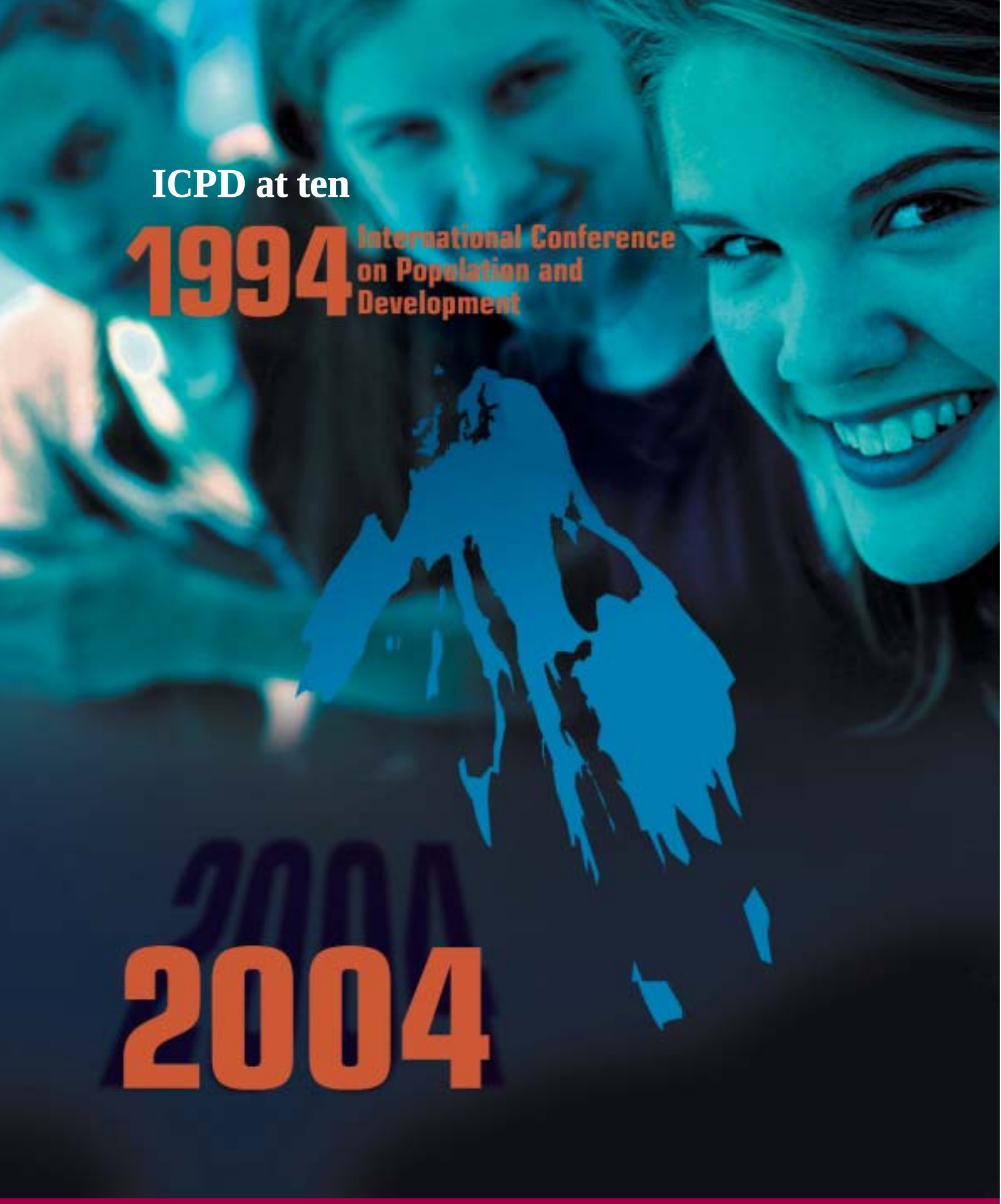


UNFPA
# Entre Nous
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Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark
Tel: (+45) 3917 1341
Fax: (+45) 3917 1850
E-mail: entrenous@who.dk
www.euro.who.int/entrenous

**Chief editor**
Dr Gunta Lazdane
**Editor**
Jeffrey V. Lazarus
**Editorial assistant**
Dominique Gundelach
**Layout**
To om bord, Denmark. www.toombord.dk
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# CONTENTS



Page 4 Page 15 Page 17 Page 19 Page 24


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# EDITORIAL

*By Mahmoud F. Fathalla*

## Ten years after Cairo: Time to renew our commitment to sexual and reproductive rights

Mahmoud F. Fathalla

**Human rights have been in the hearts of many people throughout history. But we can feel proud to belong to the first generation that dared to imagine a world where all people enjoy their human rights, and to take action to help make it happen.**

For a long time, the human rights movement has been gender blind, focusing on the public sphere, mostly inhabited by men, and ignoring the private sphere of sexuality and reproduction, mostly a concern of women. The Cairo International Conference on Population and Development (ICPD) in 1994 was a landmark, making an explicit international commitment for reproductive rights. In paragraph 7.1., the Programme of Action recognized that "reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents". Progress has been made since Cairo. But the agenda is still unfinished.


Reproductive rights, as affirmed in the ICPD programme of action, rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so. Reproductive subordination of women is a violation of the right to liberty and security of the person. Fertility control by women should not change into fertility control of women. Examples abound when women were coerced into contraception, sterilization or abortion to serve demographic objectives. But what is less realized is that from a human rights point of view, there is little to choose between coerced contraception and coerced motherhood. Motherhood, to a woman, should be a free informed choice. Coerced contraception and coerced motherhood are two sides of the same bad coin. Women are coerced into motherhood when women, including adolescents, are denied access to family planning, when women are forced to keep an unwanted pregnancy, when women are denied any other choice in life except childbearing and child rearing, and when children are considered the only goods that a woman is expected to deliver.

One tragic consequence of reproductive subordination of women is the dilemma of unsafe abortion. While the widely divergent views on the issue of abortion deserve full respect, the issue cannot be kept under the carpet, when about 20 million women are risking their health or life every year in pursuit of reproductive freedom, and when more than 200 women are dying every day.

Women have the right to be free from inhuman and degrading treatment. Gender violence is still endemic in almost all societies, to a greater or lesser degree. As highlighted in the Beijing platform for action, physical, sexual and psychological abuse cuts across lines of income, class and culture. According to a World Bank report, conditions resulting from rape and gender violence accounted for about 5 per cent of the global disease burden in women. The psychological impact on the woman should not be underestimated. Wounds of the body ultimately heal leaving a scar. Wounds of the soul never heal completely, and can start to bleed again any time in the future.

An example of a human right that is yet to be fulfilled is women's right to life as they go through the risky journey of pregnancy and childbirth. Pregnancy and childbirth are not diseases. Pregnancy and childbirth are a privileged function of women, essential for the survival of our species. The tragedy of maternal deaths in the world has reached dimensions that can no longer be ignored. If there were a Daily Reproductive Health News Bulletin for our global village, the front page would have the same scary headline every day about the death toll in human reproduction: 1450 women are reported killed during physiological duty; thousands more are seriously injured. The ICPD programme of action stated the goal of a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. This goal was adopted as one of the Millennium Development Goals. A recently released WHO, UNICEF, UNFPA report does not provide ground for optimism. The number of maternal deaths was estimated to be 529 000 in the year 2000. The estimate for 1990 was 585 000. The maternal mortality ratio, measured as the number of deaths to women per 100 000 live births due to pregnancy-related complications, was estimated to be 400 globally in 2000. The corresponding estimate for 1990 was 430. A woman living in sub-Saharan Africa has a 1 in 16 chance of dying in pregnancy or childbirth. This compares with a 1 in 2,800 risk for a woman from a developed region. These women are not dying because of conditions that are difficult to manage. They are dying because the societies in which they live did not see fit to invest what is needed to save their health or did not receive enough international support to do so.

The Cairo consensus was not an easy accomplishment. It was an uphill struggle for a long time preceding the Conference. In recent years, opposition forces, also in Europe, have gathered momentum and are trying to derail the course. For those who uphold sexual and reproductive rights this is no time for complacency.

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**Mahmoud F. Fathalla**
Professor of Obstetrics and Gynaecology,
Assiut University, Egypt

# THE CAIRO PROGRAMME OF ACTION: THE PROMISE AND THE PITFALLS

*By Werner Fornos*


Werner Fornos and Mrs. Nane Annan at the ceremony in New York honouring him as winner in the individual category of the 2003 United Nations Population Award, which took place on 18 June 2003.
" The selection is in recognition of your outstanding contribution to the awareness of population growth," Thoraya Obaid, secretary of the award committee and executive director of UNFPA, wrote to Mr Fornos informing him of his selection.

**The Cairo Programme of Action, adopted by 180 nations at the 1994 International Conference on Population and Development, was primarily designed for the less developed countries of Africa, Asia, and Latin America and the Caribbean.**

The somewhat different, but equally urgent, reproductive health and family planning needs of the countries with economies in transition of eastern Europe and central Asia were not at the forefront of this highly important conference.

Still, the Programme of Action has significant and beneficial implications for these 18 newly independent nations, particularly in terms of quantitative goals for significantly reducing maternal mortality and ensuring universal access to reproductive health including family planning.

Indeed, countries with economies in transition comprise a whole new category of nations in that their literacy levels, technological advances and cultural and religious characteristics more closely mirror those of the industrialized world than those of the developing countries of the southern hemisphere.

However, due to the political and economic upheavals the former states of the Soviet Union have experienced in more recent years, their needs for development assistance – particularly in the areas of health and environmental concerns – more closely resemble those of less developed nations.

For example, while an overriding population characteristic of the developing world, excluding China, is a fertility rate of 3.5 children per woman, only four of the 18 countries with economies in transition have fertility rates above the 2.1 replacement level: Tajikistan (2.4), Turkmenistan (2.2), Uzbekistan (2.5) and Kyrgyzstan (2.4). On the other hand, the countries of eastern Europe have a combined fertility rate of 1.2 children per woman, falling below the 1.5 fertility rate of the more developed world as a whole.

Among the more striking contrasts between the countries in economic transition and the developing world is the modern contraceptive prevalence rate (MCPR). The eight countries of eastern Europe have a combined MCPR of 41% of reproductive age married women or women "in union" – considerably lower than the modern contraceptive prevalence in Latin America and the Caribbean (62%) and Asia (57%).

Because contraceptive knowledge is high within the countries in economic transition, this perhaps surprising difference in contraceptive use has been attrib-

uted to a lack of access to contraceptive methods under the Soviet system. Moreover, when supplies were available they were often of such poor quality that couples refused to use them. This accounts for the virtual reliance in many of the countries on abortion.

It is fair to say that nowhere else in the world had so many women come to be dependent upon abortion as a means of fertility regulation – a concept universally repudiated by nations, multilateral organizations and family planning organizations.

There may be no greater evidence that modern contraceptives are the first line of defense against abortion than the experience of two of the countries in economic transition – Kazakhstan and the Russian Federation – between 1992 and 1998. When reliable modern contraceptives became more generally available in these two countries at the threshold of the post-Soviet period, the abortion rate dropped by 56% in Kazakhstan and by 30% in the Russian Federation.

The reliance upon abortion still remains unacceptably high in the newly independent states. Ironically, the United States international population policy against funding organizations that perform, promote or counsel on abortion bears at least partial responsibility for this situation.

The result of this reprehensible global gag rule instituted by the Bush administration in Washington, as well as the administration's adamant refusal to provide funding for the United Nations Population Fund (UNFPA), the leading multilateral source of reproductive health and family planning programs worldwide, has been a continuing demand for abortions.

The reason is that many of the overseas family planning organizations that no longer receive US funds were leading providers of modern contraceptive supplies, and, though UNFPA has a mandate against providing abortion services, it is among the world's leading providers of reproductive health and family planning.

The current international population policy of the United States government under President George W. Bush has amounted to a setback in reproductive health and family planning progress, even contributing to the high sexually transmitted infection (STI) and HIV/AIDS rates in many countries of eastern Europe and central Asia. The very agencies that are now denied US population funding are the same agencies that were among the major distributors of condoms, widely considered to be the most effective defense against STIs and HIV.

Fortunately, the population/family planning non-governmental organization community in the US remains determined to continue to educate both the United States Congress and the White House regarding the correlation between withholding population assistance and both the rising rates of HIV and continuing high incidences of abortion, as well as high fertility in the poorer nations of the world.

Though it is a decidedly uphill battle, the stakes are simply too high and too important to give up the fight. There is no question that reason will eventually carry the day over ignorance and demagoguery, as it virtually always does. It is only a matter of time for reason to prevail, but it is tragic that the price for this wrong-headed neglect will continue to be unnecessary suffering, while the leaders of the nation with the greatest capacity to catalyze a vital course change remain impervious to obvious and urgent needs throughout the world.


*www.populationinstitute.org*

**The Population Institute is an international, educational, non-profit organization that seeks to reduce excessive population growth. It strives to achieve a world population in balance with a healthy global environment and resource base. Established in 1969, the Institute, with members in 172 countries, is headquartered on Capitol Hill in Washington, DC.**

**Its programmes advance education and activism, and international and US support for voluntary family planning programmes.**
**The official newsletter of the Institute, POPLINE, deals exclusively with global population concerns. The Institute publishes six bi-monthly issues of POPLINE annually. See the website for details on this and how to sign up for electronic action alerts.**

**Werner Fornos**
has been president of the Population Institute since 1982.

# ACHIEVING REPRODUCTIVE HEALTH FOR ALL

*By Steven W. Sinding*

**This year commemorates the tenth anniversary of the International Conference on Population and Development (ICPD) in Cairo - a watershed in humanity's progress towards reproductive health for all by 2015.**

However, despite the progress achieved so far by reproductive health programmes, many sectors of society, mainly people in rural areas, the marginalized and socially-excluded, and above all young people, still lack access to reproductive health programmes because of a variety of political, economic, social or cultural barriers.

In addition, the emergence of new international development priorities such as the Millennium Development Goals (MDGs), the HIV/AIDS pandemic and fighting terrorism appear to have weakened commitment to the ICPD Programme of Action (PoA) in general and to reproductive health programmes in particular. And this is despite the fact that few of the MDG goals can be realized if the core goals of the ICPD are not achieved.

The key question today is: What must we do to ensure that the central goals of the PoA are achieved so that the reproductive revolution that began nearly 50 years ago can be successfully completed?

## Successful social revolution, but much unfinished business

In terms of global population growth, the increase declined from a high of some 89 million additional people per year in the late 1980s to 77 million in early 2002 – well below the forecasts made by the United Nations as recently as the early 1990s. Despite these results, the success of family planning programmes might have been even greater had the people who expressed a desire to reduce their fertility had access to family planning services.

Some of the reactions complain that the Cairo and Beijing conferences undermine basic family structures and the traditional division of roles between men and women; others maintain that Cairo went too far in recognizing sexual and reproductive rights – that the concept of reproductive rights is a code name for abortion – and that the agenda for action encourages under-age sex and promiscuity. Family planning has always engendered such fears among social and religious conservatives, but the Cairo and Beijing conferences reawakened these groups after years during which voluntary family planning programmes had moved steadily forward. Today, nearly ten years after ICPD, we face a double challenge:

- Persuading governments that there is still an urgency regarding the PoA, which requires them to meet the commitments – especially the financial commitments – they made at the conference in Cairo; and
- Overcoming the strong and growing conservative backlash that is being led by the US Government – one of the strongest erstwhile champions and architects of the ICPD consensus.

## Many successes, but the job is not finished

It seems quite clear that we will not achieve the funding goals of the ICPD Programme of Action - US $17 billion per year in 2000, gradually rising to some $23 billion by 2015. Today, global funding stands at about $9.5 billion, just about half of what was committed at ICPD. Inasmuch as official development assistance (ODA) has not risen at all over the same period of time, and given that other priorities have emerged that threaten further the funding for sexual and reproductive health and rights programmes, it is time to conclude that we must focus and concentrate the very limited resources we have – and are likely to have in the future – on a small number of the highest priority undertakings. For Europe, these are:

1. Universal access to reproductive health services
2. Young people, especially adolescents
3. HIV/AIDS

## International support: not enough to cover the needs and is declining

Since the end of the Second World War, ODA became a major feature of international relations and international cooperation.

**Table 1. Official development assistance trends in select years (in constant 1999 US$ million)**

| COUNTRY | 1954 | 1974 | 1984 | 1994 | 1999 | 2000 | 2001 |
|---|---|---|---|---|---|---|---|
| Australia | 100 | 483 | 777 | 1,091 | 982 | 987 | 873 |
| Canada | 78 | 716 | 1,625 | 2,250 | 1,706 | 1,744 | 1,533 |
| Denmark | 10 | 168 | 449 | 1,446 | 1,733 | 1,664 | 1,634 |
| France | 828 | 1,176 | 3,026 | 8,466 | 5,639 | 4,105 | 4,198 |
| Germany | 459 | 1,433 | 2,782 | 6,818 | 5,515 | 5,030 | 4,990 |
| Italy | 48 | 216 | 1,133 | 2,705 | 1,806 | 1,376 | 1,627 |
| Japan | 116 | 1,148 | 4,319 | 13,239 | 15,323 | 13,508 | 9,847 |
| Netherlands | 49 | 463 | 1,268 | 2,517 | 3,234 | 3,135 | 3,172 |
| Norway | 10 | 131 | 540 | 1,137 | 1,370 | 1,264 | 1,346 |
| Spain | - | - | 135 | 1,305 | 1,363 | 1,195 | 1,737 |
| Sweden | 33 | 402 | 741 | 1,819 | 1,630 | 1,799 | 1,666 |
| Switzerland | 9 | 68 | 286 | 982 | 984 | 890 | 908 |
| UK | 493 | 787 | 1,430 | 3,197 | 3,426 | 4,501 | 4,579 |
| US | 3,602 | 3,674 | 8,711 | 9,927 | 9,145 | 9,955 | 11,429 |
| TOTAL | 5,924 | 11,180 | 28,130 | 59,152 | 56,424 | 53,734 | 52,336 |

***Source:*** **OECD/ Development Assistance Committee, ODA 1950-2001. Updated on 18 December 2002**

Table 1 shows the historical developments relating to the ODA of the major 14 donors who in the course of the last 40 years gave at some point or another more than US $1 million. The table below shows the ODA trends in select years (1954, the baseline; 1974, Bucharest Conference; 1984, Mexico City Conference; 1994, Cairo (ICPD) Conference; 1999, Cairo +5 (The Hague Forum); and 2000 and 2001.

Table 1 permits the following observations:

- The following countries increased their ODA after ICPD: Denmark, Japan, the Netherlands, Norway, Spain, UK and US;
- Countries which decreased their ODA since ICPD are: Australia, Canada, France, Germany, Italy, Sweden and Switzerland;
- Overall OECD/ OECD/ Development Assistance Committee ODA has decreased since ICPD;
- After reaching an all-time high of US

**"Few of the MDG goals can be realized if the core goals of the ICPD are not achieved."**

Steven W. Sinding

$15.323 billion in 1999, Japan's ODA has seen a major decrease, particularly from 2000 to 2001.

**Table 2. Percentage of ODA in comparison with gross national income**

| COUNTRY | 1985-86 average | 1990-91 average | 2000 | 2001 |
|---|---|---|---|---|
| Australia | 0.47 | 0.36 | 0.27 | 0.25 |
| Canada | 0.49 | 0.45 | 0.25 | 0.22 |
| Denmark | 0.84 | 0.95 | 1.06 | 1.03 |
| France | 0.59 | 0.61 | 0.32 | 0.32 |
| Germany | 0.45 | 0.40 | 0.27 | 0.27 |
| Italy | 0.33 | 0.30 | 0.13 | 0.15 |
| Japan | 0.29 | 0.31 | 0.28 | 0.23 |
| Netherlands | 0.96 | 0.90 | 0.84 | 0.82 |
| Norway | 1.09 | 1.15 | 0.80 | 0.83 |
| Spain | 0.10 | 0.22 | 0.22 | 0.30 |
| Sweden | 0.85 | 0.90 | 0.80 | 0.81 |
| Switzerland | 0.30 | 0.34 | 0.34 | 0.34 |
| UK | 0.32 | 0.30 | 0.32 | 0.32 |
| US | 0.23 | 0.20 | 0.10 | 0.11 |
| **TOTAL DAC** | **0.33** | **0.32** | **0.22** | **0.22** |
| of which EU members | 0.45 | 0.44 | 0.32 | 0.33 |

*Source:* **OECD/DAC – Net ODA. Updated on 11 December 2002**

Table 2 indicates the following:

- A general decrease of ODA has occurred, from 0.44% of gross national product (GNP) prior to ICPD to 0.33 in 2001.
- The following countries have honoured the commitment to devote at least 0.7% of GNP to ODA more than 40% between the time of the Mexico Conference and 2001: Denmark, the Netherlands, Norway and Sweden.

## Calls for renewed commitment to ICPD

During The Hague Forum held in February 1999 to prepare for the events commemorating ICPD +5, it was clear that the international community needed a reminder to renew commitment to ICPD and to increase ODA in general, and the share relating to population and reproductive health in particular.

At their 2003 meeting in Paris, the OECD governments reviewed the state of development assistance in light of the results of some major international meetings held in 2002-03: the Doha meeting of the World Trade Organisation, the Financing for Development Conference held in Monterrey, Mexico and the Johannesburg World Summit on Sustainable Development. The Paris meeting confirmed that ODA increased from US $52.3 billion in 2001 to $57 billion in 2002 and that it is estimated that by 2006 there would be an increase of 30% in comparison with 2001. Despite the increase in 2002, the total ODA in that year is equivalent to the amount of ODA in 1991 and is below the all-time high level of $60.8 billion given in 1992, as well as below the amount of ODA given one year after ICPD ($59.1 billion).

## ODA to population and health

While only US $500 million was allocated by DAC countries to health and population in 1973, this amount grew by an average of 3.3% per year to reach $3.5 billion in 1998 (in constant 1997 prices) (1). In Table 3 and Fig 1. we can see the performances of individual countries. Table 3 shows that:

**Table 3. ODA to Health 1990-2001 (in US$ million)**

| COUNTRY | 1990-92 | 1993-95 | 1996-98 | 1999-2001 | Percentage of total ODA to health 1999-2001 |
|---|---|---|---|---|---|
| Australia | 14 | 43 | 83 | 124 | 3 |
| Canada | 31 | 57 | 36 | 69 | 2 |
| Denmark | 69 | 71 | 90 | 56 | 2 |
| France | 71 | 65 | 100 | 59 | 2 |
| Germany | 37 | 114 | 163 | 125 | 3 |
| Italy | 94 | 31 | 26 | 38 | 1 |
| Japan | 107 | 198 | 242 | 152 | 4 |
| Netherlands | 61 | 97 | 140 | 145 | 4 |
| Norway | 32 | 38 | 42 | 92 | 3 |
| Spain | 26 | 59 | 117 | 93 | 3 |
| Sweden | 154 | 92 | 73 | 73 | 2 |
| Switzerland | 31 | 19 | 30 | 34 | 1 |
| UK | 134 | 98 | 233 | 500 | 14 |
| US | 383 | 800 | 733 | 1108 | 30 |
| **TOTAL DAC** | **1,286** | **1,841** | **2,201** | **2,817** | **-** |

*Source:* **OECD: Aid to Health. Paris, September 2000 (for 1990-1995) and December 2002 (for 1996-2001).**

- Countries that increased ODA for health following ICPD are: Australia, Canada, Germany, Italy, the Netherlands, Norway, Spain, Switzerland, UK and US.
- The following countries decreased their ODA for health: Denmark, France, Japan and Sweden.
- The US, which ranks first in total ODA but last in ODA as a percentage of GNP, has a commanding leadership position in terms of ODA for health.

## Share of ODA for health devoted to family planning and HIV/AIDS

An analysis of the breakdown of spending within the health sector confirms that family planning is losing ground to HIV/AIDS when it comes to funding. While family planning enjoyed a dominant position between 1990 and 1998, funding began to shift rapidly toward HIV/AIDS starting from 2000, as can be seen in the Table 4 (in USD million).

**Table 4. Share of ODA for health, by area**

| Area of sexual and reproductive health | 1994 | 1999 | 2000 | 2001 |
|---|---|---|---|---|
| Population policy and administration | 14 | 98 | 131 | 135 |
| Reproductive health care | 92 | 177 | 194 | 142 |
| Family planning | 563 | 397 | 409 | 356 |
| Sexually transmitted infection control including HIV/AIDS | 193 | 282 | 521 | 587 |
| **TOTAL** | **863** | **953** | **1,255** | **1,220** |

*Source:* **OECD response to an IPPF query in September 2003**

The change in funding to the four components between 1994 and 2001:

- o Population policy + 964.3%
- o Reproductive health care + 154.3%
- o Family planning - 36.8%
- o HIV/AIDS + 300.1%
- **o TOTAL + 141.4%**

## Impact of the decrease of the share of family planning in ODA for health on contraceptive security

The decrease of ODA in general is compounded by the decrease of the share of health resources committed to family planning. The problem is particularly acute considering the fact that 105 million women have an unmet need for contraception and that an increasing number

of young people, often unmarried, become sexually active without an adequate contraceptive supply. In order to maintain the current worldwide contraceptive prevalence, the number of users of modern contraceptives needs to increase from 310 million users in 2000 to some 460 million in 2025, an additional 150 million users (2).

The current donor expenditure has to increase annually by 5.3% to cover the commodity needs by 2015. As a matter of fact, the gap in contraceptive funding was estimated at US $24 million in 2000 and is projected to increase to some US $210 million by 2015 (3).

## Millennium Development Goals

During the Millennium Summit held in New York in September 2000, the world community adopted the MDGs as a way to sharpen the focus of governments and NGOs in developed and developing countries on specific development objectives to be achieved by 2015.

While the MDGs represent a step forward in alleviating poverty and other health and social ills, unfortunately they remain silent on a number of objectives of the ICPD PoA, such as achieving universal access to reproductive health services by 2015. Some of the MDGs are directly linked to reproductive health and rights – for example, improving maternal health, combating HIV/AIDS, promoting gender equality and empowering women, and reducing child mortality.

It is important for the reproductive health community to go beyond merely recognizing the linkage between reproductive health and the MDGs. What is needed is evidence-based analysis of the direct impact of family planning and reproductive health on the MDGs. So far, the message from recent research is clear: No ICPD = No MDGs.

## Where do we go from here?

The analysis of ODA trends earlier above does not give much grounds for optimism about the commitment of the development community either to the MDGs or to the ICPD PoA. While effectively combating HIV/AIDS now occupies centre stage in the development field and transferring resources to countries recently devastated by the so-called war against terrorism has captured significant new resources, funding to realize the objectives of ICPD and to achieve the MDGs is basically declining.

This is why we need to have a second look at the ICPD objectives and the MDGs with a view to adopting a new approach to implementation – an approach that would concentrate on those most strategic interventions that actually enhance the synergy among several of the related objectives. These include:

1. Ensuring access of the poor, rural populations and young people to reproductive health services. This would necessitate a partnership at the country level between public authorities, NGOs and the private sector. Achieving contraceptive security and filling the condom gap cannot be achieved without such a dynamic partnership.
2. Create innovative forms of partnership between the private sector (especially the music, entertainment and pharmaceutical sectors) and NGOs in order to reach young people with the right messages and with credible substance. Here the issue is not "Keep hope alive" but rather "create hope" before it is too late on all fronts.

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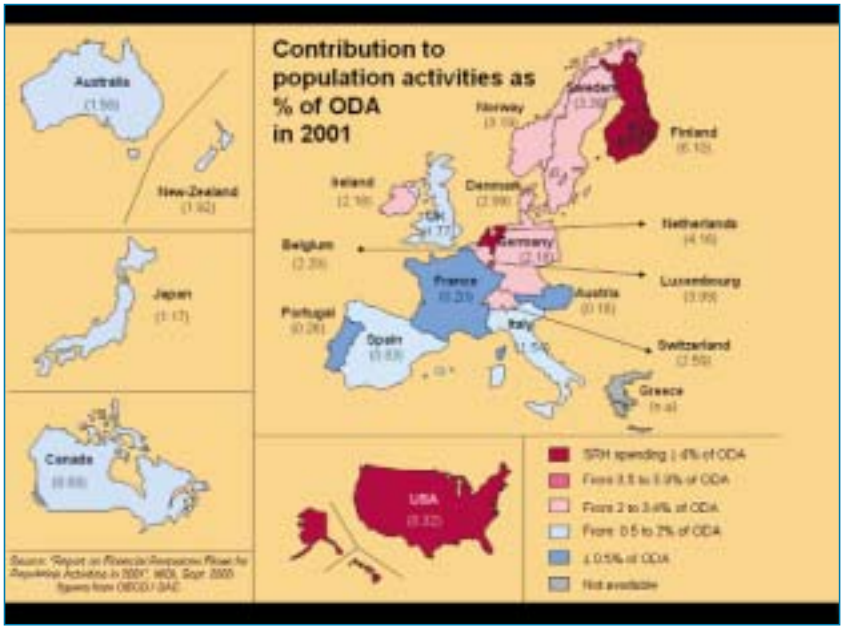
**Dr Steven W. Sinding**
[SSinding@ippf.org]
Director-General of the International Planned Parenthood Federation
www.ippf.org


**Fig. 1.**
**Contribution to population activities as percentage of ODA in 2001**




*Source:* **"Report on Financial Resources Flows for Population Activities in 2001", NIDI and ODA figures from OECD/DAC**

# POPULATION AND REPRODUCTIVE HEALTH IN THE MILLENNIUM DEVELOPMENT GOALS

*By Elizabeth Lule*

**The most urgent problems facing the world today are absolute poverty in all its various dimensions, and growing inequalities between the poor and the rich within and between countries.**

Elizabeth Lule

Despite impressive progress in the last century in the reduction of poverty, fertility decline and advances in health, some 1.2 billion people still live on less than a dollar (US$1) per day and life expectancy of people in developing countries is 14 years lower than the rich countries. In developing countries larger cohorts of young people will enter their reproductive age each year because of past high fertility. While developing countries face a growing burden of new and remerging communicable diseases including HIV/AIDS, population ageing in middle income countries is rapidly increasing the burden of non-communicable disease. Population and reproductive health are, therefore, at the center of a global effort to accelerate progress towards sustainable development and a world free of poverty.

During the 1990s, reducing poverty became a priority for the global community. Agreements, declarations and commitments were made to reduce poverty and work towards sustainable development at several international conferences including the International Conference on Population and Development (ICPD) and the Fourth Women's Conference in Beijing. The twenty year ICPD Programme of Action endorsed by the international community in 1994 in Cairo moved macro level discussions of population and development to the micro level of individual welfare, incorporating individual needs in policy formulation and implementation to improve the quality of life of people. The international community acknowledged that investing in people, in their health and education, was the key to sustained economic growth and sustainable development and placing population issues in the broader strategy for achieving sustainable development and poverty eradication.

Although the global commitment on the population stabilization goal was retained, ICPD recommended integration of vertical family planning activities into the wider context of reproductive health services. It called upon countries to make reproductive health information and services accessible through the primary health care system to all individuals of appropriate age by 2015. Reproductive health was defined more broadly to incorporate sexual health, sexually transmitted infections including HIV/AIDS, cancers, maternal health including unsafe abortion and adolescent sexual and reproductive health. These services were to be provided without coercion emphasizing the basic human right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information, education and services to do so.

The ICPD+5 review in 1999 showed that although political will to implement the ICPD Programme of Action had improved insufficient financing and weak institutional capacity remained major challenges to achieving the ICPD goals. Donors had also not fulfilled their promises to contribute to the US $17 billion required annually by 2000 to implement the ICPD Programme of Action.

Recognizing that much more was needed to be done to reduce poverty, in September 2000, at the UN Summit, 189 countries reaffirmed their commitment to work towards the elimination of poverty and sustainable development and signed the Millennium Declaration. The Millennium Development Goals (MDGs) commit both rich and poor countries to focus their efforts on achieving measurable improvements in people's lives drawing together an enlarged set of ambitious numeric and time-bound development objectives, targets and indicators to be achieved by 2015, from their level in 1990. See Table 1 on both ICPD and MDG goals.

Subsequently, the UN meeting on Financing for Development in March 2002 in Monterrey endorsed a renewed partnership between developed and developing countries with each side accepting mutual accountability and responsibility. Developed countries made pledges to increase official development aid (ODA) to accelerate achievement of the MDGs and agreed to conditions of free trade, more foreign investment, debt relief and efficient government while developing countries agreed to better accountability and improved governance.

The MDGs, therefore, build on and embrace but do not replace agreements reached at previous world conferences in the last decade including ICPD's resolutions and its Programme of Action. All of the ICPD goals and targets are still valid and are mirrored in the MDGs as illus-

# Table 1. The Millennium Development Goals and the International Conference on Population and Development Goals

| Millennium Development Goals | ICPD Goals |
|---|---|
| **Goal 1: Eradicate Extreme Poverty and Hunger**<br>• Halve between 1990 and 2015 the proportion of people whose income is less than US $1 a day;<br>• Halve between 1990 and 2015 the proportion of people who suffer from hunger. | **Universal Access to sexual and reproductive health services** |
| **Goal 2: Achieve universal primary education**<br>• Ensure that by 2015, all children will be able to complete a full course of primary schooling. | **Education and Literacy**<br>• Achieve universal access to primary education by 2015;<br>• Eliminate the gender gap in primary and secondary education by 2005;<br>• Strive to ensure that by 2010 the net primary schoolenrolment ratio for children of both sexes will be at least 90 per cent compared with and estimated 85% in 2000. |
| **Goal 3: Promote Gender Equality and empower women**<br>• Eliminate gender disparity in primary and secondary education by 2005 and in all levels of education by 2015;<br>• Improve the ratio of literate females to males among 15 to 24 year olds;<br>• Increase the share of women in wage employment in the non-agricultural sector;<br>• Increase the seats held by women in national parliament. | **Gender Equality and Equity**<br>• Countries should eliminate all practices that discriminate against women and should help women establish and realize their rights, including those that relate to reproductive health. |
| **Goal 4: Reduce Child Mortality**<br>• Reduce by two thirds, between 1990 and 2015, the under-five mortality rate;<br>• Reduce infant mortality rates;<br>• Increase proportion of one-year old children immunized against measles. | **Reduction of Infant and Child Mortality**<br>• Reduce infant and under-five mortality rates by one third or to 50 and 70 per 1000 live births, respectively, whichever is less, by 2000;<br>• Achieve an infant mortality rate below 50 deaths per 1000 live births and an under five mortality rate below 60 deaths per 1000 live births by 2005;<br>• By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1000 live births and an under-five mortality rate below 45 per 1000. |
| **Goal 5: Improve Maternal Health**<br>• Reduce by three-quarters between 1990 and 2015 the maternal mortality ratio;<br>• Increase the proportion of births attended by skilled health personnel. | **Reduction of Maternal Mortality**<br>• Reduce maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015;<br>• All countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem;<br>• Disparities in maternal mortality within countries and between geographic regions, socio-economic and ethnic groups should be narrowed. |
| **Goal 6: Combat HIV/AIDS, malaria and other diseases**<br>• Have halted by 2015 and begun to reverse the spread of HIV/AIDS;<br>• Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases. | **Access to Reproductive and Sexual Health Services Including Family Planning**<br>• Increase the availability of reproductive health services to all individuals through the primary health care system by 2015;<br>• Decrease the gap between contraceptive use and the proportion of individuals wanting to space or limit their families by at least 50% by 2005, 75% by 2010 and 100% by 2050. Ensure referrals for family planning services and further diagnosis and treatment;<br>• Discouraging harmful practices, such as female genital mutilation, should be an integral component of primary health care. |
| **Goal 7: Ensure environmental sustainability**<br>• Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources;<br>• Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation;<br>• Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers. | **Population and Environment**<br>• Ensure population and environmental integration, including integrating environmental factors into planning and decision-making, modifying unsustainable consumption and production patterns so as to foster sustainable resource use and prevent environmental degradation, and the implementation of policies to address the ecological implication of demographic dynamics. |
| **Goal 8: Develop a global partnership for development**<br>• Develop further an open, rule-based, predictable, non-discriminatory trading and financial system (includes a commitment to good governance, development and poverty reduction-both nationally and internationally);<br>• Address the special needs of the least developed countries, landlocked countries and small island developing states;<br>• Take measures to help countries with debt with sustainable efforts;<br>• In cooperation with developing countries, pharmaceutical companies and private sector, develop and implement strategies for decent and productive work for youth, provide access to affordable, essential drugs in developing countries, and make available the benefits of new technologies. | **Broad-based Partnerships for ICPD Implementation**<br>• Promote broad and effective partnerships among governments, NGOs, the private sector and the international community in all aspects of program development implementation and evaluation. Such partnerships will depend on appropriate systems that enable each organization to contribute according to its distinctive role, responsibility, autonomy and capacity. |

**"The MDGs provide us with an opportunity to review and identify policy gaps and implementation barriers that impede scaling up of reproductive health interventions and programmes."**

trated in Table 1. Although the ICPD goal to "make accessible, through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and not later than the year 2015" (paragraph 7.6 PoA) is not explicitly included as an MDG, it is still the bridge and means to achieve several of the MDGs. Given the persistent gender inequalities and poor reproductive health of women in developing countries, the high disease burden from unsafe sex, especially HIV infection, and because poor reproductive health is a major cause of death and disability of women and children, concerns have been raised that the declining support for reproductive health will not only slow down progress on ICPD goals but will also hinder achieving the MDGs as well. However, while the ICPD goal focuses on increasing access, demand and utilization of reproductive health services are equally important and can be improved through achieving the other MDG goals such as closing the gender gap in education, promoting gender equality and reducing extreme poverty and hunger.

Almost ten years later, the ICPD, like many global initiatives, has suffered from the inverse relationship between intensity and duration. The renewed global focus and political endorsement, around a shared vision of a much improved world by 2015 within the MDG framework provides a great opportunity to reexamine, refocus and reenergize efforts towards the ICPD goals. It will be necessary to look beyond averages provided by the MDGs. Averages mask the disparities between and within socioeconomic groups and disadvantaged groups and can be misleading and the poor are often by passed by average progress. Political commitment to reduce socioeconomic inequities is critical to accelerating progress on achieving the MDGs.

As ICPD+10 approaches, working within the MDG framework challenges us to learn from past experience and create new knowledge and additional evidence to demonstrate the economic benefits of investing in reproductive and maternal health and build the human capital of young people to strengthen the business case for why governments should make these investments. If poverty is at the center of development and achieving the MDGs, more analytical work is needed at the macro and micro levels to articulate the relationship between poverty, population and reproductive health issues more clearly.

At the implementation level, the MDGs provide us with an opportunity to review and identify policy gaps and implementation barriers that impede scaling up of reproductive health interventions and programmes. Access to basic health services including reproductive health through primary health care is hampered by weak health systems, the complex political economy for reproductive health, weak management capacity, and the changing policy and programme environment. Achieving the MDGs will require strengthening the health systems to address the human resource and health financing issues, improving referral linkages, improving management information and logistics systems to improve access to contraceptives and reproductive health commodities, and building management capacity to monitor and evaluate progress on health outcomes and build the evidence base of promising approaches.

To promote country ownership and doner harmonization, donor support is shifting from projects to sectorwide approaches and supporting health reform. The World Bank, IMF and some bilateral donors are moving to direct budgetary support for the broader goal of poverty reduction through the Poverty Reduction Strategy Paper (PRSP) process. Linking the MDG framework to PRSPs provides an opportunity to place population and reproductive health within a broader macroeconomic, structural and social policy framework promoting growth and poverty reduction ensuring country commitment, appropriate resource allocation, cross-sectoral linkages and mainstreaming gender equality.

In conclusion, the MDGs are not new; they embody previous agreements of other UN organized world conferences in the last decade. As ICPD+10 approaches we need to learn from past experience and use lessons learned to pave the way forward adapting to change. Even though the goal to universal access to reproductive health is not explicitly included in the MDGs, it is the means to achieve many of the other MDGs that also indirectly improve reproductive health outcomes since mutural reinforcements between the goals and multisectoral approaches improve demand and utilization of services. Achieving the ICPD goals will depend on renewed political commitment, strengthened strategic partnerships, improved policies and institutions, good leadership and accountability; effective use of additional resources, better analytical work, rigorous research, monitoring and evaluation, improved management capacity and better participation of the poor, women and civil society in the process of development.

Strengthened health systems for achieving the MDGs will also improve primary health care systems to improve access to and utilization of reproductive health services. Progress will depend on defining the MDGs more broadly, and how quickly we adjust and adapt to the changing donor support instruments and arrangements and emerging priorities such as HIV/AIDS. The PRSP process is likely to be the entry point in poor countries to incorporate population and reproductive health issues in poverty reduction strategies.

Realizing our dream of a more equitable world that is free of poverty is feasible and affordable. Working together, we can ensure that countries are capable of dealing effectively with the changing social, demographic and economic realities they face in this new millennium.

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**Elizabeth Lule**
[elule@worldbank.org]
Population and Reproductive Health Adviser
The World Bank

*The opinions expressed in this article are entirely those of the auther and should not be attributed to the World Bank.*

# INTERVIEW WITH INGAR BRUEGGEMANN

***Entre Nous*: To what extent does the ICPD [International Conference on Population and Development] Programme of Action live up to its expectations?**

Ingar Brueggemann: On the positive side, the Programme of Action is firmly enshrined in the international agenda. The Programme receives wide policy support, and is being strongly advocated worldwide. It is the subject of international conferences, notably in the United Nations (UN). One important conference was the UN General Assembly Special Session in 1999 to review progress towards meeting the ICPD goals (ICPD+5). That Conference agreed on a new set of benchmarks in the areas of education and literacy, reproductive health care and unmet need for contraception, the reduction of maternal mortality and HIV/AIDS. The good intentions of the Millennium Development Goals reflect many of ICPD's preoccupations.

However, a tremendous amount of work remains to be undertaken to implement the policy by means of appropriate action, and the outcomes to date are far from being satisfactory. I shall give you some examples of that later.

The International Planned Parenthood Federation (IPPF) took the Programme's recommendations very seriously, particularly as its own Vision 2000, that it adopted in 1992, covered much of the same ground (1, 2). We were not content to leave it at the stage of policy. We formulated a strategic plan to achieve the goals of our Vision 2000, and guidelines for implementing that plan (3, 4). Moreover, we developed an integrated management system to ensure modern management throughout the Federation and issued guidelines for its implementation (5-7). This Management System has taken root among the Federation's national family planning associations.

**EN: One of the objectives of ICPD was to promote an effective partnership between governments and NGOs. For seven years you served as Director-General of a worldwide NGO, the International Planned Parenthood Federation. Is this ICPD objective being adequately met?**

IB: I believe it is to a large extent. NGOs now undoubtedly play a much more important role than they did in the past. They are regularly invited to participate in international conferences. For example, as Director-General of IPPF I participated in the Beijing Conference on Women in 1995, and had the privilege of addressing the UN Special Session on ICPD+5 in 1999. I have also been invited to address parliamentary groups and academic institutions, as well as UN agencies such as UNFPA and the World Bank. IPPF has also acted jointly with WHO, UNFPA and UNICEF.

**EN: Do you believe ICPD has contributed significantly to ensuring universal human rights in line with the very first three Principles of its Programme of Action?**

IB: I'm afraid there is still a long way to go to ensuring human rights in far too many countries. IPPF has taken strong action to improve the situation by being very active in furthering sexual and reproductive rights. I'll just mention a few, for example the rights of people to make free and informed choices regarding their sexual and reproductive health, that no woman's life should be put at risk by reason of pregnancy, and that no child's life should be endangered. We spelled them all out in a Charter that we issued. (8, 9) Their application permeates a large number of IPPF's programmes. We strongly urged countries to pass legislation adopting them.

**EN: An important principle of ICPD is the advancement of gender equality and equity and the empowerment of women. Has the situation improved since then?**

IB: Only to a limited extent. You just can't speak in the same breath of the situation of the vast majority of women who live in developing countries and of the minority who live in the industrialized countries. They belong to the same planet, but they are worlds apart. Even in the most affluent of democratic countries, women with few exceptions still have a long way to go to achieve equality with men, particularly with regard to their sexual and reproductive rights. And in all too many countries at the opposite pole of development the situation is catastrophic. So it is high time to pay much more permanent attention – not just an annual women's day – to the achievement of gender equality and the empowerment of women regarding their sexual and reproductive health and the number and spacing of their children. The situation is even more dramatic concerning girls. They are still exposed in many countries to infanticide, genital mutilation, illiteracy, sexual violence and unwanted pregnancies due to ignorance or rape. To attempt forcefully to put an end to the gruesome practice of female genital mutilation, we have to contend not so much with the legal action of governments as with the culture-bound behaviour of family members!

**EN: ICPD was forthright concerning sustainable development and alleviation of poverty. How do you see the situation today?**

IB: The fact that the first Millennium Development Goal for the 21st century [www.un.org/millenniumgoals] calls for reducing poverty and hunger by half only by the year 2015 speaks for itself. I can only repeat what I declared in my address to the UN Special Session on ICPD+5 in 1999, and that is that the alleviation of poverty, sexual and reproductive health and rights, and population growth in balance with existing resources are key elements for achieving sustainable development.

**EN: With your background, you are no doubt particularly sensitive to ICPD's emphasis on the right to the enjoyment of the highest attainable standard of health, and in particular women's health and safe motherhood?**

IB: You are right! Inherent in the right to health care and protection is the right to safe motherhood. From my perspective that includes adequate birth spacing, proper nutrition, workload adapted to the constraints of pregnancy and childbirth, antenatal care, safe childbirth and breast-feeding. Safe motherhood is essential in order to end the tragedy of women dying unnecessarily during pregnancy and childbirth. Recent findings on maternal mortality by WHO, UNICEF and UNFPA show that a woman living in sub-Saharan Africa has a 1 in 16 chance of dying in pregnancy or childbirth as

**Ingar Brueggemann is the former Director-General of the International Planned Parenthood Federation and a former WHO staff member**

compared with a 1 in 2,800 risk for a woman in a developed country (10). Between 1995 and 2000 there has been no improvement in maternal mortality levels in developing regions and in the world as a whole, and there has even been an increase in Asia (11). That situation is completely unacceptable. In IPPF, we realized that in addition to health care, social factors too are essential for safe motherhood. We responded to the challenge of safe motherhood by providing education, counselling and service through our more than 140 national family planning Associations throughout the world, by advocating our reproductive health policies and Charter of Rights, and by stimulating political will to deal with the matter, particularly in societies in which women have inferior social and economic status.

**EN: What is your reaction to the ICPD principle concerning the right to education, with particular attention to women and the girl-child?**

IB: I shall respond mainly with regard to sex education. I have just talked about safe motherhood. That starts long before motherhood begins. In fact it starts in childhood, in sex education for young people. I realize that that is a controversial issue, but numerous studies have shown how such education led to an increase in the age at first intercourse, a decrease in overall sexual activity, the adoption of safer sexual practices in sexually active youth, more frequent use of contraception, and reduced incidence of teenage pregnancies. As for education of the girl-child in general, female literacy is crucial.

**EN: ICPD laid great emphasis on the survival of children and the health of children and adolescents. Did these issues also fall within your remit in IPPF?**

IB: They did, and are still of great concern to me. In many countries the infant mortality rate is still more than 100 per 1,000 live births. Since 1970 it has fallen from 32 to 9 in high human development countries, that is by 72%, and from 139 to 104 in low human development countries, that is by only 25% (12). These figures are surely a manifestation of reproductive health failure. So to improve the situation more emphasis has to be given to reproductive health.

As for under-five mortality, it has fallen from 42 per 1,000 live births to 11 in high human development countries, which is by 74%, and from 226 to 162 in low human development countries, that is by only 28% (13). Again people across the planet live in vastly different worlds, an inadmissible situation in the context of the much-debated globalisation. No wonder the drafters of the Millennium Development Goal of reducing child mortality to one-third of their 1990 levels by 2015 stated that at current rates of progress, only a few countries are likely to achieve this goal.

We assume that most young people become healthy and productive adults, but many millions unfortunately do not. More than half of new HIV infections occur in young people. Today, one in 20 adolescents worldwide contract a sexually transmitted infection. One-tenth of all births are to teenage girls, posing increased risks to both the far-too-young mother and the child. That is why IPPF paid particular attention to the specific sexual and reproductive health needs and rights of young people, and that includes the prevention of pregnancies among young teenage girls and of HIV/AIDS and other STIs.

We appealed to governments to adopt policies and legislation to meet their specific sexual and reproductive health needs, and to ensure that services for them respect their human rights and dignity, their privacy and their confidentiality, and that they are provided in an environment of gender equality. We pointed out that it is a good investment since they will be the parents and leaders of tomorrow, and the survival of our planet is in their hands. We found that they have a powerful voice and good advice to give. So we enhanced their roles in IPPF governance and they are now well represented on its Governing Council. We encouraged them to prepare for themselves sex educational material that would be likely to influence their peers. They rose to the occasion and called them “sexplanations”! I firmly believe these initiatives constitute a model worthy of repetition in other organizations.

**EN: Last but not least you no doubt have a lot to say about ICPD’s objectives concerning family planning.**

IB: I see family planning as an integral part of sexual and reproductive rights and health. It plays an important role in avoiding unwanted pregnancies, especially among the young, and in reducing the incidence of maternal deaths. Regrettably, influential groups throughout the world are against all forms of family planning, other than the so-called natural method as a minor concession. They advise unmarried people to abstain from sexual activity.

Unfortunately also, unscrupulous right to life activists are using harsh anti-abortion rhetoric to arouse vicious antagonism to family planning in general. I continue to challenge our opponents to pay for the feeding, clothing, housing and education of all the unwanted children in the poor countries of the world. There is a sad silence to that request.

Among many people the very word "abortion" is taboo, to the extent that the current President of the United States of America forbids financial support to any organization even only suspected of condoning abortion – the infamous Gag Rule [www.globalgagrule.org]. I take this opportunity to repeat my stance regarding abortion. In no case should it be used as a routine method of family planning. Safe abortion, and I repeat safe, is a decision and right of any woman. However, it should only be used as a last resort, and certainly not after the twelth week of pregnancy, when contraceptive methods have failed and pregnancy is unwanted, particulary in cases of rape, or is seriously detrimental to the health of a woman.

From a social perspective, family planning is now undoubtedly more widely accepted than it was twenty years ago, even if its methods are not universally accepted. This acceptance is an indicator of significant progress as compared with the situation in 1978 when there was opposition to including it in the Declaration of Alma-Ata on Primary Health Care. To have it accepted it had to be subsumed under maternal and child health. But of course it goes much further than that. It facilitates sustainable economic development in a sustainable environment and ensures the maintenance of the world’s population in har-

mony with our planet's ecology. This implies integrating family planning with agricultural, environmental, social and economic programmes.

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# REFUGEES AND THE CAIRO PROGRAMME OF ACTION

*By Samantha Guy*

**Prior to the International Conference on Population and Development (ICPD) in 1994, reproductive health (RH) services in conflict settings had been somewhat sporadic. Some services were being provided, but there was little cohesive action and the RH needs of refugees were not part of the international policy framework.**

The Cairo Programme of Action, signed by 179 countries, provides not only the clearest definition of RH but also acknowledged refugees as an important underserved group. The international community has been working to provide refugees and internally displaced people with high quality RH care. The Programme of Action provided the mandate for many organizations to develop RH services for refugee communities and gave a backdrop against which the international refugee RH initiative could evolve and expand.

### Initiatives since Cairo

In 1995 the Inter-Agency Working Group on Reproductive Health in Refugee Situations (IAWG) was formed by UNHCR and UNFPA with over 30 members from UN agencies, NGOs, research organizations and governments. In 1999, the IAWG produced the first ever field manual on RH for refugees to facilitate the provision of services.

The manual has detailed chapters for each of the technical areas of RH for refugees: safe motherhood; sexual and gender-based violence; sexually transmitted diseases, including HIV/AIDS; and family planning. It also covers RH and young people, surveillance and monitoring, information, education and communication, and legal considerations. One of the key concepts within the manual is the Minimum Initial Service Package (MISP), which sets out those services that are most critical in the first phase of an emergency.

In 1995 the Reproductive Health Response in Conflict Consortium (RHRC Consortium) was created as a joint initiative of CARE, International Rescue Committee, JSI Research & Training Institute, Marie Stopes International and the Women's Commission for Refugee Women and Children. Columbia University's Heilbrunn Department of Population and Family Health and the American Refugee Committee joined the Consortium at a later stage. The RHRC Consortium seeks to increase access to a broad range of good quality, voluntary RH services for refugees and internally displaced persons around the world who have traditionally lacked these services.

A number of key tools and guidelines have been produced by the IAWG, the RHRC Consortium and others to facilitate the provision of quality RH services to communities affected by armed conflict. Most recent of the new tools is the Sexual and Gender-Based Violence Against Refugees, Returnees and Internally Displaced Persons - Guidelines for Prevention and Response, produced by UNHCR.

### Barriers to quality service provision

In spite of the growing awareness within the international community for the need for RH services in conflict situations, a huge unmet demand persists.

This is due in part to residual reluctance on the part of some agencies to provide RH services at all, as well as a lack of capacity among others to effectively introduce a new range of health services. Despite effective advocacy and awareness raising, barriers remain at headquarter and field levels to effective implementation. Major organizations providing services in humanitarian relief

Samantha Guy

operations have yet to prioritize or standardize RH care as a component of health care provision, despite the evidence that doing so saves lives.

Whilst UN agencies are increasingly recognizing the importance of integrating RH services into their programme planning and implementation, major donors have not followed this lead, and this lack of commitment only serves to exacerbate the lack of priority accorded to RH by NGOs. Funding constraints not only prevent direct service delivery but also have a negative impact on potential changes in organizational policy and steps that could build capacity.

## Latest policy developments

In addition to lack of capacity or prioritisation of RH care among agencies, policy also plays a part in the lack of provision of these services in refugee settings.

Ideological opposition to the provision of RH services in conflict-affected settings has long been a barrier to effective implementation and such thinking continues to hinder efforts to improve service provision. Donors to both RH and refugee programmes are becoming increasingly targeted by powerful conservative lobby groups, often religious in nature, within their countries. For example, restrictions by the US administration on funding for global RH care services are having a harmful effect on refugee communities worldwide.

In January 2001, the Mexico City Policy (or Global Gag Rule) was reimposed by President Bush. Under this policy, US Agency for International Development (USAID) funding is denied to any international reproductive health NGO that so much as mentions abortion, even in countries where abortion is legal. Until this year, the Gag Rule (www.globalgagrule.org) applied only to programmes administered by USAID. However, in late August 2003, President Bush issued a Memorandum that placed additional restrictions on US financial assistance to foreign NGOs that use their own funds to counsel, perform or advocate on the issue of abortion. The Memorandum extends the Mexico City Policy to all voluntary population planning funds administered by any part of the State Department.

The nuances of these policy developments are difficult to fully understand and require time-consuming interpretation, and although the full implications of the extension of this policy are yet to be clarified, many groups are concerned that this policy will encumber efforts and slow responses in refugee situations where speed is critical. When war and migration make millions of women acutely vulnerable to disease and violence, agencies need to be able to move quickly to provide life-saving services. By requiring US agencies to spend time investigating their partner agencies in the field, this policy could delay or prevent implementation of critical health care programmes proven to reduce rates of maternal and child morbidity and mortality.

In addition, the very agencies best placed to move forward in the provision of services to conflict affected populations are the ones tying up resources trying to analyze the impact and interpret the fine details of these new policies. This latest development forms part of an ongoing and steadily evolving process as the measures taken by the current US administration become more far reaching. It remains to be seen what further, damaging actions will be taken.

## Next steps

In the face of barriers at both service delivery and policy levels, the international community needs to work together to safeguard the rights of refugee communities and try to force the repeal of new policies aimed at denying women their reproductive rights. Alliances between development and relief, advocacy and service delivery agencies need to be strengthened to bring about changes in policy and practice.

As we approach the tenth anniversary of ICPD, we need to ensure that the international community remains committed to the Programme of Action and does not renege on its promises to keep RH at the centre of development efforts.

**Samantha Guy**
[Sam.guy@mariestopes.org.uk]
Senior advisor, reproductive health for refugees initiative
Marie Stopes International

# RECENT RESOURCES


**Reproductive health during conflict and displacement: A guide for programme managers, WHO 2000.**


**The global decade report, Marie Stopes International, 2003**

**Guidelines for Prevention and Response: Sexual and Gender-based Violence against Refugees, Returnees and Internally Displaced Persons, UNHCR 2003**

**Raising Awareness for Reproductive Health in Complex Emergencies, CARE/RHRC 2003**

# STRATEGIES AND TRENDS IN EUROPE SINCE ICPD

*By Jeffrey V. Lazarus*

**The International Conference on Population and Development (ICPD) will celebrate its tenth anniversary in September 2004. Since the ICPD+5 conference in The Hague, the sexual and reproductive health and rights approach, which seeks universal access to quality services, has gained momentum but still falls short of need (1).**

Of the 17 reproductive health indicators for global monitoring agreed upon by the United Nations and partner agencies (2), there are current data from all European countries for only a few. However, available figures from the WHO European health for all database (www.who.dk/hfadb) show an alarming trend since the ICPD Programme of Action was signed in 1994 (3). In many central and south-eastern European countries and the Commonwealth of Independent States, the incidence of sexually transmitted infections (STIs) like syphilis rapidly increased in the mid-1990s and, though now declining, remains high. Eastern Europe, especially Estonia, the Russian Federation and Ukraine, is experiencing a rapid increase in new HIV cases. However, even if it is the highest increase of HIV cases in the world, infection rates are below western European levels, which means there is still time to keep prevalence rates low.

In short, the European Region, with 870 million inhabitants in 52 countries, faces challenges that, although not as daunting as those in Africa and parts of Latin America and Asia, still require ongoing efforts, coordination and considerable resources.

Through strategies and consultations, the WHO Regional Office for Europe has worked to promote the ICPD Programme of Action throughout the Region. Below, WHO strategies are presented as well as examples of national strategies, a United Nations interagency consultation and a health promotion in schools network, followed by trends in key sexual and reproductive health indicators monitored by WHO.

**ICPD Programme of Action, Cairo, 5-13 September 1994 "Actions:**

**7.6.** All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and not later than the year 2015. .

**7.7.** Reproductive health-care programmes should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services..."

## The WHO European Regional Strategy on Sexual and Reproductive Health

• European health policy-makers and programme managers need to maintain and improve health care delivery despite increasing demand and diminishing resources. This regional strategy provides strategic guidance in improving sexual and reproductive health policies and programmes. Making due allowance for national differences, the strategy assigns national and international responsibilities, proposes an implementation framework, makes suggestions for resource mobilization, and addresses monitoring and evaluation. The document, available in English and Russian, is useful for developing national policies and programmes. (www.euro.who.int/reproductive-health)

## The WHO Strategic Action Plan for the Health of Women in Europe

• Even the richest countries often ignore health differences between women and men. Compared to men, women have a disease-resistant biology but less social status and financial independence, and such reproductive and social differences create different patterns of ill health. Women live longer than men yet suffer greater morbidity. They are likelier to be poor, with average incomes only 70% of men's. Women also utilize the public health care system more. The health problems of more than 4 million European women who are migrants, refugees or ethnic minorities also deserve special attention.

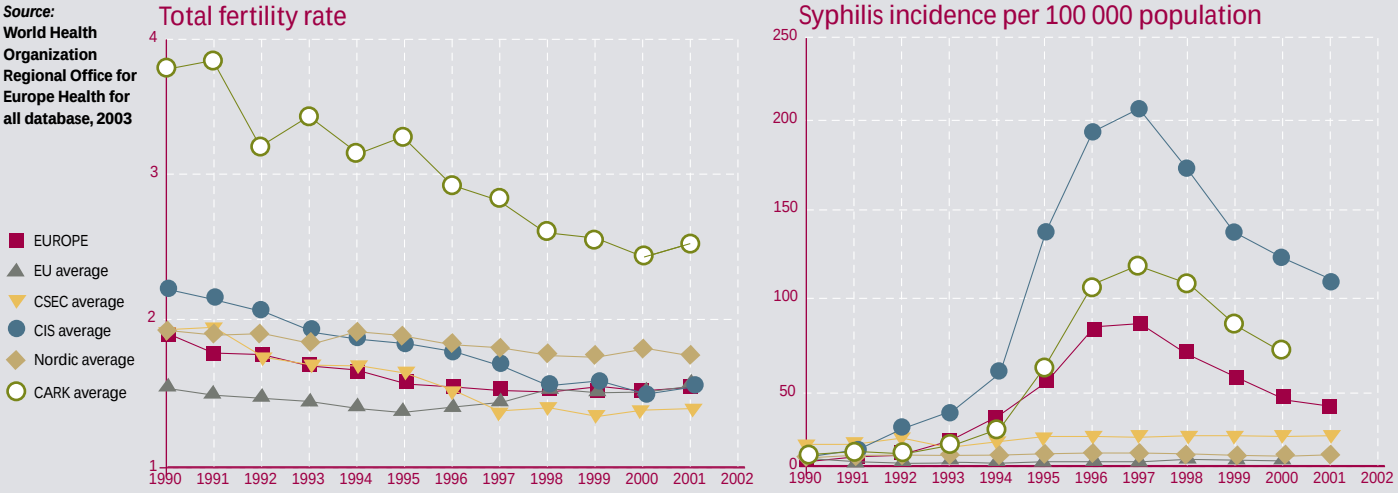
This Action Plan seeks to help national and local governments achieve greater gender equity in health and health care, and to make women's health issues an explicit part of any strategies addressing health inequities in the European Region. (www.euro.who.int/reproductive-health)

## National strategies in Romania

• The current sexual and reproductive health situation in Romania, including STIs, requires a complex intersectorial approach. During 2003, the Ministry of



***Source:*** **World Health Organization Regional Office for Europe Health for all database, 2003**



Jeffrey V. Lazarus

Health in Romania finalized two important national strategies, one on sexual and reproductive health and the other on the prevention and control of STIs.

Following WHO principles and recommendations in the two areas, both documents set the framework and the specific measures to ensure and improve the overall sexual and reproductive health situation in the country. They reflect the long-term vision of the government under the leadership of the Ministry of Health regarding the policies and programmes on sexual and reproductive health/STIs respectively and present the steps for operationalisation of the strategies for 2003-2006. The strategies also offer a framework for the development and harmonization of national legislation and regulations with European standards, a necessary step for Romanian accession to the EU.

Various governmental institutions, national and international NGOs and international agencies contributed to the planning of the two strategies. UNFPA and JSI/USAID provided the technical and financial assistance.

For copies of strategies contact: office@unfpa.ro or office@jsi.ro.

**"Actions:**

**7.46.** Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies.

**7.47.** Governments, in collaboration with non-governmental organizations, are urged to meet special needs of adolescents and to establish appropriate programmes to respond to those needs..."

## European Network of Health Promoting Schools

• Health promoting schools can provide a safe and secure environment for both pupils and teachers when addressing issues of sexual and reproductive health. Many examples exist in the WHO European Network of Health Promoting Schools programme where schools have successfully introduced and developed programmes where not only teachers feel confident and relaxed about approaching the subject, but also where pupils have taken on responsibilities for sensitive areas of the work, through peer education approaches.

The health promoting school approach can enable sex education programmes to build integrated elements into the programme, from the involvement and participation of parents and the community, to the creation of a safe school environment and the true participation of pupils in the learning process. Sexual and reproductive health education can be de-mystified for parents, students and also for teachers by using approaches that encourage participation and discussion.

The European Network of Health Promoting Schools works in over 40 countries in the WHO European Region. It seeks to build consensus on best practice in school health programme development and in assisting countries to establish sustainable health promoting school approaches.
For more information: www.euro.who.int/enhps

## Youth friendly health services

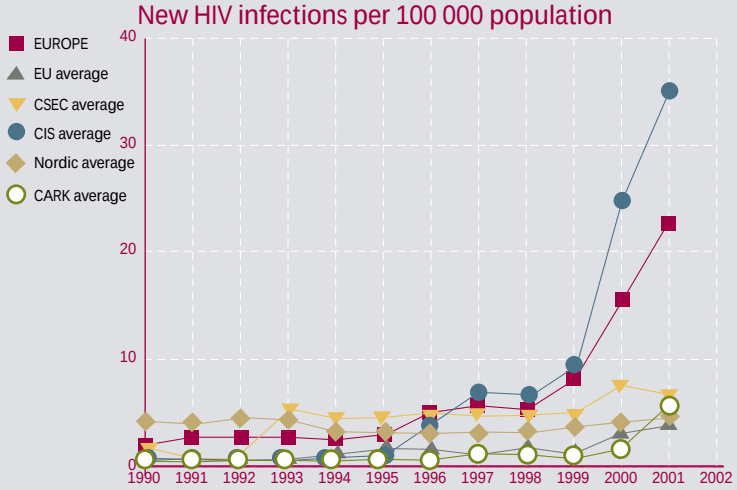
• The United Nations Inter-Agency Group (IAG) on Young People's Health, Development and Protection sub-group on Youth Friendly Services held two forums to share understandings and experiences in the design and implementation of youth friendly services from the Baltic States and south-east Europe. Examples of good practices from outside of the Region were also shared. The main objectives of the meetings were to examine the concept of youth friendly services (YFS) and apply the criteria of YFS to existing service provision, with a special focus on quality norms and standards in YFS provision, scaling up good practice and identifying indicators to measure accessibility, acceptability, appropriateness, affordability, coordination between agencies and youth participation. These activities also included an extensive mapping exercise using tools and checklists drawn up by the IAG and in collaboration with partners in countries. Youth friendly services are those which are based on the needs and rights of children and young people and the responsibilities of duty bearers to promote young people's health and development and provide quality services.

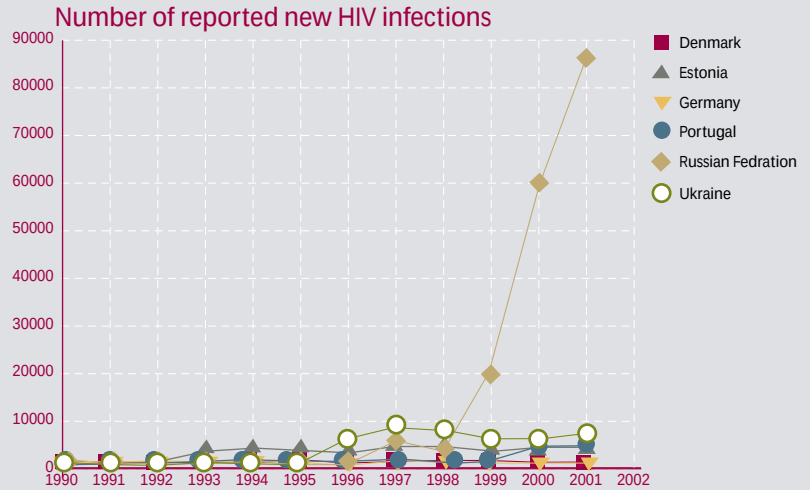
A CD-ROM with the background papers and all of the presentations made is available upon request from Mr David Rivett [dri@euro.who.int]

**"Action:**

**14.11.** The international community should strive for the fulfilment of the agreed target of 0.7 per cent of the gross national product for overall official development assistance and development programmes commernsurate with the scope and scale of activities required to achieve the objectives and goals of the present Programme of Action..."





## European overseas development aid

• The International Planned Parenthood Federation European Network has undertaken a mapping exercise of overseas development aid with a specific focus on aid to UNAIDS, UNFPA and IPPF. The Euromapping Project is aimed at strengthening European advocacy and mobilizing public funding in the fields of population, sexual and reproductive health and HIV/AIDS. More specifically, this will provide an overview of public funding with regard to financing the ICPD Programme of Action for 17 European countries and the European Commission. Additionally, an overview of the policies of each of these countries and of the European Commission with regard to sexual and reproductive health, HIV/AIDS and gender is given, as well as the kind of projects which can be financed.

Contact Eef Wuyts [ewuyts@ippfen.org] of the International Planned Parenthood Federation European Network for further details.

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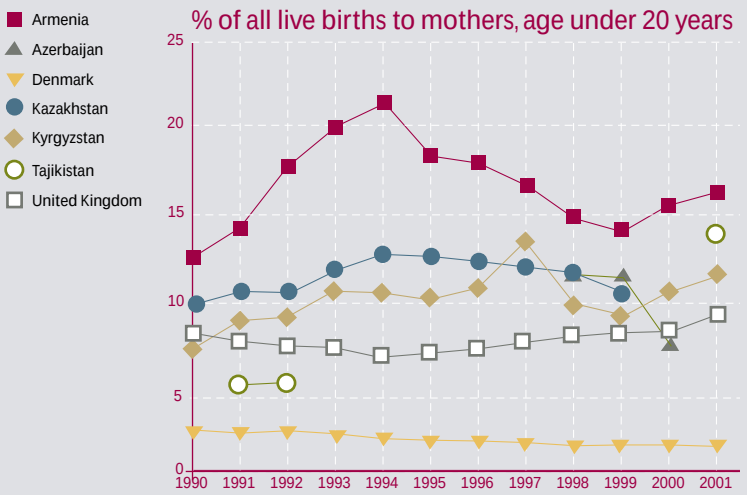
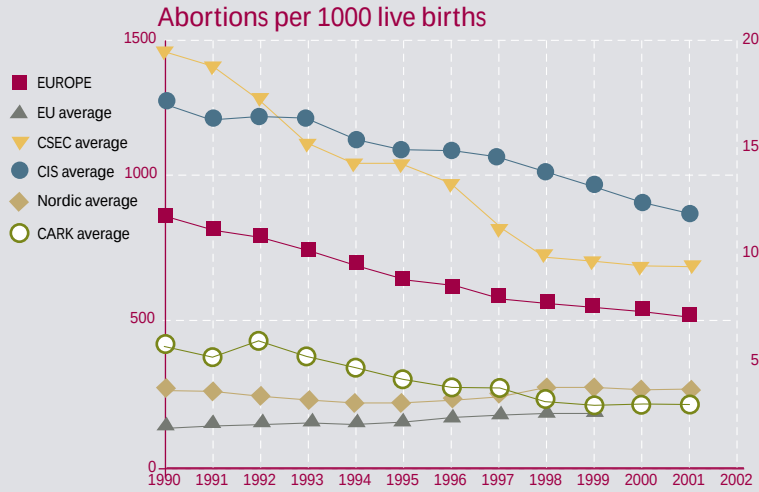
**Jeffrey V. Lazarus**
[jla@who.dk]
Editor, *Entre Nous* magazine

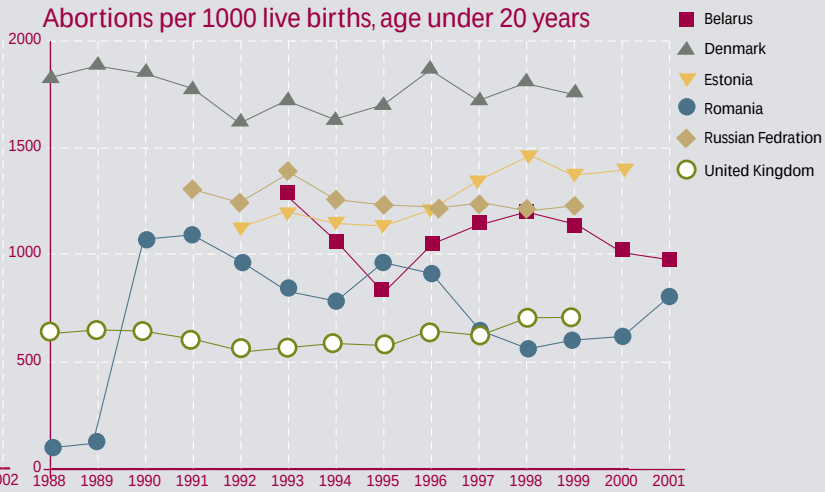



### Key

**CARK average** (5 central Asian republics, including Kazakhstan)
**CSEC average** (15 central and south-eastern European countries, including Estonia, Latvia and Lithuania)
**CIS average** (12 Commonwealth of Independent States, the countries of the former USSR excluding Estonia, Latvia and Lithuania, which are now included in the CSEC average)
**EU average** (15 European Union countries)
**EUR average** (51 WHO European Member States)
**Nordic average** (5 Nordic countries).



# PRESERVING POWER AND PRIVILEGE

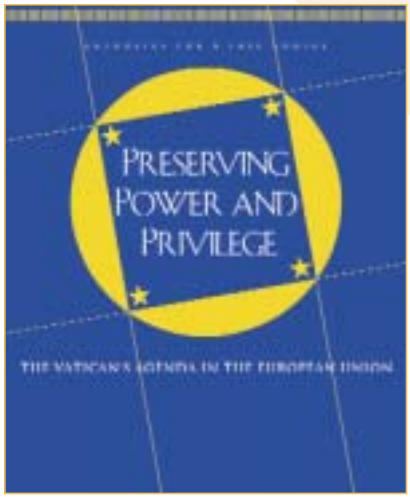
## The Vatican's Agenda in the European Union

*A new publication from Catholics for a Free Choice*

**The conflict and polarization that have characterized the public debate about reproductive health issues in the United States is well known worldwide.**

Whether the subject is sexuality education for adolescents, access to safe and legal abortion services, international family planning assistance to developing countries or emergency contraception, a small but vocal minority of Americans opposed to these services on moral grounds has led a persistent and at times violent effort to limit or ban such services. Sadly, the leadership of most of these efforts rests with the country's Catholic bishops, who have disproportionately invested both their moral and financial capital in lobbying and media efforts against reproductive health services and rights. The bishops' efforts have been peaceful and legal, focused primarily on lobbying and media campaigns. Others in both the Catholic community and among fundamentalist Christians, though, have engaged in trespass, destruction of property (including bombing family planning and abortion clinics), verbal and physical assault of women seeking abortions, and the murder of health care personnel who provide abortion services. Some of these violent actors have even been Christian clergy.

Europe has watched the debate in the US, believing that such religious fanaticism is part and parcel of what has come to be termed American exceptionalism. It could not, most observers believed, ever happen in Europe, where matters of sexual and reproductive health have been approached rationally and within the larger framework of public health policy. Sensible health policy has included sexuality education and access to contraceptives for young people—and has resulted in abortion rates far lower in most European countries than in the US. Sporadic attempts by US anti-abortion activists to export their efforts to France, Ireland, and Great Britain were met with prompt legal action and the most extreme activists have been detained or




**Read the full report online at www.catholicsforchoice.org, or order a copy by phone (+1 202 986-6093), fax (+1 202 332-7995) or e-mail (cffc@catholicsforchoice.org).**

deported. Europe's Catholic bishops have made little effort to influence reproductive health policy in most countries, with notable exceptions in Ireland, Malta, Poland, and Slovakia.

But things have changed. Beginning in 1994, a series of United Nations' conferences reflected an international consensus on the importance of reproductive health and rights in the context of human rights. The consensus was sweeping; the only opposition came from the Roman Catholic church, which has a special status as a non-member state permanent observer in the UN, from a few Islamic states, and a very few Latin American countries. The United States, led by President Clinton, and the European Union played strong public roles in support of a new paradigm that placed women at the centre of reproductive health policy.

The stinging defeat experienced by the Vatican in these conferences galvanised conservative Catholics in the United States and Europe to work for a reversal of what has come to be known as the Cairo consensus. In the US, the transition to George W. Bush's presidency and a conservative Congress made their task easier. US policy now excludes funding for the United Nations Population Fund (UNFPA), while other UN agencies such as UNICEF and WHO are under pressure from the US government to limit their involvement in reproductive health services. The United States Agency for International Development (USAID) denies family planning funding to agencies in developing countries if they use their own funds for any abortion-related activities from education to research as well as counselling or medical services.

And make no mistake; Europe and the European Union are the next targets of anti-family planning advocates from the Vatican and its conservative Catholic allies. Statements made by the European Union delegates at UN conferences have been roundly criticised and mischaracterised by Vatican spokesman Joaquin Navarro-Valls in an effort to discredit the Union. Conservative Catholic Members of the European Parliament (MEPs) have attacked a recent European Parliament report on sexual and reproductive health claiming that it will lead to forced abortions. These claims were soundly rejected. Other MEPs have sponsored lobbying visits of US anti-abortionists to the Parliament in an attempt to deny EU funding to UNFPA. These lobbyists have claimed that UNFPA is involved in coercive practices in China, claims that have been rejected by several independent investigative missions undertaken by a respected British delegation and the former Dutch ambassador to the UN, Nicolaas Biegman. Poul Nielson, the EU's development minister, was attacked by anti-family planning activists who deliberately misinterpreted his efforts to ensure that the European Commission fulfils its obligations to agreements reached at the International Conference on Population and Development in Cairo in 1994.

The information contained in this report is critical to an understanding of the profound differences in worldview and values that divide most of Europe from conservative Roman Catholic thought. What is at stake is no less than the lives and well-being of the world's women—which for the present are very much in the hands of the European people.

*Excerpts from the Foreword.*

# SEXUAL AND REPRODUCTIVE HEALTH: KEY TO POVERTY REDUCTION

*Amsterdam Call for Action*

**225 participants from four continents representing 78 organisations met in Amsterdam on 21 November 2003 for the International Conference "Reproductive Health: Key to Poverty Reduction" organised by World Population Foundation (WPF), NCDO (National Committee for International Cooperation and Sustainable Development) and Share-net (Netherlands Network on Sexual and Reproductive Health and AIDS). While reaffirming the Cairo and Beijing commitments and that of their +5 reviews, the conference adopts as follows:**

## Guiding principles

### Development

- Acknowledge that sexual and reproductive rights and health are mainstream in development and key to poverty reduction
- Acknowledge that sexual and reproductive rights and health for all are key to the realisation of all Millennium Development Goals

### Youth

- Recognize the rights and needs of young people for sexual and reproductive health education and services
- Affirm the importance of meaningful and active youth participation in projects, programmes and policies affecting young people's lives at all levels

### Gender

- Re-iterate that gender equity is key to overall development and to the realisation of sexual and reproductive rights
- Recognise the specific needs of men and women and the importance of male responsibility and involvement related to sexual and reproductive health

### Financing

- Condemn the shortfall in meeting the agreed global resource target for sexual and reproductive health programmes, including HIV/AIDS
- Are highly concerned about shortages in reproductive health supplies (particularly condoms) needed to provide protection against unwanted pregnancy, HIV/AIDS and other STDs, and to provide hygienic conditions in giving birth

### Stakeholders

- Acknowledge the role of civil society to improve sexual and reproductive rights and health
- Appreciate the leading role of the Dutch government in supporting sexual and reproductive health, including the participation of young people
- Acknowledge the crucial role of parliamentarians in promoting sexual and reproductive rights
- Acknowledge that the state is responsible to create the conditions through legislation and policy for people to enjoy their sexual and reproductive rights

## Amsterdam Call for Action

Therefore, we the participants of the International Conference "Reproductive Health: Key to Poverty Reduction" (Amsterdam, 21 November 2003) call upon all stakeholders involved to take an active role in the realisation of the ICPD Programme of Action (Cairo 1994).

### We call for

**… Inclusion** of sexual and reproductive health goals in all poverty reduction strategies and projects

**… Inclusion** of sexual and reproductive health goals in the implementation process of the UN Millennium Development Goals



**"If you are concerned about population, shift your concerns to people"**

**… Action** to realise young people's sexual and reproductive rights, including access to information and services and funding

**… Promoting** active, meaningful and gender balanced youth participation and youth-adult partnership, as well as women's participation at all levels of policy making

**… Inclusion** of youth delegates in governmental and NGO delegations related to the ICPD +10 process and the Millennium Summit +5

**… Promoting** gender equity and empowerment of women, especially through education, and making comprehensive sexual and reproductive health services compatible to the needs of both sexes and readily available to both sexes

**… Improving** access of women and men to sexual and reproductive health services and promote the responsibility of men, and communication and respect between men and women on sexual and reproductive health issues

**… Fulfilment** of at least the agreed target of 0.7% of GNP for Official Development Assistance and make every effort to mobilize the agreed estimated financial resources needed for sexual and reproductive health programmes, including HIV/AIDS

**… Creating** awareness on reproductive health supplies shortages and allocating sufficient financial resources to overcome these shortages

**… Improving** access to basic and comprehensive emergency obstetric care to reduce maternal morbidity and mortality

**… Making** sexual and reproductive health services available to people in conflict areas, refugees and displaced persons

**… Recommitment** to the ICPD programme of action by all stakeholders and call upon the Dutch government to use their influence to this end during the Dutch Presidency of the European Union in 2004

**… Establishment** of national all-party parliamentary groups on sexual and reproductive rights and health in general and in the Netherlands specifically for the implementation of these internationally recognised sexual and reproductive rights in international and regional forums

**… Respect** and fulfilment of sexual and reproductive rights through legislation and policy

## Reproductive Health: Key to Poverty Reduction

The conference took place just before the tenth anniversary of the United Nations International Conference on Population and Development (ICPD) held in Cairo in 1994. ICPD was a landmark in history about population and development, and the ICPD Programme of Action is still the benchmark for policy and programmes. Here the rights of all people to have a responsible, satisfying and safe sex life and the freedom to decide if, when and how often to have children, was unanimously adopted. "If you are concerned about population, shift your concerns to people". This motto made the big change in Cairo.

Reproductive health is key to poverty reduction. The UN Millennium Development Goals, adopted in 2000, call for halving extreme poverty in the world by 2015. By the same year, maternal mortality must be reduced by three-quarters, and infant mortality by two-thirds. Universal access to sexual and reproductive health information and services is essential, if not indispensable, for reaching these goals.

Given the extent of disability, illness and premature death caused by sexual and reproductive health problems in the poorest nations, young adults - especially women - are unable to lift themselves from poverty without full access to basic sexual and reproductive health information and services. HIV/AIDS has emerged as an immense threat to women's reproductive health and the death toll among young people, men and women, is rising. Half of all HIV positives are in the 15 to 24 age group. HIV/AIDS is therefore one of the foremost challenges for poverty alleviation and development.

Ten years on from Cairo, we see international positions harden. The conference was concluded with a Call for Action, which reaffirms the importance of sexual and reproductive health, youth participation and gender equity. It calls upon all stakeholders to strive for the realization of the ICPD goals. Policy- and decision-makers are asked to meet the crucial needs in the field of sexual and reproductive health for all people. The Call for Action was unanimously adopted and will be used during the Cairo+10 processes throughout 2004.




# CALENDAR OF EVENTS IN THE WHO REGION FOR EUROPE

**27-29 August 2003**
**Tallinn, Estonia**
– WHO Regional Advisory Panel Meeting on Research and Training in Reproductive Health in the European Region. Report will be available on www.euro.who.int/reproductivehealth

**8-11 September 2003**
**Dubrovnik, Croatia**
– Annual International Family Planning and Reproductive Health Course Next course planned: 13-16 September, 2004. Women's Health Initiative meeting 16-19 September, 2004

**10-12 September 2003**
**Sofia, Bulgaria**
– South-eastern Europe Inter-country Consultation on Youth Friendly Services organized by UNICEF/UNFPA/WHO

**17 September 2003**
**Bishkek, Kyrgyzstan**
– Roundtable discussion and launch of "Results of the Rapid Assessment of the Reproductive Health of Population in Kyrgyzstan" (available in English and Russian from www.euro.who.int/reproductivehealth) and "Results of the Screening of Cancer of Uterine Cervix in Pilot Regions in Kyrgyzstan"

**5-18 October 2003**
**St.Petersburg, Russia**
– The third theoretical course "The latest achievements of perinatal medicine and reproductive health" organized by St. Petersburg International School of Perinatal Medicine and Reproductive Health

**14 October 2003**
**Berlin, Germany**
– Second International Dialogue Population and Sustainable Development "New Ways out of the Crisis – Reproductive Health in Need of New Ideas" organized by Deutche Stiftung Weltbevölkerung, GTZ, IPPG, KFW in cooperation with Schering

**23-25 October 2003**
**Verona, Italy**
– Making Pregnancy Safer/Promoting Effective Perinatal Care Taskforce workshop - from Evidence to Practice. Trainers and experts in the maternal and perinatal health care field from the European Region met to share the newest results and latest tools in the field

**8-11 November 2003**
**Venice, Italy**
– 8th World Congress for Infectious and Immunological Diseases in Obstetrics and Gynaecology, collaboration discussed between WHO RHR and European Society for Infectious Diseases in Obstetrics and Gynaecology

**21 November 2003**
**Paris, France**
– Social, health and Family Affairs Committee of Parliamentary Assembly of Council of Europe exchanges the views with representatives of WHO/Europe and IPPF European Network on "A European strategy for the promotion of sexual and reproductive health"

**29 November - 1 December 2003**
**Vilnius, Lithuania**
– ASTRA Network organized a regional workshop for NGOs on "Using international human rights instruments to execute women's human rights in the area of sexual and reproductive health"

**2-3 December 2003**
**Geneva, Switzerland**
– Measuring Access to Reproductive Health Services: An Inter-agency meeting organized by WHO-RHR/UNFPA

**9-12 December 2003**
**Geneva, Switzerland**
– WHO Technical consultation on married adolescents

**9-10 December 2003**
**Dushanbe, Tajikistan**
– Workshop "Where are we and where are we going in reproductive health in Tajikistan?" organised by Ministry of Health of Tajikistan and WHO Regional Office for Europe

**17 December 2003**
**Moscow, Russian Federation**
– Workshop of obstetricians and gynaecologists on the problems of abortion in the Russian Federation. Presentation of the WHO publication Safe Abortion: Technical and Policy Guidance for Health Systems

## Important events for 2004:

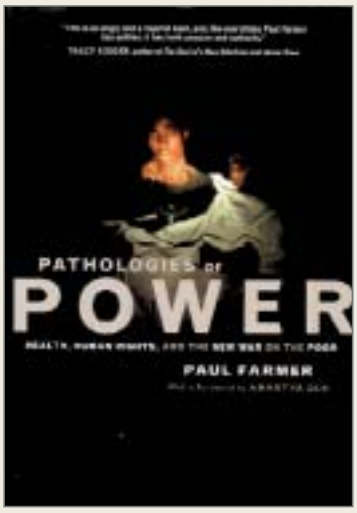
**The European Population Forum, 12-14 January 2004**, Geneva, Switzerland – organized by the United Nations Economic Commission for Europe (UNECE) and the United Nations Population Fund (UNFPA) as co-organizer and the Swiss Government (see www.unece.org)

**The Global Population Forum 2004, 13-15 May 2004**, Washington, DC, USA – organized by the Population Institute and Population 2005 in celebration of the 10th anniversary of the United Nations International Conference on Population and Development (www.population2005.org)

**International Roundtable at 10, 30 August-2 September 2004**, London, the United Kingdom
– organized by the International Planned Parenthood Federation, Population Action International and Family Care International. The roundtable will work to develop strategies to move forward the ICPD vision and broaden the constituency of key stakeholders.

# RESOURCES

## Pathologies of Power: AIDS and Human Rights

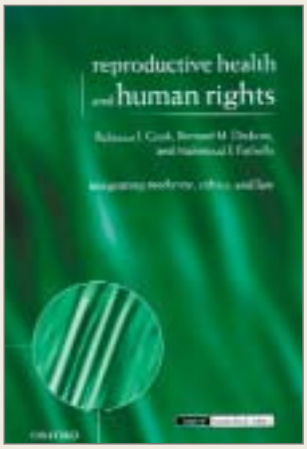



Poor people – the destitute sick – should not be given equal access to health care but preferential access. At least that is what the physician, anthropologist and AIDS activist Paul Farmer claims in his latest book. Written in planes and hotels between missions to the prisons in Russia and the remote villages of Chiapas and Haiti, Paul Farmer shows that the same social forces – poverty and discrimination – give rise to the devastating epidemics of TB and HIV.

Farmer, a professor of medical anthropology at Harvard University and a physician in Haiti, is known for his interdisciplinary activism based on his innovative AIDS work in Haiti. He views international health in a human right perspectives and points out that the fight against AIDS has catalysed an understanding of the fact that promoting and protecting both health and human rights are closely connected.

**Paul Farmer. *Pathologies of Power: Health, Human Rights, and the New War on the Poor,* foreword by Amartya Sen, Berkeley, University of California Press, 2003**

## Reproductive health and human rights




To improve reproductive health, the issue today is not just technologies and services, but the laws and policies that ensure and protect reproductive health and rights. This is arguably the most comprehensive book on the subject. It sets out to help advocates, practitioners and policy-makers understand the essential ethical issues and basic rights related to sexual and reproductive health and apply them in their own settings.

**Rebecca J. Cook, Bernard M. Dickens and Mahmoud F. Fathalla. *Reproductive health and human rights: integrating medicine, ethics, and law.* Oxford, Clarendon Press, 2003**

## Violence against Women: The Health Sector Responds

This book is a collaborative effort between the Pan-American Health Organization (PAHO/-WHO), and the Program for Appropriate Technologies in Health (PATH), with technical assistance provided by the U.S. Center for Disease Control and Prevention (CDC). It provides a strategy and concrete approaches for addressing the complex problem of violence against women, not only for those on the front lines attending to the women who live with violence, but also for the decision-makers who may incorporate the lessons in the development of policies and resources. For those communities where support for women does not yet exist, the authors hope that this book will motivate health providers and leaders to more directly confront the issue of gender-related violence and ensure support to affected women in resolving their situation.

**For more information about the book (published June 2003), visit:**
**www.paho.org/English/DPM/GPP/GH/VAWhealthsector.htm**

## Gendering Prevention Practices. A Practical guide to working with gender in

**HIV/AIDS prevention & sexual safety education**

This manual lays out eight workshop sessions, each with an array of diverse, interactive learning activities, for capacity building to help participants grasp the implications of working with gender in HIV prevention. The session themes are: Perceptions of Gender, Ways of Understanding Gender, Key Aspects of Gender for HIV prevention, Sex as a Gendered Activity, Gender and HIV, Embodying Change, A Sense of Working Together, Reviewing Gender Issues in Context.

**Available free on request from: nikk@nikk.uio.no or accessible through the website**
**www.nikk.uio.no/forskning/nikk/living/lft_pubtext.html**
**Living for Tomorrow**

## UNFPA Global Field Inquiry Report on the ICPD Programme of Action

As mandated by the United Nations General Assembly resolution on the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt, UNFPA is expected to assist countries in their review of operational experiences in implementing the Programme of Action (PoA). To achieve this and as part of the tenth anniversary celebration, UNFPA undertook a global field inquiry among developing countries, countries with economies in transition and developed countries. The aim to systematically was appraise national experiences during the decade since Cairo.

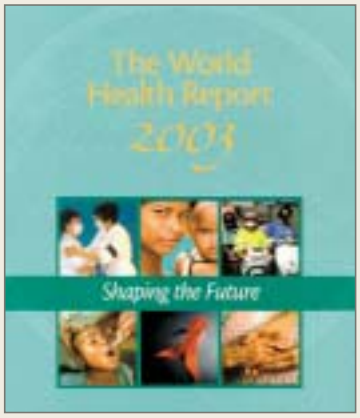
As with the ICPD+5 review, the focus of the field inquiry is on the operational dimensions of population and reproductive health programmes and assessing progress countries have made in achieving the ICPD goals and what obstacles they still face. Specifically, the inquiry focuses on: (i) policies and programmes in population and development; (ii) reproductive rights and reproductive health, (iii) HIV/AIDS; (iv) gender equality and women's empowerment; (v) adolescent reproductive health and youth; (vi) advocacy and behavioural change communication; (vii) partnerships and resources; and (viii) perspectives of developed countries, including population issues in their own countries. The questionnaire for developed countries covers issues relating to gender, reproductive health and HIV/AIDS, partnerships with NGOs and civil society, and international cooperation in population and reproductive health.

The 10-year comprehensive review of the ICPD PoA will reinforce and complement efforts to track progress in achieving the Millennium Development Goals. The report underscores that attaining the ICPD goals will contribute to the overarching development goal of poverty reduction.

**The global field inquiry report will be released during a special event at the annual session of the UNDP/UNFPA Executive Board, which will be held in June 2004 in Geneva.**


## New UNFPA report highlights need to address adolescents' reproductive health concerns as a global priority

Enabling the largest-ever generation of adolescents to protect their reproductive health is an urgent priority in the global fight against poverty and HIV/AIDS emphasizes The State of World Population 2003 report by the United Nations Population Fund (UNFPA). This year's report, subtitled Making 1 Billion Count: Investing in Adolescents' Health and Rights, examines the challenges and risks, including early pregnancy and high rates of HIV infection, facing 1.2 billion adolescents in a rapidly changing world. It makes the case for greater investments and expanded programmes to ensure that young people have the knowledge and means to stay healthy, as both a matter of human rights and an economic imperative (www.unfpa.org).




## The World Health Report 2003

The new World Health Report is a response to the alarming evidence of the widening gap in health between the rich and the poor worldwide. The Report outlines solid strategies for health care and public health to shape a healthier future for all. One issue to consider is that the WHO European Region is experiencing the fastest-growing HIV epidemic in the world, and significant further growth is likely. Low coverage by preventive services and severely limited access to treatment and care are the main reasons for the continuously worsening HIV epidemic in central and eastern Europe and the former Soviet Union. While the report as a whole makes for extremely interesting and timely reading, chapter two on the Millennium Development Goals and chapter three on HIV/AIDS are especially relevant for *Entre Nous*' readers.

**The full report is available online at www.euro.who.int**

# INTERNET RESOURCES

Josh Gross

## 10th Anniversary of the International Conference on Population and Development
www.unfpa.org/icpd/10/index.htm

A link directly to UNFPA's page commemorating the 10th anniversary of ICPD. A more dense and informative page cannot be found. It contains a summary of the ICPD Programme of Action and Key Actions Programme +5. The page has great navigation and a clean design.

## Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning
Population Briefs Vol. 8, No 2
www.popcouncil.org/publications/popbriefs/pb8(2)_1.html

Review of this book of 22 case studies, co-edited by Population Council researcher Nicole Haberland and consultant Diana Measham. The publication "adds a critical new dimension of analysis to the body of material evaluating efforts to promote ICPD goals."

## Population Action International
www.populationaction.org

Great site with thoughtful navigation and external links. The site contains diverse resources and many articles on populationa and ICDP such as: Why Donor Countries Must Renew Their Commitment to Population Assistance www.populationaction.org/resources/factsheets/factsheet_8.htm. Developing nations need financial support from wealthy countries for their efforts to improve reproductive health and slow population growth. Yet, five years after the International Conference on Population and Development (ICPD) in Cairo, donor contributions still lag far behind agreed upon ICPD funding targets. To achieve the conference goal of providing reproductive health care to all those in need, the wealthy countries must live up to their financial commitments. Featured article: World Population Day 2003: Spotlight on Adolescent Reproductive Health Care

## The Youth Coalition
www.youthcoalition.org

A brightly colored and youthful page full of vital information from this Ottawa based youth group. The navigation can sometimes be confusing making it difficult to know where to click. Plus the site is built up in frames so there are no links to individual pages
One article of interest presented on the page is: Report of the Youth Forum - ICPD+5 Almost 20% of the world's population, 1.06 billion people, is between the ages of 15-24; the largest generation of young people ever in history. It has to be recognized that the needs of young people differ from those of adults. These young people have an enormous potential for the development of their countries and the world as a whole. This document contains recommendations for realizing that potential.

## Article: Russia's Demographic Decline Continues
by Timothy Heleniak
Population Reference Bureau
www.prb.org

Recently released population estimates for Russia confirm the accelerating population decline that has been underway since the breakup of the Soviet Union more than a decade ago. The Russian population stood at 144 million on January 1, 2002, down 4.3 million from its peak at the beginning of 1992.

# STAY INFORMED

*By Jeffrey V. Lazarus*

**The e-mail bulletins presented here cover all aspects of sexual and reproductive health, from pure news to advocacy and scientific articles. They often allow you to pick and choose the categories of news most relevant to you and the frequency of delivery - daily, weekly or monthly. Subscriptions are free.**

## ASTRA

### www.astra.org.pl

The Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA) was established by organizations in the region who share common concerns and goals.
To subscribe send an email to: info@astra.org.pl, with “Please add to email bulletin” in the subject line.

## Development Gateway

### www.developmentgateway.org

The Development Gateway is an interactive site for information on sustainable development and poverty reduction, and a space for communities to share experiences on development efforts. The section entitled Population and Reproductive Health is moderated by experts from the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs and UNFPA.
To subscribe go to www.development-gateway.org and create a profile and choose which groups you would like to be a part of.

## Engender Health

### www.engenderhealth.org

EngenderHealth’s monthly bulletin offers an insider's look at their work in international family planning and reproductive health. The organization provides technical assistance, training and information, with a focus on practical solutions that improve services where resources are scarce.
To subscribe, follow the instructions at www.engenderhealth.org.

## EuroNGOs
### www.eurongos.org

The European NGOs for Sexual and Reproductive Health and Rights, Population and Development (EuroNGOs) seeks to translate the commitments of the International Conference on Population and Development into international cooperative programmes in the field of sexual and reproductive health in developing countries.
To subscribe to Worldpoplist, the mailing list for non-EuroNGOs members, send an e-mail to: alexandra.mueller@ dsw-hannover.de with your full name, e-mail address and organization.
EuroNGOs also runs nEUws, a summary of the latest developments at European Union institutions with regard to development aid, but with a focus on sexual and reproductive issues.
Subscribe at www.eurongos.org/english/news.htm

## Center for Reproductive Rights

### www.reproductiverights.org

The Centre’s listserve, Reproductive Freedom News, has links to updates on its reproductive rights cases, international advocacy efforts and new publications. Although very US focused, there is a “worldwide” section.
To subscribe, follow the instructions at www.reproductiverights.org.

## Communication Initiative

### www.comminit.com

Although the Communication Initiative covers all aspects of communication, there are special sections on health and HIV/AIDS on its website. Its listserve, the Drum Beat, includes a pulse poll on development and communication issues and a classifieds section.
To subscribe, follow the instructions at www.comminit.com.

## Global Health Council
### www.globalhealth.org

Although covering all aspects of health and very US focused, HIV/AIDS is frequently featured. There is also a classifieds section.
To subscribe, follow the instructions at www.globalhealth.org.

Jeffrey V. Lazarus

## Kaiser Network

### www.kaisernetwork.org

The mission of the Kaiser Family Foundation is to provide information on US and international health issues. Kaisernetwork.org has a comprehensive service with daily reports on reproductive health and HIV/AIDS, as they relate to health policy.
To subscribe, go to www.kaisernetwork.org/email and set up a user profile.

## International Planned Parenthood Federation

### www.ippf.org

The International Planned Parenthood Federation (IPPF) links national family planning associations (FPAs) in over 180 countries worldwide. It is registered as a charity in the United Kingdom and is the largest voluntary organization in the world working with sexual and reproductive health and rights. NewsNewsNews is a free, daily service featuring short articles with news from around the world. Subscribe at www.ippf.org/newsinfo/subs.

## The Johns Hopkins Bloomberg School of Public Health
## www.infoforhealth.org

The Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs INFO Project publishes the Pop Reporter, a weekly electronic bulletin which presents all aspects of aspects of sexual and reproductive health.
To subscribe, go to http://prds.infoforhealth.org/signup.php and set up a user profile.

## Population Reference Bureau

### www.prb.org

The Population Reference Bureau has two e-mail lists you can sign up for: PRB E-Mail News (looking at population issues) and E-Library (publications on different population and health topics).
To subscribe, follow the instructions at www.prb.org.

## Periodic Updates of Sexual and Reproductive Health Issue around the World (PUSH)
## www.pushjournal.org

This news service is the product of a partnership between the Communications Consortium Media Center and UNFPA, the United Nations Population Fund. Receive one e-mail a day, five days a week, containing all the stories on the topics you choose from the countries you select. Each day's edition of PUSH JOURNAL carries story headlines at the top and complete versions of each story below. PUSH adds no text or commentary.
To subscribe, follow the instructions at www.pushjournal.org.

## Planet Wire
## www.planetwire.org

Planet Wire is a newsroom for journalists who want the latest information about reproductive health rights and services, maternal and child health, women's empowerment and more. The serivce provides reporters with story ideas, facts and figures, expert spokespeople and information from organizations and government agencies to provide background on these issues.
To subscribe, follow the instructions at www.planetwire.org.

## Q-Web
## www.qweb.kvinnoforum.se

Q-Web is not just for men and is not only in Swedish. The Q-Web e-mail bulletins sporadically bring interesting news in the categories of your choice.
To subscribe, go to www.qweb.kvinnoforum.se and set up a user profile.

## Supply Initiative
## www.rhsupplies.org

The Supply Initiative works to meet the reproductive health supply needs for family planning, contraception, HIV/-AIDS and other sexual and reproductive health programmes.
To subscribe to their monthly newsletter, choose Supply News under resources at www.rhsupplies.org and follow the instructions.

## TerraViva
## www.ipsterraviva.net

TerraViva Europe is published by the international news agency Inter Press Service and provides special coverage of development issues, closely following the work of the European Union and its institutions. Reproductive health, AIDS and other population issues are reported in the context of global development issues.
To subscribe, follow the instructions at www.ipsterraviva.net.

## Youth InfoNet
## www.fhi.org/youthnet

Youth InfoNet is a one-stop monthly source for new publications and information on youth reproductive health and HIV prevention, that was just launched in December 2003. It provides information on programme resources and research articles. YouthNet is a five-year global programme to improve reproductive health and prevent the spread of HIV infection among youth aged 10-24.
To subscribe, send an e-mail to: youthnetpubs@fhi.org


Entre Nous

WHO Regional Office for Europe

Reproductive Health and Research Programme

Scherfigsvej 8

DK-2100 Copenhagen Ø

Denmark

Tel: (+45) 3917 1341 or 1451

Fax: (+45) 3917 1850

[entrenous@who.dk]

www.euro.who.int/entrenous

Entre Nous