planning and capacities to monitor and effectively advocate is also very important.

NGOs need to take bold steps to engage government and UN agencies in policy dialogue backed by credible monitoring and research findings. They also need to come together nationally and regionally to plan and support one another for the long-term work that lies ahead in order to ensure that the ICPD Plan of Action is implemented. Women NGOs will require long-term partnerships with funding agencies that provide core support for monitoring and advocacy. ❄️

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Annex 1

~x *Cairo + 5 : Moving Forward* x~ *in the Eye of the Storm*

Sonia Correa and Gita Sen¹

In the first half of 1999, the United Nations will assess what has been achieved by way of implementing the recommendations of the International Conference on Population and Development - Cairo 1994. The process is known as Cairo+ 5 and will start in February in The Hague, where a NGO Forum and a Youth Forum will precede a first governmental meeting. In New York during March 22th-30th, a Special Session of the UN Commission on Population and Development will debate the Secretary General's Draft Report on ICPD Implementation, which is expected to highlight key areas for future action. The final stage of negotiations is scheduled for a Special Session of the UN General Assembly in late June.

The Cairo Consensus represented a major paradigm shift with respect to the population debate and related policies. But agreements reached in Cairo with respect to gender and reproductive rights were built upon agreements on women's human rights that had been previously reached at the UN conference on human rights in 1993 in Vienna. Following in this progression, the commitments to gender equality and reproductive health that were reached at the World Summit on Social Development in Copenhagen in 1995 were fundamentally based on ICPD definitions, while the Beijing Platform for Action of the Fourth World Conference on Women expanded on the Vienna agreements on women's human rights, Cairo recommendations on reproductive health and rights and the WSSD macro economic agenda. Cairo+ 5 is an important global

policy exercise in itself. Given the close substantive linkages between the four conferences mentioned above, its importance increases as it may inspire strategic implications for what happens later at Copenhagen+5 and Beijing +5.

This article is organised in four sections. The first recaptures the meanings of Cairo, particularly in relation to the core concerns of the WSSD and the Beijing Platform for Action. The second analyses progress in and bottlenecks to ICPD implementation in fourteen Southern countries, on the basis of case studies written by DAWN members and collaborators. The third examines the changes in the global scenario since 1994 in order to identify its potential impact on the political climate surrounding the Cairo+5 negotiations. The fourth explores what may be the requirements to ensure the effective implementation of ICPD resolutions in the future, that in many aspects also apply to the subsequent and closely related UN agreements.

The Meaning of the Cairo Agreements

Population policy has always been contentious. Clashes between different perspectives and points of view occurred at both the previous World Population Conferences, at Bucharest in 1974 and in Mexico City in 1984. Never before Cairo, however, have there been so many sets of actors discussing population policies in the public arena. The resulting transformation of the public debate was profound. ICPD shifted policy direction away from demographically driven approaches and towards policies oriented towards human rights, social well being and gender equality, with particular emphasis to reproductive health and rights.

During and after ICPD there were some complaints in the Southern NGO community that development issues were being short-changed by the battle over abortion². The negotiation of Chapter III, Interrelations Between Population, Sustained Economic Growth and Sustainable Development, of the ICPD Programme of Action were, in fact, tense and difficult. A climate of growing distance between North and South that has characterised the 1990s vitiated the atmosphere of all the UN conferences of this decade. And the positions of the Group

77 were much less cohesive than in the past. Given this context, the agreed text of Chapter III contains a good deal favourable to the South. It acknowledges the right to development as a universal and inalienable right and as an integral part of fundamental human rights, and argues that “*structural adjustment programs ..(be) so designed and implemented as to be responsive to social and environmental concerns*”.

Chapter III speaks strongly to the problems of inequality within and between nations, and the needs of poor women everywhere. Its section on sustainability defines as its objective the need to reduce unsustainable consumption and production and agrees that the North should lead in sustainable consumption and effective waste management³. It argues in favour of investment in human beings and the need to strengthen food security. Thus, although concise, the ICPD agreements on Population, Development and the Environment in fact established a sound basis for the Copenhagen WSSD negotiations. The latter could, as a result, be more sharp and clear with respect to the enabling economic environment requirements: the acknowledgment of the detrimental impacts of structural adjustment programs, the importance of debt reduction and the value of the 20/20 compact.

Most important, however, is that ICPD was a critical watershed for women. For the first time, outside conferences specifically for women, the world community made a major directional change in policy that was initiated and supported by women, and that can work in women’s interests. Chapter IV, Gender Equality, Equity and Women’s Empowerment, abandons the old and neutral language of women’s status for a more pro-active acknowledgment of gender power relations. It contains strong sections on women’s empowerment including economic rights, on the girl child including opposition to son-preference and sex-selection, against female genital mutilation, infanticide, trafficking and child prostitution and pornography, and in favour of programs to educate men towards more responsible behaviour.

Chapter V, The Family, Its Roles, Rights, Composition and Structure, acknowledges the existence of a variety of family forms and defines the policy objectives as being to support families, to provide social security for child-rearing, and to protect the rights of women and children within families. Recognizing the worsening conditions of poor

families due to declining social expenditures (consequent on budget cuts), it argues for special support especially for single-parent households. Chapter VI similarly addresses the needs of those hitherto under-served by policies and programs: children and youth, the elderly, indigenous people, and the disabled.

Chapter VII, Reproductive Health, Reproductive Rights and Family Planning, occasioned the most protracted negotiation. Starting with WHO definitions of reproductive and sexual health⁴ the chapter goes on to define reproductive rights as the right to make reproduction decisions free of discrimination, coercion, and violence. The chapter states that reproductive health services (including sexual health and family planning) should be linked to the primary health care system, and should include making abortion safe (where it is not against the law), treating reproductive tract infections, sexually transmitted diseases, and infertility, in addition to maternal and child health services and counseling men and youth for responsible sexual behavior. The chapter supports the decentralization of services, improvement of quality in family planning programs, and has a strong statement against any form of coercion in family planning programs including targets, quotas, incentives and disincentives. .

Chapter VIII, Health, Morbidity and Mortality, was relatively uncontroversial barring paragraph 8.25 that addresses the problem of abortion. Although the text was considerably watered down from its initial versions, it acknowledges unsafe abortion as a major public health concern. It states that women should have access to services to manage the complications of unsafe abortion under all circumstances. It also contains an enabling statement requiring abortion to be safe in circumstances in which it is not against the law. A year later in Beijing, the Platform for Action added a sentence to the ICPD text on abortion which reads as follows: "*Member states should consider reviewing existing punitive legislation (with respect to abortion)* (IV WCW paragraph 106 k).

The ICPD Programme of Action also defined targets in terms of financing its various components: US\$17 billion dollars to be reached in the year 2000. Family Planning expenditures were estimated at US\$10.2 billion and reproductive health services (excepting family planning) at US\$

5 billion, HIV/AIDS at US\$1.3 billion, and research, data collection (including decennial censuses), and policy analysis at US\$ 0.5 billion. Overall, about 65 per cent of the total of US\$17 billion was supposed to go towards the delivery system. It was also recommended that the share of external finance should rise from its figure of about 20 per cent to roughly one-third of the total. Thus, regarding North-South sharing of the financial responsibilities, it was indicated that, in the year 2000, US\$5.7 billion should come from external donors and the rest from domestic resources.⁵

The ICPD Program of Action also established fairly clear guidelines concerning the institutional frames and principles for monitoring and accountability of ICPD implementation, something that did not happen consistently at all the conferences of the 1990s.

Partnership Monitoring and Accountability Mechanisms: ICPD Relevant Agreements

ICPD recommendations on Partnership and Monitoring and Accountability mechanism are found in Chapter XV. Among the various agreements reached in Cairo, two can be seen as guidelines to assess progress made since 1994:

- ~ Paragraph 15.8. Governments and intergovernmental organisations, in dialogue with non-governmental organisations and local community groups, and in full respect for their autonomy, should integrate them in their decision-making and facilitate the contribution that non-governmental organisations can make at all levels towards finding solutions to population and development concerns and, in particular, to ensure the implementation of the present Programme of Action. Non-governmental organisations should have a key role in national and international development processes.
- ~ Paragraph 15.9. Governments should ensure the essential roles and participation of women's organisations in the design and implementation of population and development programs. Involving women at all levels, especially the managerial level, is critical to meeting the objectives and implementing the present Programme of Action.

1994-1998: Progress and Bottlenecks

The DAWN network has assessed post - ICPD policies in Bolivia, Brazil, Nicaragua, Peru, Puerto Rico, India, Malaysia, Thailand, Indonesia, Vietnam, Laos Cambodia, Philippines and Fiji.⁶ What emerges from this exercise in policy analysis is a mixed picture of both progress and bottlenecks.

Although variations do exist across countries, policy shifts in at least some started even before Cairo. In Brazil, India, and the Philippines, the Cairo agenda was anticipated some years previously. But even in these countries, the ICPD provided a major fillip to the changes taking place. In other countries such changes as have occurred were largely mobilised by the preparations for the Conference. In South-east Asian countries, (other than the Philippines), governmental officials declare that policies were already in line with the directions pointed by ICPD even before 1994. These statements are questioned by health activists from the region. While it is true that a number of South-east Asian governments had effective social development and anti-poverty policies in the two decades prior to the current crisis, it would probably be appropriate to say these policies were more in line with the agreements of the First World Population Conference held in Bucharest in 1974 than with the Cairo agenda per se. The Cairo agenda builds on the Bucharest agenda in emphasising the importance of social development policies but goes considerably beyond it through its emphasis on reproductive and sexual health, reproductive rights, gender equality and women's empowerment. In all the countries analysed from 1995 on, the ICPD agenda appears to have been strengthened by pre- and post- Beijing processes.

The case studies demonstrate that since 1994 policy discourses have moved from demographic imperatives towards a health approach. In many countries - Bolivia, Thailand, Philippines, Fiji - family planning programs have been renamed as Reproductive Health Programs. In India, a potentially more radical change has occurred. In 1996 the three decades old programme implementation method of setting targets for contraceptive acceptors was removed. Even in the case of Brazil, where a national comprehensive women's health policy has been in place since 1984, Cairo and Beijing have meant a booster, particularly with respect to

abortion. Services to provide abortion in the cases permitted by law - rape and threat to the woman's life - have expanded rapidly.

These developments should not be underestimated. The political and economic climate prevailing in the last four years has not been favourable to the Cairo agenda. Across Latin America, most especially in Central America and Puerto Rico, religious forces, particularly the Catholic hierarchy, have been openly attacking the Cairo and Beijing agendas. In Asia and the Pacific, the moral conservative reaction is not so open and clear – the exception being the Philippines. But governments are clearly oversensitive with regard to reproductive rights, sexual health, adolescent health and abortion.

Everywhere, implementation efforts are taking place in an entirely unsatisfactorily economic environment. Across the South deep inequality patterns and poverty levels have worsened after 1994. Reproductive health policies are being implemented amidst state and health reform that, in many cases, imply cuts in social investments and privatisation of services. After 1997, the global storm of financial instability has directly affected both South East Asia and Latin America.

But in spite of these various constraints, the movement forward was clear everywhere, at least until early 1998. In various countries effort are being made to overcome the lack of integration between the various components of a reproductive health policy: maternal and child health, contraceptive assistance, STD and HIV-AIDS prevention. Greater attention is being given to maternal mortality. In India policy makers, providers and health activists are struggling with the tremendous challenges to turn upside down a long established vertical and narrow family planning program. In various countries initiatives are developing to respond to adolescent needs. Additionally, as a result of Beijing, in all countries policy makers, NGOs and the media are talking of gender, violence against women, affirmative action, and political quotas.

There are striking positive examples of institutional arrangements in which governments, non governmental organisation including the reproductive health and rights advocacy community, and international agencies are interacting, and jointly discussing how to implement the Cairo agreements. In Brazil, monitoring mechanisms are

built into the structure of the health system through the health councils. Together with the National Commission on Population and Development created to track ICPD implementation, health councils have been crucial to sustain the ICPD related policies. In Peru a tripartite negotiating mechanism that involves the Ministry of Health, feminist organisations and donor agencies has been created to follow ICPD implementation. In Bolivia, monitoring and accountability efforts have taken place at the level of the National Maternal Mortality Commission. In Uruguay, linkages have been built between the advocacy community and both the national health system and the municipal one in the capital Montevideo.

Positive as these signs may be, it is also clear that much remains to be done. There is still a lack of clarity regarding such key ICPD concepts as gender, women's empowerment, and male responsibility. Similar problems are to be found in the case of sexual health and reproductive rights. Where sexual health is being adopted as a concept, it is basically translated as STD/HIV prevention. In most settings, reproductive rights are interpreted merely as right or access to reproductive health services, leaving aside other critical dimensions such as informed choice and reproductive self-determination. Reaction and confusion is also evident in the area of adolescent needs.

One of the areas where movement has been slow has been abortion. Among the countries analysed by DAWN, it is only in Brazil that clear breakthroughs have been achieved⁷, In Bolivia - in the context of health reform - reproductive health and rights advocates have managed to ensure that post abortion treatment will be reimbursed by public funds. In India and Vietnam, where abortion is legal, there is greater recognition of the need to improve existing services. But in Fiji where there is room to improve abortion services - the procedure is allowed in the case of rape and physical or mental risks - ICPD has not mobilised initiatives in this direction. In Central America it is probably fair to say that there has been some retrogression. On the whole, progress has been relatively meagre, and there is considerable need to move more rapidly.

The findings also indicate that the effective improvement of reproductive health services has been very limited, especially in the case of urban poor and rural populations. In many contexts, vertical family planning programs are being reorganised or simply renamed as reproductive health. These vertical packages do not always establish necessary linkages

with other strategic areas, e.g., HIV-AIDS Prevention or Cervical Cancer Screening. Other recurrent obstacles to improving the quality of services in either family planning or reproductive health more broadly are the inadequate training, bureaucratic mindset, and gender-insensitive attitude of health managers and providers.

A major issue for ICPD implementation is insufficient understanding on how good quality reproductive health services can be expanded in the context of health reforms as they are currently being framed and implemented. The World Bank has now replaced WHO as the major donor in the health field, and strongly emphasises the importance of health sector reform. This involves reaching an agreement between the government and all the donors within a country to adopt a three-pronged approach involving:

- ~ Common sector wide policies and strategies;
- ~ A prioritized public expenditure approach, based on cost effectiveness exercises using burden-of-disease and DALYs measures, and the identification of a package of “essential services”; and
- ~ A common management framework.⁸

While the value of a common approach cannot be denied, it also reduces the flexibility available to governments and donors to experiment with other approaches. Given the technocratic hegemony of the World Bank and its growing financial dominance in the health field, this is a discomfiting probability. It means that those less wedded than the World Bank to cost-effectiveness as the principal criterion for health interventions might have fewer policy or program avenues open to them. The case studies also demonstrate that agencies, managers and advocates involved with reproductive health programming are not interacting adequately with the sectors designing and implementing health reform, either globally or at country level.

Last but not least, monitoring and accountability mechanisms have not been established everywhere. In most countries, the observed progress can be mostly attributed to the persistent efforts of the reproductive health and rights advocacy community. In some cases such as Nicaragua and Puerto Rico, these efforts are being undertaken with very weak institutional support. In other countries such as Cambodia,

Laos, Vietnam and Fiji, international agencies have played a stronger role as ICPD stakeholders. On the whole, policies are moving more swiftly in the right directions wherever governments, agencies and reproductive health and rights NGO are cooperating and consulting, or accountability mechanisms have been established. Effective cooperation and dialogue between at least two of the three major sets of stakeholders appear to be needed to push forward the ICPD agenda: government + NGOs, or government + agencies, or agencies + NGOs. It is also clear that NGO role gains greater centrality where government resistance to ICPD implementation is greater.

Financing Reproductive Health Services

Data collected at the global level suggest that recipient governments have come closer to the financial commitments agreed upon in 1994 than donor countries in term of population related aid. This reflects in part the greater importance of domestic expenditures in the basic infrastructure of the health system. At country level, the collection of consistent data on resource allocation for implementing ICPD is not exactly an easy task. A more substantive analysis has been possible just in case of Brazil and India. In spite of this limitation, the studies indicate that in the majority of the fifteen DAWN study countries in which policies have been analysed, reproductive health programs *per se* remain heavily dependent upon international assistance. In countries like Bolivia, Philippines and Peru, the national programs have been renamed as Reproductive Health but the bulk of resources are still going to family planning. In other settings – India is one example – resources are channelled in ways that do not favour the effective overcoming of major epidemiological problems. The reduction of maternal mortality, for example, requires investments in primary health programs to be combined with the improvement of referral systems and obstetric assistance. But in the current scenario, donors are reluctant to fund infrastructure, and structural adjustment requirements curtail domestic investment. But the sharper insight with respect to resource allocations is that quality of expenditure is as critical as the amount of resources invested. Additional international and domestic resources are necessary but not sufficient. The potential impact of “more money” is clearly conditioned by policy, management and accountability factors.

Cairo+5 in the Global Scenario of 1999-2000

In the best of circumstances the advancement of the Cairo+5 agenda will not be an easy task as it involves further semantic struggles, macro policy transformations, and micro interventions to change the quality of services as well as the mindset and attitudes of providers. The global economic and political scenario for 1999-2000 provides a sobering reminder of just how difficult this is going to be. A year ago no one could have foreseen the magnitude of the earthquake set off by Asian financial crisis. There was little expectation that the financial upheaval would spread so rapidly and extensively into other regions including the heart of the global financial system itself. One immediate impact of the current economic hurricane has been the reduction of health budgets in countries – like Brazil, Malaysia and Thailand – where domestic expenditures in primary and reproductive health had been expanding.

Additionally, as we have seen, Southern governments have met their ICPD financial commitments much better than have the donor countries. Consequently, strong positions can be expected on the part of G-77 countries in The Hague and beyond. In 1994, even if the global economic climate was not easy, the Cairo Consensus was made possible after a careful building of North-South bridges around the reproductive health and rights agenda. Prevailing political conditions today cannot so easily propitiate the atmosphere of dialogue that became known as the “Spirit of Cairo”. It is vital to recall that in all the UN conferences of the decade, fundamentalist forces have systematically taken advantage of the political climate that followed the widening of North-South breaches:

In Rio the Holy See put itself forward as a champion of the South, arguing that poverty and inequality were greater problems than population growth per se. Clear even then was the effort by the Holy See to use the North-South divide to attack family planning programs and thereby the availability of both contraception and abortion in the South.⁹

The potential dark side of the Cairo+5 political scenario, however, must be balanced with unusual signs that can also be mapped in the global economic debate. If one year ago few would preview the extension of the coming crisis, no one – other than the “usual suspects” of

environmentalists, women's organisation, trade unionists, left-liberal development organisations and thinkers - seriously thought that the ideological consensus that has ruled the world economy for the last two decades would crack apart. Today the strongest supporters and beneficiaries of the "globalised" economy are on the defensive and are pulling back from unbridled globalism to call for better management of the world economy and greater inclusion of those who have been marginalised.

Nervousness grips not only global financial markets but also the highest levels of OECD governments. The spectacular growth miracle of South-east Asia has been succeeded by an equally spectacular collapse that has threatened the entire global system. In the process, cherished neo-liberal beliefs of the last two decades are being challenged from the very heart of the system. Not only have the normally pliant governments of Malaysia and Hong Kong imposed some version of capital controls, not only has Russia unilaterally rescheduled its debt, but doubt has crept in within the Bretton Woods organisations themselves. A number of mainstream economists and influential public figures¹⁰ have criticised the IMF for refusing to alter the recession-inducing advice it has been giving to the beleaguered economies of South-east Asia, and for throwing billions of dollars into the ever-widening breaches of a collapsing dike with very little effect.


But the single most important criticism of the Washington consensus has come from the World Bank's chief economist and vice-president, Joe Stiglitz. In his WIDER lecture at Helsinki in early 1998, and a series of other talks and written papers, Stiglitz has criticized the IMF for its wrong-headed approach, and argued for a post-Washington consensus - one that would impose stronger controls on capital movements, that would not use national recession as an instrument to bring countries into line with the global order, and that would focus more on human development needs and inclusion of the marginalized. It is ironic that the World Bank, which enforced structural adjustment programs throughout the world during the 1980's and much of the 1990's should now be attacking the very premises of its own previous actions. But this split in thinking between the highest levels of the Bank and the Fund is probably the most important sign that the days of pure neo-liberalism are over.

This climate has definitely created space for a range of civil society initiatives to bring greater transparency and accountability to the

global political economy. The Cairo+5 negotiations, particularly in those aspects that are strongly dependant upon a deeper transformation of the cracking neo-liberal paradigm - as is the case of international cooperation trends and health reform premises - should be seen as a challenging but fertile opportunity to raise the profile of women's concerns and needs at the core of the debates about the needed changes in the global order.

The road ahead: steps to be taken

Conclusions, although preliminary, can be drawn from this exercise. An overarching one is that ICPD has certainly triggered major changes not only in population policies, but also in development debates more generally. While the pre-Cairo policy scenarios were extremely heterogeneous across countries, after 1994 convergent positive trends and similar obstacles can be identified with respect to ICPD implementation. Consequently, in view of key future actions to be taken, a minimal agenda can be defined to orient the Cairo+5 debates and negotiations.

- ~ Consistent and systematic clarification of key ICPD concepts and recommendations;
- ~ Conceptual and practical strategies to address reproductive health needs and expand services – as defined by Cairo—in the context of health reform debates and implementation;
- ~ Creation and sustenance of functional, transparent and democratic mechanisms for monitoring and accountability at community, local, national and international levels, guaranteeing the participation of women as users and advocates;
- ~ Creative combination of efforts aiming at increasing financial resources for ICPD implementation with clear criteria to ensure quality of expenditures at all levels.
- ~ Implementation of both paragraph 8.25 of ICPD Program of Action and paragraph 106.k of the Beijing Platform of Action to ensure women's reproductive self determination and universal access to safe abortion procedures. 

Note: This article first appeared in Social Watch 3, 1999.

- 1 Sonia Correa is a researcher at IBASE (Brazilian Institute for Social and Economic Analysis) and Gita Sen is a professor of Economics at the Indian Institute of Management, Bangalore.. Both are Research Coordinators of DAWN–Development Alternatives with Women for a New Era. Gita Sen is responsible for the theme, “The Political Economy of Globalization” and Sonia Correa coordinates research and analysis on “Social Reproduction, Reproductive Rights, Sexuality and Gender Justice”. This article relies on previous writings by the two writers: Correa, Sonia. 1998, “Cairo+5: Good News, Obstacles, Challenges Ahead”, DAWN INFORMS – 2; Sen, Gita, Jan-Feb 1995, “The World Program of Action: A New Paradigm for Population Policy”, Environment volume 37: number 1; published in Portuguese as “O Programa de Acao do Cairo”, in Cadernos do CIM-1, 1994, Sao Paulo; Gita Sen and Anita Gurumurthy, 1998, “The impact of globalization on women’s health”; ARROWS FOR CHANGE, volume 4: number 1; Sen, Gita, 1998, “The global crisis: cracks in the neoliberal consensus”, DAWN INFORMS -3
- 2 In fact the struggle over abortion was no more protracted in actual fact than the negotiation over migration, but this was not highlighted by media coverage. It was more than ironic that some South-based journalists and other were willing to dichotomize women’s health and rights from development, perhaps without realizing that they were falling thereby into the Holy See’s world-view!
- 3 There is much in Chapter 3 that those interested in social and economic equity can support. For instance, minority women from the US were delighted when, as a result of informal advocacy, the US amended para 3.16, which defines the objective of raising the quality of life, to include poor women in both developed
- 4 and developing countries as deserving of special attention.
- 5 The definition of sexual health was considerably abbreviated in the final version of the ICPD Programme of Action to meet the objections of Iran and Pakistan.
- 6 A valid point that has been raised with respect to resource allocation by UNICEF, among others, is that resource needs for broad primary health care, child survival, primary education, and for other aspects of women’s empowerment remain unspecified. In 1994, the expectation was that this would be addressed in a consistent manner by the Social Summit. As we know
- 7 ,the most clear outcome in this regard at Copenhagen was the 20/20 compact.
- 8 The case studies were by the following researchers: Brazil, Sonia Correa, relying on another study performed in collaboration with Sergio Piola and Margareth Arilla; Bolivia, Ximena Machicao; Fiji, Margaret Chung; India, Gita Sen, Vanita Mukerjee, Vimala Ramachandran and Anita Gurumurthy; Nicaragua, Ana Maria Pizarro; Peru, Cecilia Mandelengoitia; Philippines, Gigi Fransisco; Puerto Rico, Isabel Laboy and Alicia Warren; Uruguay, Cristina Grela and Alejandra Lopes.
- 9 A regional review of South East Asia was provided by ARROW.
- 10 Significant progress in ensuring women access to legal abortion has been made since ICPD in countries such as South Africa and Guyana.
- Disability-Adjusted Life Year expresses years of life lost from premature death or lived with a severe or long-lasting disability.
- Sen, 1995, op cit.
- Among the economists are Jagdish Bhagwati, Jeffery Sachs and Paul Kurgman; influential public figures include Henry Kissinger and George Schultz.

Annex 2

Gender Justice and Economic Justice - Reflections on the Five Year Reviews of the UN Conferences of the 1990's¹

Gita Sen and Sonia Onufer Corrêa

1. Globalization and patriarchal control: women's dilemmas

On the verge of a new millenium, the challenges facing feminist attempts to link gender justice with economic justice at the global, national, and local levels come from two directions. On the one hand, complex, yet poorly understood and even more poorly regulated processes of globalization appear as the new form of a free-market juggernaut. This juggernaut obscures all possible alternatives to a global capitalist order that is driven by deep and growing inequalities of wealth and income,² and in which rising numbers of impoverished people are being marginalized from access to secure livelihoods. On the other hand, at least one set of reactions to these processes of globalization includes the strengthening of national, religion-based, ethnic or other identities through the assertion of 'traditional'³ gender roles and systems of authority and control.

Women's relationship to these processes is mixed and often contradictory. The 1980s and 1990s have seen women enter labor markets and become income earners in large numbers, sometimes under the pressure of family economic needs, and sometimes in response to new opportunities thrown up by labor market and other changes. The results

in terms of women's control over income and personal autonomy can be contradictory. Entering the labor market for a woman does not automatically mean that she will have greater control over income; it may mean, instead, increased work burden, greater drudgery and multiple responsibilities as she is caught up in a global assembly line over which she has little control. Earning more income almost always raises a woman's value in her family, but ironically this can sometimes result in even tighter controls over her life and being. However, it can also sometimes mean greater physical mobility, increased personal autonomy, and the possibility of breaking through gendered barriers and patriarchal or other mechanisms of male control.

These contradictions mean that women's struggles for greater personal autonomy - including, among other things, control over and access to familial or community resources; a fairer share in inheritance; rights in decision-making; and sexual and reproductive rights - may not mesh simply or easily with their concerns and demands for a more just and equal economic order.

The irony for women is that, on the one hand, the supporters and promoters of a globalized world economy are often also the ones who support the breaking of traditional patriarchal orders. On the other hand, some of those who oppose globalization do so in the name of values and control systems that strongly oppress women. The challenge for women, therefore, is how to assert the need for both economic justice and gender justice in an increasingly globalised world in which at the same time we witness the proliferation of diverse forms of moral conservatism that systematically target women's self-determination.

2. Sowing the wind

The global UN conferences of the 1990s proved to be fertile ground for the blooming of these tensions and conflicts. These include the UN Conference on Environment and Development (UNCED, Rio 1992), the World Conference on Human Rights (Vienna 1993), the International Conference on Population and Development (ICPD, Cairo 1994), the World Summit on Social Development (WSSD, Copenhagen 1995), the Fourth World Conference on Women (FWCW, Beijing 1995), and Habitat II

(Istanbul, 1996). The South-North divide surfaced as expected in all these meetings, but the power and clout of Northern governments in global negotiations had clearly become significantly greater in the 1990s as compared to the 1970s. The intervening decade of debt crises, structural adjustment programs, uneven economic growth rates, and growing disparities among Southern countries themselves appeared to have eroded the capacity and political will of the South to negotiate effectively together against the North on these issues.

In this climate moral conservative groups that oppose an agenda for women's rights have systematically attempted to emerge as champions of the South. Around the time of UNCED in Rio, in 1992, the Vatican began making statements against growing poverty and South-North economic inequalities and in favor of debt relief. On the other side, the positions taken by Northern negotiators on every economic issue from the right to development, to debt, to trade, to structural adjustment provided fertile soil for a growing closeness between the Vatican and at least some Southern negotiators.

During the 1990s, the moral conservative forces have systematically used their political influence to oppose the women's rights agenda in international *fora*. UNCED was the first site of major mobilization by women's organizations, albeit largely in the NGO Forum rather than in the official conference. By the time of the Vienna conference on human rights in 1993, the Vatican had begun to mobilize its forces against the recognition of women's rights as human rights. In Cairo in 1994, the Vatican allied itself with a number of countries to strongly resist the adoption of a reproductive health and rights agenda in the ICPD Programme of Action. At the Social Summit in Copenhagen six months later, this alliance worked to oppose every innovative aspect related to gender and reproductive health. This opposition continued through Beijing and the Habitat conference. But while the principal text of these negotiations appeared to be women's rights, the critical sub-text was the continuing South-North divide and the growing frustration of the South.

Three further points need to be made about the conferences of the 1990s. First, where women delegates (official and unofficial) were not present in significant numbers, issues relating to gender equality and women's rights tended to almost disappear in the negotiations, or to

be compromised. There appeared to be tacit understandings among many delegates from both South and North not to raise 'controversial' issues. (Read 'controversial' as code for 'women's rights', since there were plenty of other equally controversial issues such as poverty, debt and development assistance that remained.) The few feminist delegates present during the Social Summit in Copenhagen had their work cut out in terms of protecting the gains women had made through Vienna and Cairo.

Second, and importantly, despite efforts to the contrary, only a few Southern governments actually bought into an alliance in which women's rights were traded away.⁴ The advances in recognition of women's rights in Vienna, and the Cairo consensus on the centrality of reproductive and sexual health, reproductive rights, and women's empowerment in development policy, and their further elaboration and affirmation in Beijing were possible because the large majority of Southern and Northern governments supported them. In Cairo and also in Beijing, consensus became possible because the G-77 agreed to speak as a group on economic issues, but as individual countries on matters relating to gender equality, women's rights, reproductive and sexual health, adolescents' health and rights. It became clear to delegates at Cairo (and later at Beijing) that differences on these latter issues within G-77 between the minority that opposed and the majority that supported them were far too serious to patch over.

Third, feminist coalitions from the North and South who were present both as official and as NGO delegates at the conferences attempted to bridge the divide that opposing countries and groups were trying to create between economic justice and gender justice. The Cairo Programme of Action contains some of the most progressive language regarding development more generally, structural adjustment, and the importance of the North's taking a lead with respect to sustainable consumption and effective waste management. Much of this language was either initiated or strongly supported by women delegates and a few Southern governments who opposed the North's intransigence on economic issues as much as they opposed the attack of moral conservative forces on gender justice and women's human rights. In this way women attempted to combine economic justice with gender justice in both Cairo and Beijing.

3. Reaping the whirlwind

Between March and July 1999, three of the 'plus five' reviews of the conferences of the 1990s were in progress. In March, the Commission on the Status of Women (CSW) met to discuss the implementation of the health section of the Beijing Platform for Action. This was followed by the Prepcom for ICPD plus five which was unable to complete its work in the allotted days in March. Intersessional meetings and internal group meetings continued until the Prepcom was formally resumed at the end of June just before the scheduled [ICPD] Special Session of the UN General Assembly. In May was also held the first Prepcom for Copenhagen plus five at which again progress was slow, and negotiations were slated to resume as Intersessionals at the end of August.

Certain common features emerged in all these processes. Progress in negotiation was painfully slow and often stalemated. There were two apparent reasons for stalemates: the wide gap between South and North on economic issues, and the difficulty of reaching consensus on gender issues. Most striking was the fact that, starting with the CSW meeting and continuing through much of the ICPD +5 negotiations until near the end, the G-77 insisted on speaking with one voice on all issues, unlike what they had done in Cairo or Beijing. At the same time and not surprisingly, the Vatican appeared to have been working closely with conservative delegations to try to roll back the Cairo, Beijing and Vienna agreements if possible, or to impede serious discussion about barriers to implementation or future actions to be taken. Additionally, a vocal backlash against the participation of NGOs was registered during both the Cairo+5 and the Copenhagen+5 Prepcoms, with a number of (largely conservative) government delegations objecting to NGO presence and participation.

At one level, none of the above seems to be new, if we refer back to our earlier analysis.⁵ Yet, the mood and tone of the negotiations were certainly harsher from women's and NGO perspectives than one would have expected. One would not have anticipated reopening of language that had already been agreed to at Cairo and Beijing given the fact that, at least in the case of the ICPD Programme of Action, the overwhelming majority of countries have been positively implementing Cairo in the intervening years since 1994.

One reason for this could be that the G-77 feels more strongly the need to speak with one voice in light of the upcoming World Trade Organization (WTO) ministerial meeting in Seattle as well as at the ongoing UN debate on financing development. The financial and economic crisis of the recent past must also be taken into account as it has considerably leveled the growth experience among its members. On the other hand, the global political pendulum has also swung back a bit from the hard years of conservative governments in North America and Europe, possibly creating a bit more space for negotiation on economic issues.⁶ The neo-liberal orthodoxy is itself in considerable disarray in the wake of the financial crisis, with the IMF and the World Bank publicly taking different stances.⁷ All this might explain the G-77 feeling the pressure and taking the opportunity to show a united front against the North. But it does not explain why the more liberal Southern delegations had such a difficult time asserting the *modus operandi* of Cairo and Beijing, viz., one voice on economic issues, and separate voices on gender issues. To understand this, we need to turn to other factors.

4. Lessons from the Cairo +5 Negotiations

One important reason for this could have been the fact that many and especially Southern official delegations to the ICPD+5 Prepcom were drawn from the staff of country missions to UN Headquarters in New York. A very large number of delegates therefore were diplomats responsible to foreign ministries rather than bureaucrats drawn from ministries of health or family planning. This meant that they often lacked the experience that those who had been through the whole process leading up to and during Cairo had. Few were knowledgeable about the subtle balances in some of the agreements that had been reached at Cairo. Thus, even with the best will in the world, many delegations were not always clear about what exactly was being proposed by the forces opposing women's rights or what it implied.

Women's NGOs and the few feminists on official delegations who had been through the protracted negotiations of Cairo and Beijing worked diligently to provide background briefings to delegations. We were also faced with the problem of the mindset of New York based

diplomats whose daily negotiations are heavily influenced by South-North conflicts and global, regional, or national geopolitical agendas. Gender equality tends to fall relatively low on their priorities and at least some of them clearly expressed that it was not worth struggling over in this forum.

A deeper question this raises has to do with the premises on the basis of which the UN is conducting these +5 reviews. Implementation can and ought to be discussed and evaluated by implementors. It should not be handled by those who have had little to do with implementation. The first lesson therefore is that there is an urgent need for the UN at the highest level to rethink how the evaluation of implementation is being done. In fact NGOs gathered at the final stage of the Cairo+5 process have written a letter to the UN Secretary General requesting the immediate creation of a high level commission to fundamentally re-consider the premises and mechanisms of the +5 reviews.

Furthermore, the review of implementation should certainly not be open to those who opposed the primary agreement or sections of the agreement. Thus, given the Vatican's fundamental reservations to the ICPD Programme of Action, it had no business participating in a review of implementation in which it played no role, and which it certainly opposed. Basic ethics would have required the Vatican to withdraw from the review. Thus, what ought to have been an assessment of gains and obstacles became once again a protracted negotiation over language – this could possibly have been minimized if the review had been structured to include only those who had signed on to the ICPD consensus in the first place. This is the second lesson of the ICPD +5 review process.

Women's organisations from the South and North can draw other lessons as well. Unless they work hard to ensure the quality of delegations, they run the risk of having gender justice traded off against South-North issues. This is particularly problematic in the context of the on-going Copenhagen +5 Review whose working text is very weak on gender issues, and where few NGOs are present and almost no women's organizations. The Vatican appears to be working hard to emerge as the champion of the South on economic issues, and to weaken human rights language by references to 'human dignity', its preferred substitute for human rights. But it can also be a problem for Beijing +5 if official

delegations are not adequately briefed in advance at national and regional levels. This is the third critical lesson.

And finally, a concern rather than a lesson. A major problem at Beijing was the distance, both physical and psychological between the NGO Forum and the official conference. While the majority of women concentrated on the NGO Forum, the few at the official conference had to work hard to prevent backsliding from Cairo and Vienna. Conservative forces tend to lie low in the NGO events and to save their energy for the official conference – the exact opposite of what women's NGOs tend to do. There should therefore be more systematic planning to link the non-governmental and official events, so that the energy and ethos of the former can be brought to bear on the latter. ✎

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- ¹ This paper was prepared for UNIFEM in preparation for the five-year review of the Beijing Platform for Action
 - ² Human Development Report, 1999.
 - ³ 'Traditional' customs and beliefs are often not traditional at all but are customs of recent vintage created for the specific purpose of controlling women or other groups.
 - ⁴ Closer analysis of the nature of the conservative alliance built by the Vatican suggests that what was negotiated among them was not really economic issues versus gender issues but mutual support for each one's pet conservative positions vis a vis women's rights. However, within the larger group of Southern countries, the Vatican's positions received a hearing that no other non-member of G 77 received.
 - ⁵ For an early analysis of the risks inherent in the Cairo +5 review, see Sonia Correa and Gita Sen, 'Cairo +5: moving forward in the eye of the storm,' *SOCIAL WATCH* No 3, 1999
 - ⁶ A reading of some of the texts for the ongoing Copenhagen +5 negotiation suggests at least some parting of the ways between the US, the EU, and Canada. On WTO issues certainly, there are major differences of opinion in the Northern consensus. Certainly the confidence of the North was shaken by the major defeat it suffered at the hands of global civil society in its attempt to force through a privately negotiated Multilateral Agreement on Investment (MAI).
 - ⁷ Gita Sen, 'Cracks in the neo-liberal consensus', *DAWN INFORMS* #2/1998