IMPLEMENTING I C P D:

Moving Forward in the Eye of the Storm

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DAWN'S PLATFORM FOR CAIRO+5

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Between 1992 and 1994 DAWN – Development Alternatives with Women for a New Era – strongly invested in creating a Southern-based consensus on the linkages between Population, Development and Reproductive Health and Rights. The network mobilized debates and analyses in Latin America, the Caribbean Region, Africa and the Pacific in preparation for the International Conference on Population and Development (ICPD) in Cairo in 1994, and was fully involved in advocacy efforts during the Cairo negotiations. The DAWN strategy was informed by the understanding that adequate responses to women's reproductive needs and full respect for their sexual and reproductive rights are non-negotiable components of a gendered human development agenda.

Population policy has always been contentious. Clashes between different perspectives and points of view had occurred at both previous World Population Conferences, in Bucharest (1974) and Mexico City (1984). Never before Cairo, however, had there been so many sets of actors discussing population policies in the public arena. Nor had the transformation of the public debate ever been as profound. ICPD fundamentally shifted policy direction away from demographically-driven approaches towards policies grounded in concerns for human rights, social well being and gender equality, with particular emphasis on reproductive health and rights. This transformation confirmed that DAWN's strategic focus in the early 1990s had impact and meaning.

DAWN could not ignore the opportunity presented by the Cairo+ 5 Review of the Programme of Action adopted at the ICPD to assess and analyse the progress of implementation. A policy research effort was devised to appraise advancements and identify bottlenecks in the implementation of the Cairo Reproductive Health and Rights recommendations across the South.

In Latin America the research covered Bolivia, Brazil, Nicaragua, Peru, Puerto Rico, and Uruguay. In the case of Brazil, the basic data used in the analyses was collected from the Cairo in Action Project sponsored by the Population Reference Bureau (PRB). In South East Asia through collaboration with ARROW (Malaysia) a regional overview of implementation in Malaysia, Thailand, Indonesia,Vietnam, Laos, Cambodia and the Philippines was carried out. In addition, a specific country study of the Philippines was undertaken. In the Pacific a country assessment of Fiji was completed; the research effort is now expanding to include Papua New Guinea and regional trends. In South Asia a full assessment was carried out on India. Research on implementation in the Caribbean is still underway, but preliminary information was processed at an inter-regional meeting held in Mexico in November 1998. In Africa, national analyses were developed in the context of a meeting held in Doula, Cameroon, in January 1999 in which six West Africa countries were represented: Cameroun, Gabon, Ghana, Ivory Coast, Nigeria and Sao Tome and Principe.

Country analyses were guided by a common analytical framework addressing three interrelated dimensions: the pre-Cairo policy scenario; the identification of ICPD recommendations most relevant in each country; and the post-ICPD policy scenario. The assessments paid attention to five different aspects of the post-Cairo policy scenario:

- National level impacts of ICPD
- Progress observed with respect to reproductive health services
- Debates and legal changes affecting sexual and reproductive rights, with particular attention to unsafe abortion
- The political, economic and social environment in which implementation is taking place
- The presence and role of ICPD advocates and adversaries

This report has been designed as a mid-term product of the DAWN Cairo+5 policy research effort. It synthesizes the core findings of the national case studies undertaken within the analytical framework developed by DAWN for the Cairo+5 Conferences. It emphasizes progress observed between 1994 and 1998, but also identifies obstacles that, across the South, work to hinder the full accomplishment of committments adopted at the ICPD. In DAWN's

perspective, identifying obstacles is a necessary step toward outlining key future actions required to fullfill the Cairo consensus, which is the primary objective of the Cairo+5 Review. A publication of case studies in full is scheduled for the latter half of 1999 and is aimed at ensuring that the complexities entailed in ICPD implementation across the South and the richness of country-specific analyses are widely disseminated and appreciated.

DAWN's Cairo+5 effort provided a privileged opportunity to establish and renew partnerships and develop synergy with other networks, organizations and individuals involved in Reproductive Health and Rights advocacy. We are extremely grateful to all those who collaborated with us in this effort. The strong and positive responses received from researchers and activists who undertook the case studies, and the quality of the research performed under extremely tight time contraints, were encouraging and truly gratifying.

Box 1 Research Team

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THE PRE-CAIRO POLICY SCENARIO

Great diversity prevails among the regions and countries studied in terms of political, economic, social and cultural characteristics. Nonetheless, in what concerns pre-Cairo population policies, an amazing convergence was evident. In a large majority of the countries assessed fertility control policies prevailed. These ranged from the dogmatic Malthusian guidelines – such as those implemented by the Family Welfare Program in India and by BKKBN in Indonesia – to blander versions in which assessments of program success rested largely on the contraceptive prevalence rate (CPR). This latter approach was evident in most South East Asian countries, in Fiji and to a less extent in West Africa.

Another commonality is identified in countries – mostly in Latin America but also in Francophone Africa – where strong resistance to Malthusian approaches marked the policy debate in the decade preceding Cairo. In a few cases – Puerto Rico Rico and Bolivia being examples – in addition to the pro-natalist political and cultural climate peculiar to the time, sterilization abuse episodes documented in the 1970s and early 1980s provided strong arguments against any state intervention with respect to fertility. In Nicaragua and Uruguay, the influence of pro-natalist stances remained strong in the immediate pre-Cairo period. Everywhere the historical pro-natalists versus anti-natalist controversy sigificantly delayed the necessary reframing of policy agendas to better respond to women's reproductive health needs through the public health system.

But exceptions did exist. In the English Speaking Caribbean, the implementation of family planning programs was never subject to great polemics and programs have been historically more integrated with broader reproductive health care. After the sterilization scandal of the

1970s, access to reproductive health services expanded in Puerto Rico, including legal abortion services.

Most importantly, however, policies were evidently already being transformed, in some instances long before Cairo. In most of the surveyed countries, the perceptions of governmental officials were that national policy changes preceded Cairo. While it is true that a number of governments, particularly in South East Asia, had effective social development and anti-poverty policies in place two decades prior to Cairo, it would be appropriate to say that these policies were in line more with the agreements of the First World Population Conference held in Bucharest in 1974 than with the Cairo agenda *per se.*

Nonetheless, there are a few examples in which the Cairo consensus was clearly anticipated. In Brazil and in the Phillippines, the heating up of the population debate during the 1980s led to very clear and positive policy changes long before Cairo. Similar trends occurred in India, Bolívia and Peru, albeit later in time. In these cases first moves towards changes immediately preceded ICDP. In all these cases, the role of women's organizations was crucial in documenting and denouncing the limitations of prevailing policies and advocating for transformation. These efforts have gained legitimacy and visibility in pre and post-Cairo national debates.

Box 2 Pre-ICPD Policy Changes: A Few Examples

Brazil – In Brazil a comprehensive approach to reproductive health was defined in 1984. This was initiated in the context of political democratization which brought the population debate to the forefront of the policy arena and saw the Ministry of Health formulate a Comprehensive Women's Health Program (PAISM) covering all the components defined in Para 7.6 of the ICPD Program of Action. The 1988 Constitution recognized reproductive self-determination as a right and defined provision of comprehensive reproductive health services - including contraceptive assistance – as a State responsibility. The constitutional text did not include a right to life since conception provision. After 1984 efforts were made to ensure access to abortion in the two cases permitted by the Penal Code in the public health system: rape and women's life risk. A first service was established in São Paulo in 1989.

Philippines – In 1987, a presidential directive lodged the Philippine family planning program with the Department of Health (DOH). The Commission on Population (POPCOM) that had earlier been in the forefront of implementing the country's family planning program now functioned as a coordinating agency on population whose primary concern became limited to policy formulation, information and education. Family planning became a "health issue with population implications, as opposed to family planning as a population issue with a health aspect." However an article in the 1987 constitution had a negative impact on Filipino women's reproductive health and rights: Article II, section 12 "prevents Congress from legalizing abortion and the Supreme Court from passing any pro-abortion decision."

Bolívia – In spite of strong opposition to population control, family planning programs were initiated, in 1983, through workers and peasants unions whose leaders were concerned with high maternal mortality rates. In 1989, a paragraph was included in the Child Development and Maternal Health National Plan outlining strategies directed toward women in fertile age groups and adolescents to avoid unwanted pregnancies. In 1990 the National Reproductive Health Program was formulated in which the rights of the women gained prominence. A National Committee for Coordination in Reproductive Health was created involving governmental and international agencies and NGOs. In 1993, the National Plan for Maternal, Neo-Natal and Infant Mortality Reduction prioritized woman's health and became itself a priority in the national political agenda.

India - Since the 1970s, the Indian Family Welfare Program has been critized, nationally and internationally, especially in relation to male and female sterilization abuse. By the early 1990s, the government recognized that innovation and dynamism were missing in the program: *"The Family Welfare programme has essentially remained a uni-sector programme with centralised target-setting, lack of pre-service and in-service training, and a monitoring mechanism that is incapable of identifying roadblocks or applying timely correctives"*. (8th Five Year Plan -1992-97, Planning Commission of India). In preparing for ICPD a high-level expert committee constituted by the government delivered a report calling for a new National Population Policy and for a shift away from a focus on fertility reduction per se to an approach based on human development that would be *"pro-nature, pro-poor, and pro-women"*.

Peru – In 1985 a National Population Policy Law was approved, aimed at articulating previously uncoordinated initiatives and better integrating the Family Planning and MCH Programs. For the first time in the country the right of people and couples to make free, informed and responsible decisions, and the equitable treatment of both sexes in reproductive matters were acknowledged. Policy guidelines included the prevention of abortion and its complications but expressly excluded the use of abortion and sterilization as methods of family planning. This shift, although limited, provided the initial ground for policy changes introduced through the impacts of both Cairo and Beijing.

MOVING FORWARD

The primary finding of this policy research effort is that ICPD has had effective impact at the national level across the South. The scope and depth of this impact, in each case, is related to the prevailing political, cultural, social and economic conditions in each country, as well as to processes affecting reproductive health policies and legal frames that were already underway prior to Cairo. In almost all countries, however, some movement towards policy transformation has definitely occurred. Language has changed; ICPD terminology is being spoken and used by governmental institutions and in public debates; and family planning programs are being renamed Reproductive Health Programs. A semantic revolution is underway.

Another common thread weaving together country experiences across the diverse regions is the strong synergy between post-Cairo and post-Beijing implementation. Assessing ICPD impacts requires also evaluating the policy effects of the Fourth World Conference on Women (FWCW), particularly in those aspects that relate to gender equality and equity, violence against women, and reproductive health. In many countries, preparations for and the aftermath of Beijing mobilised the energies and imaginations of both women's organizations and governmental agencies. Besides creating an enabling environment for the dissemination of ICPD premises, the health section of the Beijing Platform went beyond ICPD with respect to abortion and sexual rights, providing stronger arguments for advocacy work in controversial areas.

The tables presented in the following pages synthesize the advancements observed at country level in relation to five strategic dimensions of the ICPD Program of Action:

- Reproductive Policies and Services including adolescent and male-oriented services
- Gender Equality and Equity (Policy Level and Legal Levels)
- Abortion
- Sexual and Reproductive Rights
- Legal Frameworks, Monitoring and Accountability Mechanisms

Table 1a Progress Made: Reproductive Health Policies and Services ***(Caribbean, India, Fiji)***

Caribbean	**South Asia (India)**	**Pacific (Fiji)**
The two major post-ICPD developments in the Caribbean, in terms of services, concern the establishment of reproductive health services for men, and efforts focused on HIV/AIDS. Two clinics providing reproductive health services to men have been established in the region: in Trinidad and Tobago where the Family Planning Association of Trinidad and Tobago (FPATT) established a clinic in 1996, and in the Dominican Republic, where a male RH service, Profamilia, has been set up by NGOs. Although HIV/AIDS prevention policies have remained relatively fragmented until recently, and many countries have not been committing resources to HIV/AIDS, new interesting initiatives	Having ratified the ICPD Program of Action the Government of India, in collaboration with the World Bank, undertook a review of the Family Welfare Program (FWP). The report on this review urged that the policy should: • Move from target - incentives to client-centered program management • Expand the range of users choices in reproductive health services • Build partnerships with Panchayats (local government bodies) and non-governmental organizations to strengthen the client oriented focus. The report advocated a Reproductive and Child Health (RCH) approach that modifies and combines the Family Welfare, Child Survival and Safe	The Family Planning Program has been renamed Reproductive Health Program. Its goal is to provide: *'High quality comprehensive health services …to promote and maintain the development of a healthy family, reduce maternal and perinatal infant morbidity and mortality, and raise the standard of living for mothers and children'.* UNFPA assistance to Fiji during 1998-2001 is supporting expanded access to Reproductive and Sexual Health Services particularly for under-served communities, youths and adolescents. It also supports the training of health workers and the integration of adequate midwifery and human sexuality content in the Nursing School curriculum; operational research, data collection and public education, establishment of a

UNAIDS, a new program is targeting the youth and tourism sectors, with NGO participation. A regional plan has been formulated in which there is a clear effort to support the participation of PLWAs (Persons Living With HIV). An organization has been formed to support their networking and strengthen their participation. In Aruba, women's organizations are also working at prevention. In Surinam, attention is being given to strengthening the organization of sex workers. There is also recognition of the need to strengthen prevention programs on HIV/AIDS in view of the likely expansion of the mining industry. In Trinidad, a meeting was organized by CARE (Community Resource and Research Centre), an organization which supports PLWAs – with the Cabinet. Despite much backlash, the Minister of Health decreed that condoms will be made more available. The system to put that in place has already been established.	address reproductive tract infections and sexually transmitted diseases and increase the safety of abortion services. But as early as 1995 the target free approach had already been adopted in Tamil Nadu and Kerala.	Reproductive Health Training Program and research in reproductive health. Two Pacific regional surveys are planned, one on adolescent fertility and another on women's perspectives on reproductive health services.

Table 1b Progress Made: Reproductive Health Policies and Services (Latin America I)

Bolivia	**Brazil**	**Nicaragua**
A comprehensive women's and sexual health policy was defined as a priority in 1994 (Strategic Health Plan). The policy stressed that services should provide comprehensive reproductive health care, rather than simply family planning. The scope of contraceptive options was expanded and campaigns were launched for anti-tetanus vaccination and breast and cervical cancer prevention. The number of hospital based child deliveries increased from 70,927 in 1995 to 83,165 in 1996; the number of pap smears increased from 47,919 to 72,318; and the number of contraceptive users jumped from 12,000 in 1993 to 88,000 in 1996. Government services were created to address adolescent and youth health in La Paz, Santa Cruz, Tarija and Sucre. News norms and protocols were developed. Health Insurance for Maternity and Children (1996) and Basic Insurance for Health (1997) are helping to erode economic barriers to service access. A training program for medical students	The 1994-1997 period was one of relative institutional and economic stability. It also witnessed a positive evolution in terms of consolidation of the public health system. Under the impacts of ICPD and Beijing, the National Women's Health Program (PAISM) was re-vitalized. Greater integration developed between PAISM, the Adolescent Health Program and the National STD and Aids Prevention Program. A target was set for the year 2000 to reduce maternal mortality to 115 deaths/100,000 births but this definition is currently being revised. Pre- natal care consultations increased from 2.8 to 4.2 million (50%) between 1994 and 1996. The increase was a particularly positive result of newly adopted primary health programs. Financial incentives were introduced for natural childbirth and State Referral Systems were created for risk pregnancies. Percentile ceilings were established for C-Sections in public hospitals: 40% at the end of 1998, 37% in July of 1999, 35% at the end of 1999,	Reproductive Health Services are provided through a Comprehensive Program for Women and Child Health that replaced, from the 1980s, the former MCH Program. A National Health Policy formulated just before ICPD combined conventional guidelines such as safe motherhood initiatives with premises that would converge with Cairo recommendations, such as an emphasis on preventive health care, a gender approach and sexual education. Reproductive Health guidelines were defined by the Comprehensive Women and Child Health Model and the following targets for the 1996-2000 period were established: • 50% reduction in maternal mortality rates • Expansion of pre-natal care to reach 100% coverage in the year 2000 • Expansion of hospital based childbirths from 55% (in 1996) to 80% in the year 2000 • Increase in contraceptive prevalence rate from 10% in 1996 to 40% in the year 2000.

in gender and sexual and reproductive health has been established at the Faculty of Medicine.	and 30% in the year 2000. A pilot program for cervical cancer screening (Viva Mulher) was implemented in five cities in 1996. In June 1998 the National Cervical Cancer Screening Program was launched. During August-October 1998 screening peaked to more than 3 million women. A new strategy to ensure the provision of reversible contraceptive methods to under-served groups is being devised. Condom provision has expanded both through public and private outlets. Anti-retroviral drugs have been provided freely and universally since 1996 to some 60,000 persons who are HIV positive or AIDS infected. AIDS mortality rates have been reduced in the two main metropolitan areas of the country.	• More recently sexual and reproductive health services for adolescents have begun to be implemented at provincial levels. A major limitation of the policy as it is being implemented is the reluctance to adequately address unsafe abortion and provide post-abortion care.

Table 1b Progress Made: Reproductive Health Policies and Services (Latin America II)

Peru	**Puerto Rico**	**Uruguay**
After Cairo the Peruvian Government gave priority to population and development. The national policy is focused on reducing concentration in big cities, including the organized return of those displaced by terrorist violence. Family planning has been adopted as a core strategy of what has been called the 'war against poverty'. The National Population Policy Law was modified to include voluntary surgical contraception as a contraceptive option. In the same year, the Ministry of Health made the provision of family planning services free, and began to promote IEC activities across the public health system. Significantly, the policy also emphasizes the promotion and full exercise of women's rights. In February 1996, a Reproductive Health and Family Planning Program was approved. The Program includes a Plan for Reduction of Maternal Mortality and encompasses new norms for obstetric emergency procedures**.** Other priorities are post-abortion treatment, HIV prevention and gender violence care. On the whole, efforts are being made to incorporate quality care into the country's public health services**.** In a country affected by a long-standing economic crisis, Peruvian NGOs have in	Until 1994, the Puerto Rican government did not have a Sexual and Reproductive Health Policy although the Department of Health still offered MCH care, attention to adolescent pregnancies, family planning, and STD–HIV/AIDS prevention. These programs were jointly funded by Puerto Rico and the US federal government budget. Contraceptives which were available were supported by federal funds and distributed in many municipalities. ICPD received little if any attention from government officials. Nevertheless, some NGOs participated in preparatory regional meetings prior to the Conference, as well as in Prep Comm III, in New York. However, in September 1997, the Department of Health promulgated a Sexual and Reproductive Health Policy based on the conclusions and recommendations of a workshop in which NGOs had played a strong and effective role. The document picks up some elements of the ICPD Program of Action, among them, the definition of reproductive health, attention to STDs and the needs of adolescents, guarantee of quality attention and participation of NGOS. Important limitations in the effective implementation of these guidelines are evident, as we shall see	In early 1996 new reproductive policies were defined both nationallly and at the municipal level within the capital, prioritizing the provision of services to lower income groups. The goals of the National Policy are to improve people's capacity to exercise their reproductive rights and responsibilities, and to reduce reproductive health risks, infant mortality, unwanted pregnancies and abortions. A training program has been launched to improve care in 19 Health Centres across the country. Focal approaches have been adopted for cervical cancer screening and HIV-AIDS prevention programmes. In the Montevideo Health Department the Comprehensive Program on Women's Health Care has been conceived as a cross-sectorial initiative involving the Women's Health Division and the Municipal Women's Comission. Its core guidelines or goals are: • Informed and Voluntary Maternity (through provision of contraceptive assistance) • Prevention of Cervical and Breast Cancer • Comprehensive Pre-Natal and Post Partum Care.

would otherwise be State responsibilities. After Cairo, NGO initiatives have expanded in the area of reproductive health care. One example is the Consorcio Salud Project that monitors quality of care, mostly within the capital (Lima). **A** large pilot program is currently being developed for the various remote provinces (Reprosalud Project) with a view to assisting the identification of users' perspectives, improving quality of care and supporting the monitoring activities performed by women's community based organizations with respect to provided services.	later.	

Table 1c Progress Made: Reproductive Health Policies and Services (South East Asia I)

Cambodia and Laos	**Indonesia**	**Viet Nam**
Cambodia and Laos are two countries in which progress regarding reproductive health services can be unequivocally claimed as a direct impact of ICPD. New "population policies" defined after 1994 emphasize birth spacing and safe motherhood instead of exclusively focusing on fertility control. They also include statements on rights, which is very encouraging. Cambodia has a progressive Birth Spacing Policy (1995) in which the access of all women to contraceptives is affirmed as a right: *"All women regardless of age, marital status, ethnic or religious background, have the right to decide…."*. With the technical and financial support of donors efforts are being made to expand health infrastructure and primary health care.	The Indonesia case is also an exception as it is the only country in which the government claims to have always been committed to women's reproductive health. This was said to be manifest in the existence of a family planning program since the 1970s, a safe motherhood program since 1988, and efforts to improve the quality of family planning services. More recently the government established a network with several NGOs to promote women's reproductive health both through education and service provision. Many officials regarded the ICPD Program of Action as merely reconfirming Indonesia's position. The NGOs interviewed, however, considered that in various aspects national policy had not yet completely recognized the spirit of ICPD, specifically that of Chapter VII, i.e. the recognition of every individual's reproductive needs and rights with no legal or cultural constraints. Nonetheless, it must be acknowledged that the "Mother Friendly Movement" initiated by the Ministry of Health in 1997 to reduce maternal mortality was innovative and serious in intent.	Viet Nam had also implemented a population control policy prior to 1994. But even before Cairo, awareness was expanding in the country with respect to reproductive health needs beyond the provision of family planning. Viet Nam's population program was being criticized as having some major problems of quality and insufficient choice of contraceptives Immediately after Cairo the Quinacrine episode put Viet Nam under the spotlight, and new policy agendas have since begun to emerge. Health infrastructure is better than in other countries in the IndoChina region. The government is making efforts to reform the weaker parts of its family planning program, concerning unsafe abortion and contraceptive choice. Innovative research efforts are also being developed to elaborate women's perspectives on reproductive health services**.**

Table 1c Progress Made: Reproductive Health Policies and Services (South East Asia II)

Malaysia	Philippines	Thailand
As in other countries, the Family Planning Program has been renamed the Family Health Program. Demographic targets for family planning acceptance are no longer used. The range of services has widened to include information and counseling for adolescents, more accessible reproductive cancer screening and better quality maternal health services. The Family Health Program reaches out to all age groups, high-risk women, and marginalized groups such as indigenous communities. In 1996, an Adolescent Reproductive Health Survey (1996) was conducted. Its results are being used to formulate a National Adolescent Program.	Before Cairo the Population Commission and the Department of Health were already defining their respective women-oriented programs on population and family planning. After ICPD and FWCW, a new Philippine Family Planning Program (PFPP) was adopted by the DOH, comprising three components: • Integrated Family Planning/Maternal Health Program (IFPNHP) • Strengthened management and field implementation with a women's health care orientation in three tracks • Women's Health and Safe Motherhood Project (WHSMP) In 1998 the DOH established a national structure for its Reproductive Health Program. A tentative system of coordination between the policy-guiding POPCOM and the service-provider DOH is also being established. The Reproductive Health Program is funded by USAID. The Women's Health and Safe Motherhood Project (WHSMP) is the showcase project for 1995-2000. Aimed at reaching 77 provinces, it has four components: (a) maternal care, (b) family planning, (c) diagnosis and treatment of RTIs and STDs, and (d) detection and treatment of cervical cancer. The Program also includes innovative pilot areas where there is special need for a client-oriented perspective in service delivery.	Health policy makers consider that the Cairo conference did not have a major impact on the Thai population policy as it was already in transition before 1994. Demographic targets have been abandoned and a new institutional frame is being established to better integrate previously existing programs. Under the proposed new structure, preventive health programs of the Department of Health will be merged into holistic life-cycle programs. Health services will be divided into two main fields: preventive and curative. Family planning and reproductive health programs will be under the preventive health plan which will target health programs to four different categories (infants and mothers, student and youths, working-age people and the elderly) and include preventive health, MCH and Family Planning services. The new focus on unmet needs throughout the life cycle is a priority particularly for adolescents, hill tribes, and the Muslim population in the south.

Table 1d Progress Made: Reproductive Health Policies and Services (West Africa I)

Cameroon	Gabon	Ghana
Since Cairo access to Reproductive Health Services has improved - 160 clinics across the country now provide reproductive health services. Four Youth Health Centers have been established. A training program on Reproductive Health has been introduced for Health Personnel	In 1960, Gabon adopted an open pro-natalist policy that prohibited the use of contraception. However in 1997 a National Program on Population and Development was approved that includes references to reproductive health and family planning. In 1998, a new law on Public Health and Social Protection of mother and child redefined the role of public health and social welfare, emphasizing Reproductive Health and Family	In 1996, a National Plan for Economic and Social Development (NESDP) up to the year 2020 was adopted. This was followed, in 1977, by a National Reproductive Health Policy which addresses fertility, family planning, health, morbidity, mortality, AIDS, gender equality, empowerment of women, reproductive health and rights, and the family (its role, rights). Pre-Cairo, the National Population Council (NPC) included in its guidelines Cairo premises on Reproductive Health and

	Planning. In 1998, delivery centers were created and access to reproductive health services was increased. In 1998, a new law was introduced to promote education in Biology in 2 schools. Overall there has been a marked increase in activities concerning Reproductive Health Issues.	male responsibility. Reproductive Health has been integrated into pre-existing family planning programs. Programs for prevention of infertility and sub-fertility have been introduced. Safe motherhood has been integrated into primary health care programs. Prevention of STDs including HIV/AIDS is a priority. Big private companies, concerned about labour losses through HIV/AIDS, are providing funding for IEC on AIDS and conducting educational activities in the workplace; A new policy on adolescent reproductive health services and information has also been adopted. There is much more media coverage of sexual and reproductive health matters.

Table 1d Progress Made: Reproductive Health Policies and Services (West Africa II)

Ivory Coast	**Nigeria**	**São Tomé and Principe**
The implementation of a Program for Integration of Development Services ensures that integrated reproductive health services and family planning are provided in all districts. Family Life Education has been integrated into the civic education curriculum that is a component of basic education.	Since Cairo and Beijing there has been an upsurge in NGO efforts to create awareness on women's empowerment and women's and adolescents' reproductive health issues. A coalition of Nigerian NGOs on Health, Population and Development – CONNOHPD – has been formed to provide information and mobilize for the representation of "Voices from Below". National Guidelines on Sexuality Education have been established. In late 1998, the National Health Council made recommendations for the adoption of a reproductive health approach, in line with Cairo recommendations, for the delivery of primary health care. MoH, UNFPA, WHO and other funding agencies are working in partnership to organize a National Conference on Adolescent Reproductive Health.	A National Program on Reproductive Health was sponsored by UNFPA just before Cairo, and expanded after Cairo. Family services are now being provided at all district levels. STDs prevention has been added to family planning services. Family Life Education has been introduced into the secondary school curriculum. There is a NGO-run weekly radio program on reproductive health.

Table 2a Gender Initiatives: A Few Illustrations

Latin America and the Caribbean	**South East Asia and the Pacific**

Caribbean Region – Gender planning is being incorporated at all policy levels and sectors. Violence against women has become a priority program directed at male involvement and male responsibility. Innovative projects are being developed through the media and at private enterprise levels. **Bolivia –** Gender planning is being incorporated in policies and programs at all levels. The Intra-household Violence Law was approved in 1995. In 1997 the Political Quota Law was passed. The National Plan for Equality of Opportunity was approved but the Equality of Opportunity law has not been yet promulgated. Proposals are being debated to ensure that there are no sexist guidelines for basic education programs. **Brazil –** Legal provisions have been approved including a Political Quota Law. The National Human Rights Program prioritizes gender equality and racial parity. Labor related affirmative action is being debated. A campaign for Preventing Intra-household Violence was launched in 1998. **Nicaragua** – The Constitution ensures gender equality and the Right to Health. Article 74 defines State obligations regarding human reproduction matters. The Women's Forum organised a first meeting on Women and Politics which formulated a National Minimal Agenda to promote equality of opportunity between women and men. The issue of intra-household sexual abuse has also gained enormous visibility under the impact of the Ortega-Zoilamerica episode. **Peru –** Resolution OT 26583, of March 1996, approved the Convention to prevent, sanction and eradicate all forms of violence against women. A later policy defined that police delegations should also consist of female officers and this should be extended countrywide. New guidelines have been approved with respect to gender sensitive sexual education for the public school system. Also in 1996 the Ministry for Women's Affairs and Human Development (PROMUDEH) was created. In the same year, a Specialized Public Defense Board on Women's Rights was established. In 1997 a new electoral law was passed defining a 25 percent quota for women. **Puerto Rico** – There is effective legislation against domestic violence, reinforced by the North American government's budgetary assignments for projects in this area, as well as other legislation in favor of gender equality at the family and work place levels. More recently, educational projects on gender justice have been developed. **Uruguay** – A Women's Rights Commission has been created at the level of the municipality of Montevideo. The integration of gender perspectives is also expanding at policy levels. Particular emphasis is being given to programs of non-sexist education.	Across the region gender equality programs have become much more articulate after Beijing. Legal reforms of discriminatory laws and new legislation on VAW to protect women's rights have been slowly increasing due to women's NGOs advocacy efforts and increased government commitment. All South East Asian countries ratified CEDAW in 1995. Most governments claim to be in the implementation stage of gender equality strategies. In 1996 the Indonesia family planning program sponsored income-generating programs to redress women's economic inequality to favor more autonomous reproductive choice. **Philippines** – The most relevant recent development has been the new gender-responsive population policy formulated by POPCOM in collaboration with women's NGOs. The five components of the re-defined population management program are (1) reproductive health and family planning (RH/FP), population and development planning (POPDEV), adolescent health and youth development (AHYD), gender and women's empowerment (GENDER), and migration, population and environment (MIGRATION). **Fiji –** The Fiji Government's ratifying of CEDAW was an important outcome of the Cairo, Copenhagen and Beijing conferences. Gender planning and analyses are also being designed to assess poverty trends. The Ministry of Women and Culture recently launched a national strategy to fulfil commitments made at the WSSD in Copenhagen and the WCW in Beijing. This included a Plan of Action Against Violence Against Women and Children. At the society level the most active women's advocacy organizations are involved with gender and sexual violence issues.

Table 2b Gender Initiatives: A Few Illustrations

India	**West Africa**
The major impact of ICPD and Beijing has been the mobilizing of women from hitherto unreached regions of the country. The creation of NAWO (National Association of Women's Organizations) has brought a new network onto the scene. The main advocacy emphasis in the country has been	**Cameroon** – A Policy on Environment, an Action Plan on Women and Development and Sector Planning in Education incorporating gender perspectives have been adopted. At the society level, there is greater awareness of gender inequality and women's issues and NGO coalitions have been built to

on political empowerment: • Building the capacity of elected women representatives in local and municipal government bodies (where women have a quota of one-third of the seats reserved for them after recent amendments to the Constitution of India) • Pushing for a quota for women in the Parliament. More directly related to the health agenda is the UNFPA's new five-year Integrated Population and Development Project being implemented in 7 states that supports service provision for comprehensive reproductive health care in select districts. For the first time, in some of the states, funds for strategies to deal with violence against women (VAW) have also been provided.	overcome legal barriers. **Gabon** – After Beijing, initiatives are being implemented to reform the legal framework to redress gender inequality. **Ghana** – Research and documentation on women's issues have expanded. There is increased awareness on the issue of gender violence, e.g. practice of "TROKOSI" or shrine slave brides, is now being liberated. Small-scale community-based valley-bottom irrigation schemes and other programs to increase productivity and reduce poverty are being implemented with a gender perspective. Also micro-credit facilities for women's empowerment are prioritized. These various initiatives are related to the adoption, in 1996, of a National Economic and Social Development Plan (NESDP) up to 2020. Donor agencies have widened support for poverty-reduction activities and institutional strengthening. At the NGO level women's organizations are moving from project approaches to program and capacity building activities in rural areas. Two NGOs involved with women and media issues have been created. **Ivory Coast** – Since Beijing, women have been nominated for diplomatic and administrative positions. There has been an investment in micro-credit policies. At the societal level new women's NGOs are being created and NGOs' professional skills are increasing. **Nigeria –** There has been an upsurge in women's NGOs, since Cairo and Beijing, creating greater awareness on issues dealing with women's empowerment and reproductive health. Public awareness of gender issues has increased through media discussions on women's issues. An outstanding initiative was the "100 Women Group" strategy aimed at increasing women's involvement in politics. **São Tomé** – A Department of Women has been created in the Office of the Prime Minister. Micro credit projects for women's empowerment are being implemented although not well coordinated. The necessary reforms in legal frames have not been addressed and CEDAW has not been ratified.

Table 3a Progress Made: Abortion (Latin America I)

Bolivia	**Brazil**	**Nicaragua**
The existing legislation allows for abortion in the case of rape and risk to life. But access to procedures is not guaranteed. Prior to Cairo the Declaration on Population and Reproductive Health prepared by women's NGOs had called for the recognition of abortion as a major public health problem. The Latin American Abortion Campaign for legalizing Abortion (Campaign 28 of September) has since 1994 advocated for broadening the law as a matter of social and gender justice. A First Pan-American Conference of Parliamentary Doctors that took place in Bolivia has helped to gather support for reforming legislation and recognizing abortion as a	In 1994 two abortion services to assist in cases of rape and life risk were already established. Various proposals aimed at decriminalizing the practice were pending in the National Congress. One Bill required the Public Health System to universally implement legal abortion services (PL20-1991). Between 1995 and 1998 harsh legislative battles took place. But great progress has also been achieved with respect to the expansion of services. In 1995 a proposal was presented to the National Congress to include a "right to life since conception premise" in the Constitutional text. The proposal was defeated. In 1997, PL20-1991 was approved by a narrow margin of votes in	Neither previous national Constitutions nor the 1995 reformed text mentions abortion. The criminalization of abortion is defined in the Penal Code promulgated in 1871. The law is particularly severe with respect to clandestine abortion providers. The only circumstance in which the procedure is allowed is for therapeutic reasons (women's life risk) and the law requires that the decision must be scientifically backed with the approval of two medical doctors and with the husband's or a relative's consent. Nicaragua expressed reservation on para 8.25 of the ICPD PoA and existing policy documents underline the premise that abortion is not to be used as a

advocacy groups are concentrating their attention on a strategy to modify the Penal Code (article 266) through mobilization of medical professionals, legislators and lawyers. The new Reproductive Health Policy includes a training component aimed at changing attitudes to women who have undergone clandestine abortions. Under the pressure of NGOs and the ICPD monitoring committees both the Basic Health and Maternity and Childhood Health Insurance packages are now committed to incorporating hemorrhages in the first trimester in the list of interventions that must be subsidized by the State.	Justice. An open hearing session was held in Congress a few months later to process the resulting legislative controversy. The Bill is still pending approval. In the context of Penal Code Reform propositions have also been made to increase the number of circumstances allowing for the interruption of pregnancy. It seems clear that the law will extend abortion to cases of severe fetal abnormality and reduce penalties. The number of "legal cases abortion services" increased from two to fourteen. Presently access to abortion in the case of rape and life risk is available in at least one city in each region. There has also been a rapid expansion in innovative and qualified post-abortion treatments. In October 1998 MoH approved a protocol defining guidelines for the universal establishment of "abortion services in the two cases permitted by law " across the Public Health System.	method of family planning. Although reduction of maternal mortality rates is emphasized in the 1996 Reproductive Health Policy, no priority has been given to unsafe abortion treatments. On the other hand, women's health centres have been extensively providing good quality post-abortion care since the 1980's. The reluctance to consider unsafe abortion a prevalent public health problem is one of the major flaws observed in national policies since 1994.

Table 3b Progress Made: Abortion (Latin America and The Caribbean)

Peru	**Puerto Rico**	**Uruguay**	**Guyana**
Punitive abortion legislation in Peru was introduced in 1991, making the interruption of pregnancy to be interpreted as a crime against the body and health. The Sanitary Code, Article 17 establishes that: "Human life begins at conception. Therapeutic abortion is only allowed when other means do not exist for saving the mother's life, with her consent and with the previous opinion of two doctors". The code also prohibits therapeutic abortion based on moral, social or economic considerations; or as a means for fertility control" However, the Reproductive Health and Family Planning Program 1996-2000, recognizes that abortion is a major public health problem and defines guidelines to provide medical treatment and psychosocial support to those who have suffered it. Cairo has created a more favorable climate for advocating for legislative changes. Mobilization for	Elective abortion, in principle, is available in the public health system in cases of violation, incest or when the woman's life is in danger. Access to abortion in Puerto Rico has been directly affected since the late 1970's by the Pro-Life initiatives promoted by the North American Congress (i.e. the reduction of federal funds for social and health services, in particular, abortion) Also in the years immediately after Cairo, under the impact of health reform, funds have also been restricted for abortion provision and treatment. The result is, that in practice, abortion is only accessible in the private clinics. The 1997 Reproductive Health Policy does not mention abortion but defines the promotion of sexual education based on abstinence.	The Law criminalizing abortion dates from 1938. In 1993 a Decriminalizing Bill was presented to Parliament but was not approved. A new bill aimed at regulating the voluntary interruption of pregnancy was presented in 1998 to the Congress Health Commission but it has not yet been processed. New federal and municipal reproductive health policies include abortion prevention and treatment among the priorities.	In 1993 the Ministry of Health announced its intention to revise laws criminalizing abortion. An all-party Special Committee was created in Parliament to evaluate the proposal. In May 1995 the Parliament approved the Committee's Bill without any amendment. The Medical Termination of Pregnancy Act allows for abortion procedures upon request for up to 8 weeks under the following circumstances: life-long physical or mental threat to women; mental illness prevention; care of an infant; rape; incest; and up to 16 weeks in the case of HIV infection and contraceptive failure. Beyond 16 weeks - to save the life of the woman or to prevent permanent injury to the physical or mental health of the woman or the fetus.

changes is taking place through the LA Regional Campaign for Legalizing Abortion.			

Table 3c Progress Made: Abortion

South East Asia	**South Asia (India)**	**Pacific (Fiji)**	**West Africa**
Almost no progress is documented in the region, in the area of abortion besides Cambodia and Viet Nam. In Viet Nam, action has been taken by the Health Ministry to reduce unsafe abortions. Cambodia has a new liberal Abortion Act for approval in 1998 that includes women's rights language. In other countries even basic information on the prevalence of safe and unsafe abortion, and women's own experiences and needs has not yet surfaced. For most government personnel interviewed, abortion is regarded as a controversial western agenda contravening religious and cultural principles. In the Philippines the "right to life since conception provision" adopted in 1987 remains a major legal and political obstacle to move forward the unsafe abortion agenda. However as has been indicated before, the new Reproductive Policy conducted by DoH prioritizes prevention of abortion and management of its complication**.**	Abortion has been legal since the Medical Termination of Pregnancy Act of the early 1970s, yet safe abortion services are not part of the public health services in much of the country. A powerful medical lobby has prevented the shift to simpler technologies for menstrual regulation. Because of the lack of access to public services, women seek abortion through high-cost private providers. One of the strategic components of the Reproductive and Child Health Program is to improve abortion procedure safety and quality of care.	The Fiji penal law allows for the termination of pregnancy when the mental or physical health of the woman is under threat. Although this formulation would provide room for expanding access to safe abortion procedures no initiative in that direction has taken place after 1994.	Amongst the six West African countries included in the survey, only in Ghana has a positive development been registered with respect to abortion. Previous punitive laws were reviewed before Cairo. A woman can have access to safe abortion once two doctors agree that she needs it. However information on the laws has not been extensively disseminated and many women still resort to clandestine and unsafe procedures. In all the other countries abortion is criminalized although extensively used as a fertility regulation resource. No striking advancement has taken place as a result of ICPD or Beijing policy impacts.

Table 4 Legal Framework for Sexual and Reproductive Rights (other than abortion rights)

Latin America and the Caribbean	**Asia and the Pacific**	**West Africa**
Reproductive Rights – Almost everywhere, legislation has been changed to favor access to contraception and reproductive health services. In the case of Latin American countries, this step forward has to be understood in light of the pro-natalist ethos that	**Reproductive Rights –** The notion of reproductive rights is viewed with suspicion in most Asian countries particularly by governments. But controversies with respect to the concept also persist amongst women's NGOs. In spite of this, the post-ICPD period has	**Reproductive Rights** – As in Asia, to a large extent reproductive rights is being interpreted as the right to adequate reproductive health services, including family planning. Progress has been made in the area of services and information for adolescents (male and

deserving mention are: the Peruvian reframing of the law to permit sterilization and measures taken to countervail abuse, the approval of the Brazilian Family Planning Law that regulates sterilization procedures which has been pending in Congress since 1992. In Nicaragua, after 1995, a series of ministerial protocols was approved for the implementation of a comprehensive model to address Reproductive Health, Maternal Mortality, Family Planning, Adolescents and Intra-Household Violence. **Sexual Rights –** In all countries, greater attention and eventually legislative change has occurred with respect to rape and other forms of sexual abuse against women. In Bolivia, Brazil and Peru sexual harassment legislation has been either presented or approved. Public sexual education programs are expanding and HIV-AIDS prevention programs are overcoming religious and cultural resistance. The exception is Nicaragua where resistance remains very strong with respect to sexual education programs and to condom dissemination. There is no clear legal framework ensuring the rights of young people to information. The issue of sexual orientation has also gained greater public visibility. However in what concerns the Beijing debates on sexual rights, Brazil is, evidently, the only country where policy and legal propositions are identified. The respect for individual sexual orientation is included in the agenda of the National Human Rights Program. In 1995, a provision was presented to the National Congress to guarantee civil union rights to partners of the same sex. The Bill has provoked a harsh public controversy and is still pending in the Congress.	the notion is being adopted to address bad quality care and lack of informed consent circumstances. The outstanding example is the Quinacrine episode. The drug used for chemical sterilization was commercialized in India until the Supreme Court banned it. In working towards this ban, women's groups have grounded their argument on the ICPD premise of respect for reproductive rights. **Sexual Rights –** Suspicion of and resistance to the sexual right premise is still great. Initiatives aimed at overcoming discrimination against lesbians had been developing in Thailand even before Cairo and Beijing. But no specific progress has been identified in the case studies. An important development, however, has occurred in Fiji. A new democratic Constitution with strengthened human rights and accountability provisions, which came into effect in July 1998, makes explicit reference to 'sexual orientation' as a prohibited ground of discrimination. This was welcomed by national NGOs concerned with promoting human rights. Reactionary elements within the Methodist Church have condemned its inclusion in the constitution and lobbied the government and Parliament to remove it through a Constitutional amendment. A strong campaign against the proposed amendment has been launched by a coalition of NGOs and the matter has triggered a public debate for the first time on the rights of sexual minorities.	been adopted to allow for contraceptive use. **Sexual Rights** – Positive developments are underway in this area. The expansion of HIV prevention programs and distribution of condoms is a common trend in most of the six countries. However, both, sexual violence and female genital mutilation (FGM) are on the increase. In Cameroon, FGM is being discussed more openly. In Ghana, rape, molestation, child sexual abuse are now being documented, highlighted and discussed. In 1998, in Ivory Coast, two new laws were passed; one against rape and the other aimed at eradicating FGM. Although the struggle against FGM can be interpreted as part of the Violence Against Women agenda it also directly relates to the premise of right to bodily integrity that underlies the notion of sexual rights.

Table 5a Partnership, Monitoring, Accountability Mechanisms

Caribbean	**India**	**Pacific (Fiji)**
Reports on implementation efforts were produced by two thirds of the participating countries. At the national level, an important achievement was the formulation of population policies by most of the English-speaking Caribbean countries. Administrative processes for institutionalizing population issues within development processes have been put in place in some countries, with	After the target removal policy was defined in 1996, NGOs encouraged the Government to establish partnerships in order to monitor changes at both policy decision and community levels. These propositions were supported by those donor agencies that welcomed the new Reproductive and Child Health Program. Potentially, NGOs and the government could work together in, at least, three broad areas:	Since the mid-1990s, there has been a notable increase in donor and Government support for active partnerships with NGOs. In general, donor assistance is mostly conditional upon the NGOs complying with their agendas. But there is no sense of conflict here. Instead, NGOs are enthusiastic about moving in the direction defined by ICPD at least in the area of reproductive health rather than the wide range of reproductive rights and gender

been as successful in the Small Island States of the sub-region. The need to better coordinate population planning mechanisms, including linkages with civil society, and develop effective support systems to realize their objectives has been recognized and emphasized. At sub-regional level, activities coordinated and supported by multiple international agencies, included the production of publications, creation of information databases and convening of Conferences. Examples: a computerized data bank to access as many Caribbean data sets as possible; a new newsletter, Caribbean Action on Population and Development: ICPD Follow-up News; a Health and Family Life Education project implemented throughout schools; the 1990-1991 Population and Housing Census analyzed and National Census Reports and Regional Census Monographs produced; a Regional Campaign on Violence Against Women coordinated by UNIFEM. Main target groups in these activities were women and adolescents, and areas of scrutiny were reproductive health, adolescent fertility; migration and sustainable development. NGO's, particularly FPAs, have been especially successful in reproductive health advocacy.	• Innovative service provision models • Training, research, raising awareness; • Advocacy, planning, monitoring, evaluation and accountability. NGOs could function as independent agents and citizens, particularly at community levels. Since 1996 the Government has sought NGO involvement in the following kinds of schemes: • As "Mother Units" (known as MNGO) that identify, screen and disburse funds to field-based NGOs for specific projects in reproductive health, family planning, maternal and child health, and adolescence, following government guidelines. • National NGOs and academic institutions were requested to provide support in conducting base-line surveys, facility surveys and other studies. • State Governments are channeling aid funds for NGOs to initiate projects, including taking over and running health centers in remote and difficult rural areas. Committees were established to screen and approve project requests from NGOs. • A few select NGOs were invited as members of the Advisory Group on RCH. State advisory committees have also been established. However permanent and structured monitoring and accountability mechanisms have not yet been established It must also be mentioned that, at the civil society level, previously existing and recently created NGO networks – such as Health Watch – autonomously monitor the policy, promote public debates on distortions and mobilize at the community level.	empowerment issues. Many donor organizations are now convinced that NGOs more effectively deliver aid, particularly to particular groups such as youth. The Government's Aid Coordinating Committee must approve all NGO requests for aid donor funding. No structured monitoring and accountability mechanism has yet been established. In preparing for Cairo +5 a family planning NGO has been identified as the focal point and a more systematic process of dialogue and consultation has developed.

Table 5b Partnership, Monitoring and Accountability Mechanisms

Bolivia	**Brazil**
Exchange of information and dialogue between the State and NGOs which have been taking place since the 1980's have clearly strengthened in the 90's. The government acknowledeges that the ICPD agenda was originally raised by NGOs, while NGOs recognize the strategic need to influence public policies to increase the impact of their proposals. The ICPD follow-up is not the responsibility of one exclusive body. Instead, a series of coordinating committees in which NGOs have representation monitor specific areas related to gender, sexual and reproductive health and rights at the national level. In a context of rapid decentralization provincial	Collaboration between NGOs and the government in matters related to reproductive health and rights started in the early eighties. Since then an array of interactions has developed both at national and sub-national levels. In 1995, the National Commission on Population and Development was created as the follow-up mechanism of ICPD at the federal level. Its mandate is wider than just exclusively following sexual and reproductive health policies. At CNPD ten ministries have a seat together with eight representatives from academia and civil society.

governments and municipalities are also becoming strategic parners of NGOs in ICPD-related activities. At the national level, two bodies are to be mentioned: the *National Committee for Sexual and Reproductive Health* (NCSRH), renamed such after Cairo (originally Committe for Reproductive Health) and the *National Safe Motherhood Committee* (NSMC). The NCSRH includes the participation of roughly 30 NGOs and governmental sectors responsible for education, gender and inter-generation policies. Its main activity has been IEC programs for both urban and rural areas. The National Safe Motherhood Committe includes, besides health sector policy makers, representatives from the Treasury and from the Ministries of Education and Sustainable Development, as well from women's NGOs. It also works with province level representatives to ensure the adequate monitoring of maternal mortality across the country. The NCSRH has played an important role with respect to the abortion debate and policy measures concerning post-abortion care. The NSCM has been one of the proponents of the Health Insurance Package, ensuring that reproductive health priorities are not left out. With respect to donor agencies, the Interagency Committee has been in operation for some time. Its main function is to avoid program and funding duplication both at governmental and non-governmental levels. Within civil society, numerous coordinating groups also exist: The Unwanted Pregnancy Group and Campaign 28 of September that prioritize abortion issues, The Beijing Committee, the Women's Platform, the Political Forum, involving parliamentary women, and Citizenship Forum dealing with the defense of the civic rights. The Population Committee has been re-mobilized in preparation for Cairo+5.	Joint Protocol of Action with the Ministry of Health prioritizing cervical cancer prevention and contraceptive assistance. The Brazilian Public Health System has built-in social accountability mechanisms in the form of State and Municipal Health Councils in which providers and users have a seat (50-50 composition). At the federal level the National Health Council (CNS), acts as an advisory board to the Ministry of Health. In 1996, the Intersectorial Women's Health Commission to advise the National Health Council was re-installed. The body includes ministerial representatives – among them CNDM and CNPD - as well as representatives from civil society including women's organizations. The National STD-Aids Prevention Program also includes the National Aids Commission and other groups in permanent dialogue with NGOs and academic sectors. Since 1993, it has been financing hundreds of prevention projects developed by NGOs. The Intersectorial Women's Health Commission played a fundamental role in revitalizing the PAISM agenda by promoting synergy between sexual and reproductive health programs at MoH level and taking strategic action with respect to maternal mortality and abortion. In the area of HIV-AIDS prevention, partnerships between MoH and NGOs were fundamental to guaranteeing universal provision of anti-retroviral drugs. Civil society networks have been crucial in promoting and monitoring ICPD implementation. Prominent among these are: the National Feminist Network on Reproductive Health and Rights (RedeSaude), Women's Articulation for Beijing, Social Watch Initiative, as well as the systematic follow-up of the Federal Congress undertaken by CFEMEA. RedeSaude took the lead role in setting the tone for the debates on the difficult abortion-related legislative issues and in establishing abortion services at decentralized levels of the public health system.

Table 5c Partnership, Monitoring and Accountability Mechanisms

Nicaragua	**Peru**
A Commission for Maternal Mortality Reduction was created in 1992 in which reproductive health and rights NGOs had representation. Two other relevant monitoring participatory mechanisms must be mentioned: the National Health Council and Hospital Based Committees. Before Cairo, NGOs had been extensively mobilized. A document was prepared analyzing the flaws of policies being implemented and a proposition was made to establish a permanent dialogue between the NGOs and the Ministry for Social Action. However, the pre-Cairo proposition has never been fully incorporated into government policy because of the relatively greater weight of conservative sectors in influencing policy makers. Also, NGO women's representation in the Maternal Mortality Reduction Commission, the National Health Council and in Hospital Based Committees has been increasingly disregarded or reduced. A more recent development has been the creation of the Ministry of the Family that incorporates three institutions: the Nicaraguan Fund for Children, National Commission for Promotion and Defense of Boy's and Girls Rights, and the Women's Nicaraguan Institute. This trend towards centralization has created additional difficulties for government–NGO relations as until then, women's	Before Cairo and Beijing, NGOs did not see much engagement with public policies. However after 1995, a new approach was adopted, privileging activities surrounding the monitoring and evaluation of sexual and reproductive health- and rights-related policies. After Cairo, UNFPA reframed its approach at country level in line with the ICPD Program of Action. The agency and the PAHO country office functioned as mediators between the government and women's NGOs, facilitating the creation of cross-sectorial mechanisms to guarantee surveillance and accountability. A Tripartite Table for Follow-Up of ICPD Program of Action was established in August, 1997. Its composition includes representatives of the government sector (Women and Human Development, Health, Education, Foreign Relations, Presidency, Ministries and the INEI), NGOs, universities, and international agencies. The main mandate of the Tripartite Table is to propitiate the exchange of information between sectors committed to ICPD, to identify priorities and blank holes in implementation and monitor policy progress. A second relevant body is the National Commission for Coordination of the Family Planning and Reproductive Health Policy (Coordiplan), presided over by the Vice-minister for

organizations could interact more positively with the three institutions separately as they had more autonomy and flexibility. In spite of the great difficulties encountered in adopting a participatory monitoring mechanism for ICPD follow-up, particularly with NGO participation and respect for their autonomy, the Cairo aftermath allowed a broad public debate on sexual and reproductive health and rights issues. Another crucial development has been the Regional ICPD Monitoring Project carried out in various Latin America countries since 1996. In Nicaragua, the project involved nine NGOs that carried out an in-depth evaluation of ICPD implementation in the following areas: • Quality of care in reproductive health services, prioritizing services provided to marginalized sectors, • Quality of care vis-a-vis unsafe abortion and post-abortion care, • Adolescent Reproductive Health Services, • The girl child sexual abuse – an assessment.	Women (Promudeh) and including the Vice Ministers of Health, Education and the Presidency of the Peruvian Institute of Social Security. Its objective is to optimize the quality of services. The initiative of PAHO National Board to Eradicate Violence against Women and Girls also involves the participation of governmental and NGO representatives. The Specialized Public Defense Board for Women's Rights played an important role in the episode of sterilization abuse that became public in 1997. Before the accusations were raised, sectors of civil society and the Board searched for evidence and in light of Cairo premises required the Ministry of Health to suspend its sterilization program. The sterilization episode was also subject to debate at the level of the Tripartite Table and Cordiplan. At the local level, the monitoring activities performed by Consorcio Salud and the Reprosalud Project promote the engagement of NGOs, community organizations and service providers to ensure better quality and accountability.

Table 5d Partnership, Monitoring and Accountability Mechanisms

Puerto Rico	**Uruguay**
The NGO- Government relation with respect to ICPD implementation is hindered by the political status of Puerto Rico since the territory does not have an independent seat at the UN level and representation at US government level is problematic. The country has not followed the ICPD process. A few NGOs however had access to UN negotiations and have made efforts to disseminate the contents of the Program of Action nationally. But NGOs hardly receive funds, and in the few cases where they do, these are confined to activities towards HIV-AIDS prevention. The only NGO working on family planning is the IPPF affiliate whose funds have been reduced in recent years. Moreover, after 1994 there has been a distancing between NGOs and the administration. The Commission for Women's Affairs that promoted joint efforts with feminist groups lost hierarchy in the cabinet and restricted dialoguing and collaboration with NGOs. Neither did the ICPD Agenda have any impact at legislative level. On the contrary, women are resisting attacks aimed at limiting sexual rights and the right to abortion. The new Sexual and Reproductive Health Policy defined in 1997 has been based on the recommendations of NGOs. Among the elements of the ICPD Program of Action adopted as national policy the integration of NGO is mentioned. Nevertheless, NGOs have not been called upon to collaborate in the last stages of formulation. The document does not refer to abortion and recommends that sexual education should be based on the premise of abstinence.	After Beijing, the NGOs participating in the Follow-Up Commission sought an interview with the President of the Republic to request clearer policy definition with respect to sexual and reproductive rights and health. He expressed his surprise to be hearing for the first time that the Ministry of Health did not provide contraceptive assistance, and made a firm commitment to overcome this limitation. In April 1998, the MoH set up an Advisory Honorary Commission on Sexual and Reproductive Health, composed of representatives from MoH itself, Medical School, Women's and Family Institute, Ministry of Education and Culture, Medical Union of Uruguay and women's NGOs. The Commission laid out norms and protocols for the national program. However, the implementation of these has not yet been ensured. On the other hand the PAIM (Comprehensive Women's Health Program), formulated at the Montevideo municipal level, was framed with a clear participatory perspective. Both its formulation and implementation involve the Municipal Women's Commission, NGOs and neighborhood organizations through local Health Commissions. It has also developed cross-sectorial coordinating schemes at the Municipal government level as well as with MoH. To better appreciate the effectiveness of the PAIM it must be noted that half the population of the country lives in Montevideo. The existence of these coordinating bodies has been crucial in sustaining the reproductive health agenda, particularly in ensuring the financial sustainability of both programs that have up till now been dependent upon UNFPA resources. The PAIM has established a strategy for financial sustainability of contraceptive assistance. At the national level, there is formal political commitment to guarantee domestic allocations after UNFPA funds phase out. At the civil society level a number of networks continue to

	play a role in sustaining the Pueblo debate on sexual and reproductive health issues and monitoring activities: the National Beijing Implementation Commission; Women and Health in Uruguay; the Gender Commission of the National Medical Union and various other NGOs working on related issues.

Table 5e Partnership, Monitoring and Accountability Mechanisms

South East Asia	**West Africa**
In nearly all South Asian countries – except the Philippines – the political climate does not favor the establishment of partnerships between governments and NGOs. In the official perspective government has an exclusive decision making role on population and development issues. Various sections of the ICPD document are seen as "sensitive" (abortion, adolescent health) and must not be widely discussed due to the political implications on morality, religion, and ethnic relations issues. This rationale that has informed social development policy making in the region for the last 25 years was reinforced by the ICPD principle of "respect for religious and ethical values and cultural backgrounds of its people". Women NGOs have not been consulted prior to or after Cairo on government policies and plans. They have not been invited to sit on government committees developing the National Plan post ICPD. An additional restraint to NGOs being involved in planning, monitoring, implementation and evaluation is that national follow-up mechanisms have not been set up. As a result the country progress reports prepared for the 1998 ESCAP -UNFPA sponsored "High Level Meeting" exclusively reflected the perspective of governments, without any contribution of NGOs. Moreover, family planning and health NGOs have primarily taken on a service delivery role, described as "a complementary and supplementary role to government". Women NGOs were generally not concerned with or involved in population and development prior to ICPD. In Thailand, Malaysia and Indonesia there is no women's NGO that focuses solely on women and health issues, and is therefore sufficiently skilled in policy and programme analysis. Presently their challenge is to gain a foothold and voice in policy advocacy. By the end of 1998, however, women NGOs appeared to have become more influential with government and their potential role is acknowledged. Groups such as Women's Health Advocacy Network (WHAN) in Thailand, and Sisters in Islam in Malaysia, have collaborated with government in policy-oriented seminars. This new step is positive and may be strengthened by the lead up to Cairo+5.	The Cairo aftermath has helped create an enabling environment for the strengthening of Reproductive Health and Rights-related women's NGOs. In Nigeria, a coalition of Nigerian NGOs for Health, Population and Development has emerged that is systematically putting pressure on government. Such developments represent great achievements when seen in the context of the prevalent political conditions in the region. Nigeria still suffers from a military regime and the non-democratic climate does not foster advocacy action. In the other countries democratic transitions are very recent and societies are not yet experienced in open participatory politics. For instance, in Cameroon and Gabon, NGOs started operating only after 1990. The quality of government-NGO collaboration differs between countries. Clearly, actions are more successful in contexts where there are clearly defined legal environments established for NGOs operations and rules regarding their partnerships with government. It is also clear that everywhere NGOs are still working without sufficient coordination among themselves. Although funds allocated for reproductive health activities have increased considerably, donors have not invested much in the creation of structured channels for dialogue between NGOs and governments and monitoring mechanisms. In only two countries have monitoring committees for the implementations of the ICPD Program of Action been created: Ghana and Gabon. In these cases the follow-up is being monitored through the national commissions on population. In the case of Gabon the Commission is a post-Cairo development. In the case of Ghana the Commission's objectives have been transformed to comply with the ICPD premises.

ASSESSING PROGRESS: ON THE POSITIVE SIDE

_ *Great Progress has taken place regarding Reproductive Health Policies and Services*

This progress has occurred everywhere, even in countries where, prior to Cairo, strong

semantic revolution is underway. Everywhere family planning programs are being renamed as reproductive health programs and in most cases serious efforts are being made to better integrate actions. Major breakthroughs have occurred in India, Bolivia and Peru. But as will be explained subsequently, in spite of ICPD, newly designed programs have in many cases prioritized family planning activities.

_ *Great Progress has also occurred regarding Gender Equality and Equity Initiatives*

Information synthesized in Table 2 provides a few illustrations of the vast array of gender equality and equity initiatives that have proliferated after 1994-1995. The most relevant aspect of this positive trend is that post Cairo and Beijing Initiatives are cross sectorial and often combine policy planning, legal reforms and micro-projects. In all countries violence against women has gained visibility, and in many cases related policies have been designed or improved. Gender planning has been a breakthrough in the Caribbean and the Philippines where new population policies clearly incorporate gender analysis. In the case of Latin America and India, gender approaches to health that go beyond reproductive health *per se* are being debated and adopted. In West Africa, emphasis is being given to legal reform and gender and poverty programs; and in South East Asia and Fiji, CEDAW ratification is cited as a major step forward.

ASSESSING PROGRESS: THE MIXED PICTURE SCENARIOS

_ *Monitoring and Accountability Mechanisms: Great Imbalances*

Post Cairo and Beijing policy scenarios have witnessed, in all regions, greater interest and mobilization of women's NGOs with respect to policy advocacy and monitoring. Great progress is definitely evident in the Caribbean, the Philippines and most Latin American countries. The exceptions are Nicaragua and Puerto Rico, where relationships between government and NGOs can be characterized as tense. Positive developments are also underway in Ghana and Gabon. In most cases, however, recent positive developments are strongly associated with a previous history of NGO - government engagement (Peru, Uruguay, Ghana and Gabon, however, do not fall in this category). In the other countries, no systematic mechanism for dialogue and coordination has been established. In the particular case of India, although women's NGOs and donor agencies have pushed for it, up until now consultations have been unsystematic. In Asia and the Pacific, governments tend to interpret partnership with NGOs as involving the transfer of responsibilities: NGOs are called upon to implement components of government policy without much room for their independent advocacy and monitoring. The overall picture is of great imbalances between the regions, with Latin America and the Caribbean providing good models which may be looked to for emulation or inspiration.

_ *Sexual health policies and services: A Mixed Picture*

In most Latin American countries, a few countries in West Africa, and in Thailand and Fiji, a positive evolution is underway, particularly in the case of STD/HIV-AIDS prevention. But even in Latin America exceptions do exist, as in Nicaragua and Puerto Rico, where conservative approaches continue to prevail. Case studies also suggest that, with a few exceptions – Brazil, Bolivia, Peru, Caribbean – the integration between reproductive health and HIV-Prevention programs has not been as effective as recommended by ICPD and the FWCW Programs of Action. Also in some countries, more attention should be given to sexual health initiatives, which are still weak or non-existent.

_ *Adolescent Health Policies and Services: Uneven Progress*

Although everywhere mention is made of adolescent health policy initiatives, clear progress has been evident only in the Caribbean, Bolivia and Peru. A major advancement in most Latin American countries has been the incorporation of sexuality education in the public school system. In Nigeria, in response to pressure from NGOs, steps are also being undertaken. But resistance still prevails in most of South East Asia. In Nicaragua and Puerto Rico, in spite of

progress made, program approaches remain conservative in content or else are under attack. In other settings, in spite of some positive developments, more consistent linkages between broader sexual and reproductive health policy premises and adolescent health have not yet been consistently built.

ASSESSING PROGRESS: ON THE NEGATIVE SIDE

_ *Unsafe Abortion and Post Abortion Care: Insufficient Progress*

Out of nineteen countries and the South East Asia review, just three countries have undertaken legal reforms: Guyana, Cambodia and Ghana (the last mentioned before Cairo). In Brazil, the number of service providers for abortion in the cases of rape and women's life risk have multiplied from two to fourteen, and there has been an improvement in post abortion care. After ICPD abortion has been recognized as a major public health problem in Peru, Bolivia and Uruguay and post-abortion care has been included as a component of newly adopted reproductive health policies. Efforts are also being made to ensure access in cases permitted by law, and to reform legislation. In India and Viet Nam, the safety of legal abortions has become a priority. But in the Philippines progress is stalled. In Nicaragua and Puerto Rico, attacks on abortion advocates and legislation have actually increased after 1994. It must be mentioned that even in places where progress has been observed, this occurred in the face of hard pressure from conservative sectors. On the whole, abortion related initiatives lag far behind the contents of Paragraphs 8.25 of ICPD and 106.K from the Beijing Platform of Action.

_ *Sexual and Reproductive Rights Legal Frames: Meager Advancements*

In addition to the insufficient progress made with respect to abortion, changes have also been scarce regarding the legal environment with respect to other dimensions of reproductive rights and most principally sexual rights. The most positive evolution is probably identified in West Africa with respect to FGM and other forms of sexual violence. The Brazilian Bill regarding the "civil union of persons of the same sex" as well as the Bill of Rights under Fiji's new (1997) Constitution, which makes sexual orientation a prohibited ground of discrimination, must also be mentioned. But the Brazilian Bill has not yet been approved, and reactionary forces within church organisations in Fiji have lobbied the Parliament to amend the new Constitution to eliminate what they interpret as constitutional sanction for same sex marriages. In Brazil, Peru and Gabon, new contraceptive-related legislation has been approved. Both in India and Peru, judiciary decisions based on the right of reproductive self-determination and informed consent have countervailed abuse in the case of the Quinacrine (India) and government promoted sterilization (Peru). It may be said that these are major steps forward in relation to the pre-Cairo policy and legal scenario. However, when evolution in this area is compared with what has been achieved with respect to reproductive health policies and gender equality and equity in general, the imbalance is quite clear.

_ *Male Responsibility: Almost Nowhere*

The involvement of young males in adolescent reproductive health and rights programs which are being implemented in many countries, including Bolivia, Brazil, Peru and Fiji, has increased. In Brazil, in the wake of the rapid increase in incidence of female AIDS infection, MoH statements on male responsibility have clearly gained substance and visibility. Research and debates have also been intensifying in the other Latin America countries. Overall, however, it would not be excessive to say that, apart from the Caribbean, policy strategies that have been designed still lack consistency in light of the ICPD recommendation on male responsibility.

BALANCING THE CRITIQUE: A WIDE RANGE OF OBSTACLES

While mapping out flaws and limitations with respect to ICPD implementation in Southern countries, DAWN does not underestimate the significance of progress made since 1994. The case studies – besides providing field data on policy and legal advancements – have also

analyzed the policy context and the overall political, social and economic environment in which implementation is taking place. On the one hand this reveals positive steps forward. On the other hand, it helps identify obstacles underlying the lack of progress in many areas.

Various obstacles have been identified from the national analyses. A few relate to the overall political, social, economic and cultural environment presiding over ICPD implementation efforts. Others are more directly related to conceptual, programming and operational policy bottlenecks. As expected, in some areas, both types of hindrances overlap. This section will briefly describe and analyze obstacles relating to five inter-linked dimensions:

- Cultural and Religious Resistance
- Lack of Conceptual Clarity
- Institutional Inertia
- Policy Design and Resource Allocation: The Challenge of Health Reform
- The "Enabling Environment": Political, Economic and Social Aspects

CULTURAL AND RELIGIOUS RESISTANCE

As was the case before ICPD and during the Cairo negotiations, cultural and religious resistance is a major obstacle to implementation. In some cases it has assumed a mild form, as in South East Asia, where issues considered sensitive are passed over in silence, rationalized by the argument that ICPD also recognizes respect for the cultural and religious beliefs of each country.

In West Africa it also emerges predominantly as a diffuse obstacle. But more open reactions have also been evident in some countries. Sexist cultures and traditions and detrimental practices, such as FGM, persist in four of the six African countries studied (Cameroon, Ivory Coast, Ghana, and Nigeria). In only two of them have legal and policy measures been taken. Prevailing cultural patterns make women's access to services difficult and hinder initiatives in adolescent health. Religious groups (especially the Catholic Church) are actively influencing the reproductive rights agenda. In some countries, Catholic health services promote only natural contraceptive methods and openly oppose legal and service improvement with respect to abortion.

In Latin America, all progress observed has occurred in spite of and against powerful religious bunkers, especially the Catholic hierarchy. In Nicaragua, reactions have been, in fact, virulent. Conservative sectors have engaged in street marches, campaigned through pastoral work, and issued statements against abortion and the sin of *"scientific information on reproductive health"*. Women's organizations have been under open attack from parliamentarians and government officials. In the case of Puerto Rico, the internal religious regressive forces are backed up by the US Congress position on abortion and HIV prevention which directly affects funding for NGOs and public services. As a whole, in the South American region, pro- life civil society based initiatives are being created and are, in most cases, mobilizing youth groups in marginalized areas. This new trend is related to the fact that, in many countries, the Catholic Church is losing ground in terms of the direct influence it has historically had over policy makers.

LACK OF CONCEPTUAL CLARITY

There is still a great lack of clarity regarding key ICPD concepts. The first example concerns the concepts of gender, women's empowerment and male responsibility. The best illustration is found in the Caribbean where policies and programs have advanced most since 1995. Although gender mainstreaming and reproductive health-related male responsibility initiatives rapidly took off, these lacked a clear understanding of the linkages between the three concepts. A critical question remains with respect to "who should be responsible for raising awareness about male responsibility: men themselves or women?" Also, the overall move towards a gender approach suggests the need to review women's empowerment premises. This carries the risk of losing the original cultural and political substance of women's empowerment. With

respect to services, although progress has been positive, the linkages between sexual and reproductive rights and male responsibility still have not been clearly and consistently articulated. It must also be noted that gender disaggregated epidemiological data on HIV/AIDS remains extremely limited.

On the one hand, the flaws identified in the previous section may result from the fact that governments are moving steadily in respect to the *"well behaving components of the ICPD agenda",* while leaving aside those contents that would require deeper institutional and cultural transformation. But limitations seem as well to be associated with lack of conceptual clarity. Where sexual health is being adopted as a concept, it is basically translated as STD/HIV prevention. In most settings, reproductive rights are interpreted merely as the right of access to reproductive health services, ignoring other critical dimensions such as informed choice and reproductive self-determination. Confusion is also evident in the area of adolescent needs. This conceptual confusion makes policy and programs easily prone to attack from ICPD adversaries.

Abortion probably provides the best example. Almost nowhere has clear and precise information been provided to policy makers, making clear that Paragraph 8.25 is not aimed at legalizing abortion, but rather at ensuring access in cases permitted by national laws, and quality post-abortion care. As we know, this is not the women's organizations' agenda, which calls for decriminalization. But a strategy to make Paragraph 8.25 content more accessible and clear to policy makers and providers could prevent the confusion created by regressive forces. The discourse of a female Brazilian hospital manager – in which abortion services have been functioning since 1996 to assist pregnant victims of rapes and women at life risk – exemplifies how crucial clarification is:

"We did not know precisely the Cairo language. I have never seen the document. But we have definitely used its content to implement the service: abortion is a public health problem, when it is legal it must be safe, and incomplete abortion must be subject to adequate and human care"

Box 3 Lack of Conceptual Clarity + Institutional Inertia: The Indian Experience

A workshop held, in April 1998, to review the functioning of the target-free approach in northern states – Uttar Pradesh, Bihar and Delhi – suggested that some positive changes are occurring.

These include:

- Some improvements in the quality of reproductive health services, and shift away from coercion;
- Target setting has shifted from being top-down to bottom-up;
- Greater focus on counseling and efforts towards creation of a conducive environment leading to an increase in demand for services;
- Positive changes in IEC strategy, which is becoming more client-centered; and
- Separate training packages for re-orienting service providers towards implementing RCH and TFA are in place. The training is also bringing together different actors like NGOs and government functionaries for the first time to attempt more coordination in service provision.

However, problems and shortcomings remain. As the workshop report states, *"The rhetoric has changed, the mindset has not"*. There is still a great deal of confusion among both service providers and NGOs about the plethora of new terms and new policy directions. Shortage of staff at the administrative level is reported. Low literacy rates of women health workers, poor knowledge about service provisioning, coupled with socio-cultural barriers against women working in villages, affect the quality of services in these northern states. Inadequate medical supplies further compound this.

INSTITUTIONAL INERTIA: BLAND AND VICIOUS NEGATIVE EFFECTS

A third major factor explaining the present and future difficulties in fully implementing the Cairo agenda is institutional inertia. It can assume both a bland and a vicious form. In its bland form it means that the health sector as well as other machinery meaningful to the ICPD

Program of Action resist change, simply because they are used to doing things the old way and have become set in their ways. Lack of conceptual clarity also promotes confusion and inertia as managers and service providers will not do what they cannot fully understand. The best illustration is provided by India, where implementing ICPD has become a colossal task of turning upside down, both conceptually and practically, a gigantic system that has been functioning in a rather stagnant manner for more than 30 years.

The inertia factor is particularly critical where integrating programs that were previously disconnected and isolated is at stake. In many countries, integrative efforts are underway, but they face enormous resistance at all levels. The Brazilian case is exemplary, in this sense, as the PAISM is the oldest program being implemented among the various studied countries. Originally the program was conceived in "top down" format, addressing one specific group of people (women) and particular epidemiological problems – a "vertical bias" that was not exclusive to PAISM. In 1988, the PAISM "adolescent component" became a special program. In 1986, the National Program of STDs was created; in 1988 it was renamed the National Program of AIDS (PNAIDS). The national politics of cervical and breast cancer continue to be defined by the National Institute of Cancer.

This dissociation which prevailed at MoH level was recreated at state and municipal levels in the form of isolated "program boxes" that did not dialogue or interact with each other. One of the major challenges and achievements of the post-ICPD period in Brazil has been to move towards a renewed institutional environment to enable dialogue, coordination and collaboration between programs. At MoH level, to a large extent, this has been the effect of a clear strategy aimed at promoting cross program interactions devised by the Intersectorial Women's Health Commission after 1996.

As has been mentioned in the India case, another expression of institutional inertia is coexistence between new policy guidelines and "old mindsets". In various Latin American countries – even Brazil after 10 years of PAISM – health managers and providers remained steeped in the MCH approach. They sincerely admitted that in their understanding reproductive health equalled MCH. In other settings, the "inertia" is more directly bound with conventional family approaches, by which implementing reproductive health programs easily becomes merely expanding family planning services. There has not yet been a full translation into reviewing policies: it is doing business as usual with new names appended to the programs.

On the vicious side, this form of institutional inertia opens space for the ICPD agenda to be captured by regressive forces, on the one hand, and by the old family planning establishment on the other; the latter has been raising arguments in recent years that the Cairo agenda is not implementable: it is too broad, too complex, too expensive.

We can share a few examples. In the case of Brazil, the Catholic Children's Pastoral is a large community based work program, aimed at reducing child mortality. After Cairo it has included maternal mortality in its agenda, but remained very active in blocking initiatives regarding abortion (even those related to reducing maternal mortality rates). The positive impact of their groundwork gives them enormous leverage at the level of the Public Health system. After 1994, it has been a strenuous task to persuade high and local level health managers and service providers that strategies for reducing neo-natal, infant and maternal mortality rates were good but not enough to implement the ICPD agreements.

What prevails, however, is the trend towards making of ICPD implementation a pretext to merely expand family planning. In most countries, resource flows for family planning activities are much bigger in comparison to investments made in other areas of the reproductive health framework. Such a trend is particularly true where programs are heavily dependent on donor support (which applies almost everywhere). In Uruguay, this emphasis is not observed, in spite of donor dependency, but high fertility is not seen as a major problem. In Bolivia, there is a difficult struggle to keep an adequate balance between family planning and other components. In Peru, this distortion is definitely one major factor underlying the 1997 episode of sterilization abuse. In Nicaragua, while regressive forces react to the more progressive reproductive health and rights premises, the space is left open for other sectors to push for a less controversial item: the old and well-known family planning programs.

This trend is visible where vertical family planning programs were a norm, before 1994, but also in those settings where there was harsh resistance to expanding the use of contraception. In the latter cases, it may happen that "giving access to contraception" is perceived, by policy makers, providers or women themselves, to be a major breakthrough. But this sense of novelty

does not extend understanding of the broad Cairo agenda. In relation to the institutional inertia dimension, ICPD implementation faces at least three obstacles:

- Persistence of the "former mindset" among managers and providers;
- resistance to better integration of policies and programs; and
- the still active ideological weight of both pro-natalist and neo-Malthusian premises that prevailed in government and society before 1994.

POLICY DESIGN AND RESOURCE ALLOCATION: THE CHALLENGE OF HEALTH REFORM

In terms of policy design, the major present and future challenge is to expand understanding on how good quality reproductive health services can be developed in the context of health reforms as they are currently being framed and implemented. The reference to health reforms as a critical element of the policy environment presiding over ICPD implementation was mentioned in most cases: Bolivia, Brazil, Caribbean, Nicaragua, Peru, Philippines, Puerto Rico, Uruguay and West Africa.

In most cases, the case studies identified privatization schemes as a major obstacle to achieving quality services. This trend is particularly evident in Nicaragua and West Africa, where health reform packages are an important component of Structural Adjustment Programs (SAPs). In West Africa, cost recovery and cost-sharing in public health systems keep the poorer populations (rural, women, old persons) away from hospitals and health centers. In Nigeria, the government is vigorously pursuing a privatization program in the health sector. The same applies to Puerto Rico, where the impacts of the US have hit hard on reproductive health services. In the Caribbean, cost recovery schemes may hinder the recent positive steps taken with respect to HIV/AIDS prevention.

In other settings, however, health reform impacts have not been so negative. The Brazilian Health Reform model of the 1980s entirely differs from the SAP health packages applied elsewhere, as it attributes a central role to public regulation and financing, and is a universal, free of charge, inclusive benefit package. The system was affected from 1993 to 1996 by a serious financial crisis that was solved – albeit temporarily – by the creation of a new source of financing, namely the provisory contribution over Financial Operations (CPMF), equivalent to 0.20 percent of all banking operations. Since then its implementation has advanced, especially regarding decentralization, and in many areas this has had the benefit of expanding reproductive health services. But in view of the ICPD agenda, the major challenge has therefore been to devise strategies to transform the old vertical PAISM design into a reproductive policy strategy able to permeate the whole system.

In Bolivia – where a much more conventional health reform program is being implemented, successful strategies have been implemented to ensure that reproductive health priorities are included in the Basic Insurance Health Package. Serious attention is also being given to decentralization. Decentralization is also a major element of the Filipino Reproductive Health Program. In Peru and India, however, the health reform debate is just starting.

In any case, it is vital to acknowledge that the World Bank has now replaced WHO as the major donor in the health field. The Bank strongly emphasizes the importance of health sector reform which involves developing an agreement with the government and other donors on a three-pronged approach that entails: a) Common sector-wide policies and strategies; b) prioritized public expenditure, based on cost effectiveness exercises using burden-of-disease and DALYs measures, and the identification of a package of "essential services"; and c) a common management framework.

Box 4 Financing Reproductive Health Services

Data collected at the global level suggest that recipient governments have come closer to the financial commitments agreed upon in 1994 than donor countries in terms of population related aid. This reflects in part the greater importance of domestic expenditures in the basic infrastructure of the health system. The collection of national data on resource allocation for implementing ICPD was not exactly an easy task. More substantive

analyses were only possible in the cases of Brazil and India. In spite of this limitation, the studies indicate that in most of the countries, reproductive health programs *per se* remain heavily dependent upon international assistance. In countries like Bolivia, Philippines and Peru, national programs have been renamed Reproductive Health but the bulk of resources is still going to family planning. In West Africa, the countries under SAPs have seen their health budgets shrink steadily since 1994, and this has not been compensated by increased donor assistance.

In other settings, such as India, resources are channeled in ways that do not favor the effective overcoming of major epidemiological problems. The reduction of maternal mortality, for example, requires investments in primary health programs to be combined with improvement in referral systems and obstetric assistance. But in the current scenario, donors are reluctant to fund infrastructure, and structural adjustment requirements curtail domestic investment. The sharper insight with respect to resource allocations is that *quality* of expenditure is as critical as the amount of resources invested. This applies both to Brazil, where federal expenditures in reproductive health have reached US $1 billion in 1996, as well as India, where investments are less than US $1 per capita. Additional international and domestic resources are necessary but not sufficient. The potential impact of "more money" is clearly conditioned by policy, management and accountability factors.

While the value of a common approach cannot be denied, it reduces the flexibility available to governments and donors to experiment with alternative approaches. Given the technocratic hegemony of the World Bank and its growing financial dominance in the health field, this is a discouraging probability. It means that those less wedded than the World Bank to cost-effectiveness as the principal criterion for health interventions might have fewer policies or program avenues open to them. The case studies also demonstrate that agencies, managers and advocates involved with reproductive health programming are not interacting adequately with the sectors designing and implementing health reform, neither globally, nor at country level.

THE "ENABLING ENVIRONMENT": POLITICS, ECONOMY AND SOCIETY

The value and meaning of progress achieved between 1994 and 1995 gains stronger color and contours against the background of the overall global environment and its impacts at country level. It is true that the post-Cairo period witnessed more political stability in most of the countries surveyed, with the notable exception of Nigeria. But this should not be overestimated. The political transition in most African countries remains rather unstable. In Latin America, although democratization has been underway for some time, democratic rules are not fully established everywhere and the authoritarian culture of the past is still alive in many countries. Moreover, administrative transitions at the national and local levels often produce unstable institutional policy environments which can put at risk achievements in reproductive health policies and services, as in the case of Bolivia, after the last general elections.

Even more relevant, it is important to acknowledge that the overall economic and social situation in the countries studied has not improved since 1994. All country studies refer to high levels of poverty as a major obstacle to effectively implementing the ICPD agenda.

The social and economic situation is particularly bad in India, Nicaragua, Bolivia, and Peru. In the case of Nicaragua, the appalling social and economic situation became evident with the horrendous impact of hurricane Mitch last November. In West Africa, the six countries studied suffer from a difficult economic environment. In Nigeria, Cameroon and Gabon, the continuous fall in the price of oil is having an extremely negative effect. In all six countries, more than one third of the population lives under the poverty line. Even in the case of Brazil – the country with the highest GNP per capita – it is clear that the expansion of good quality reproductive health services is not enough. It needs to be accompanied by strong measures to reduce poverty levels and redress one of the biggest patterns of inequality in the world. Otherwise the many other effects of social injustice will be permanently drawn into the health system.

The persistence of extreme poverty and inequality – besides openly contradicting the overall equity premises of the ICPD Program of Action – has detrimental effects on women's health and tends to increase gender imbalances. It also creates a fertile ground for the proliferation of regressive religious and cultural ideologies, as, often, poor people – especially poor men – are easily prone to fundamentalist messages. Notwithstanding the fact that one of the strategies adopted by conservative religious forces in Latin America and West Africa is the recruitment and infl encing of marginalized yo th sectors

This is not new. Strong language on poverty alleviation was adopted in Cairo (Chapter III of the Program of Action). But the 1994-1998 period has witnessed surprising new, risky and challenging trends. A year ago no one could have foreseen the magnitude of the earthquake set off by the Asian, Russian and Brazilian financial crises. There was little expectation that the financial upheavals would spread so rapidly and extensively into other regions, including the heart of the global financial system itself. The spectacular growth of Southeast Asia has been succeeded by an equally spectacular collapse that has threatened the entire global system. The 'contagious' effects of the Asian crisis reached West African countries, then Russia, later in 1998, and, soon after, Brazil, where it diluted all the previous success of the 1994 stabilization plan. The Brazilian crisis risks contaminating all of Latin America.

From the point of view of the ICPD agenda, one immediate impact of the current economic hurricane has been the cutbacks in health budgets in countries such as Brazil, Malaysia and Thailand, where domestic expenditures in primary and reproductive health had been expanding. Even more seriously, the global financial storm has created social and political insecurity as well as institutional instability, neither of which are conducive to ICPD-related policy implementation.

CAIRO + 5: CHALLENGES AT ALL LEVELS

Conclusions, although preliminary, can be drawn from the exercise undertaken in the context of the DAWN Cairo+5 Policy Research effort. An overarching one is that ICPD has triggered major changes, not only in population policies, but also in development debates more generally. While the pre-Cairo policy scenarios were extremely heterogeneous across countries, after 1994 convergent positive trends and similar obstacles can be identified with respect to ICPD implementation. Consequently, in view of key future actions to be taken, a minimal agenda can be defined to orient the Cairo+5 debates and negotiations.

Box 5 Accountability Mechanisms: The Cornerstone for Key Future Actions

On the whole, policies are moving more swiftly in the right direction wherever governments, agencies and reproductive health and rights NGOs are cooperating and consulting, or where accountability mechanisms have been established. Effective cooperation and dialogue between at least two of the three major sets of stakeholders are needed to push forward the ICPD agenda: government + NGOs, or government + agencies, or agencies + NGOs. It is also clear that the NGO role gains greater centrality where government resistance to ICPD implementation is greater.

POLICY RELATED RECOMMENDATIONS

- Consistent and systematic clarification of key ICPD concepts and recommendations;
- Implementation of both paragraph 8.25 of ICPD Program of Action and paragraph 106.k of the Beijing Platform of Action to ensure women's reproductive self- determination and universal access to safe abortion procedures;
- Consistent efforts to ensure the advancement of the sexual health and sexual and reproductive rights contents of the ICPD Program of Action, both at policy and legal levels;
- Conceptual and practical strategies to address reproductive health needs and expand services – as defined by Cairo – in the context of health reform debates and implementation; and
- Creative combination of efforts that aim to increase financial resources for ICPD implementation with clear and sharp criteria to ensure quality of expenditure at all levels.

Consequently the creation and sustenance of functional, transparent and democratic mechanisms for monitoring and accountability at community, local, national and international levels – guaranteeing the participation of women as users and advocates – is a co-requisite for the completion of the previously listed tasks. However, this leap forward cannot solely rely on

the commitment and voluntary effort of civil society organizations. Monitoring and follow-up activities are long-term, costly and time-consuming. To be effective they require adequate financial support and considerable investment in institution and capacity building.

THE CAIRO +5 POLITICAL SCENARIO

Cairo +5 will be the first UN Conference Review Process to occur after the global financial hurricane has decimated national currencies, shaken the global stock market, and wiped out at least one government around the world. As we have seen, Southern governments have met their ICPD financial commitments better than have the donor countries. Consequently, strong positions can be expected on the part of G-77 countries in The Hague and beyond. In 1994, even if the global economic climate was not easy, the Cairo Consensus was made possible after a careful building of North-South bridges around the reproductive health and rights agenda. It seems clear that the global political economic conditions prevailing in early 1999 cannot so easily propitiate the atmosphere of dialogue that became known as the “Spirit of Cairo”. It is vital to recall that in all the UN conferences of the decade, fundamentalist forces have systematically taken advantage of the political climate that followed the widening of North-South breaches.

The potential dark side of the Cairo+5 political scenario, however, must be balanced with unusual signs that can also be mapped in the global economic debate. The cherished neoliberal beliefs of the last two decades are being challenged from within the very heart of the system. The normally pliant governments of Malaysia and Hong Kong imposed some version of capital controls, Russia has unilaterally rescheduled its debt, after the Brazil “melt down”, propositions of capital flow control and of internal and external debt re-negotiation have gained visibility and clout at the national level, in spite of the strict rules implied in the IMF package negotiated in September 1998.

Most importantly, doubt has crept in within the Bretton Woods organizations themselves. A number of mainstream economists and influential public figures are criticizing the IMF for refusing to alter the recession-inducing advice it has been giving to the beleaguered economies of Southeast Asia, Russia and Brazil, and for throwing billions of dollars into the ever-widening breaches of a collapsing dike, to very little effect.

But the single most important criticism of the Washington consensus has come from the World Bank’s chief economist and vice-president, Joe Stiglizt. In his WIDER lecture in Helsinki in early 1998, and in a series of other talks and written papers, Stiglitz has criticized the IMF for its wrong-headed approach, and argued for a post-Washington consensus – one that would impose stronger controls on capital movements, that would not use national recession as an instrument to bring countries into line with the global order, and that would focus more on human development needs and inclusion of the marginalized. It is ironic that the World Bank, which enforced structural adjustment programs throughout the world during the 1980’s and much of the 1990’s should now be attacking the very premises of its own previous actions. But this split in thinking between the highest levels of the Bank and the Fund is probably the most important sign that the days of pure neoliberalism are over.

This climate has created space for a range of civil society initiatives to bring greater transparency and accountability to the global political economy. The Cairo+5 negotiations, particularly those aspects that are dependant upon a deeper transformation of the cracking neoliberal paradigm – as is the case with international cooperation trends and health reform premises – should be seen as a challenging but fertile opportunity to raise the profile of women’s concerns and needs in the debates about needed changes in the global order.

ACRONYMS USED

AHYD	–	Adolescent Health and Youth Development
ARROW	–	Asia-Pacific Resource and Research Centre for Women
BKKBN	–	Indonesian National Family Planning Program
CARE	–	Community Resource and Research Centre
CEDAW	–	Convention on the Elimination of All Forms of Discrimination Against Women
CFEMEA	–	Centro Feminista de Estudos e Assessoria
CNDM	–	National Women's Rights Council
CNPD	–	National Commission on Population and Development
CNS	–	National Health Council
CONNOHPD	–	Coalition of Nigerian NGOs on Health, Population and Development
CORDIPLAN	–	National Family Planning and Reproductive Health Planning Commission
CPMF	–	Provision for Contribution on Financial Transactions
DALY	–	Disability Adjusted Life Years
CPR	–	Contraceptive Prevalence Rate
DAWN	–	Development Alternatives with Women for a New Era
DoH	–	Department of Health
IEC	–	Information, Education, Communication
IMF	–	International Monetary Fund
FPA	–	Family Planning Association
FGM	–	Female Genital Mutilation
FPATT	–	Family Planning Association of Trinidad and Tobago
FWCW	–	Fourth World Conference on Women
FWP	–	Family Welfare Program
ICPD	–	International Conference on Population and Development
IFPNHP	–	Integrated Family Planning/Maternal Health Program
MCH	–	Maternal Child Health
MoH	–	Ministry of Health
NAWO	–	National Association of Women's Organisations
NCSRH	–	National Committee for Sexual and Reproductive Health
NESDP	–	National Economic and Social Development Plan
NGO	–	Non-Governmental Organisation
NPC	–	National Population Council
NSMC	–	National Safe Motherhood Committee
PAHO	–	Pan-American Health Organisation
PAIM	–	Women's Comprehensive Health Program
PAISM	–	Comprehensive Women's Health Program
PFPP	–	Philippine Family Planning Program
PLWAs	–	Persons Living With Aids
POPCOM	–	Commission on Population

POPDEV	–	Population and Development Planning
PRB	–	Population Reference Bureau
PROMUDEH	–	Ministry for Women's Affairs and Human Development
RCH	–	Reproductive and Child Health
RH/FP	–	Reproductive Health and Family Planning
STD	–	Sexually Transmitted Diseases
UNFPA	–	United Nations Fund for Population Activities
VAW	–	Violence Against Women
WHAN	–	Women's Health Advocacy Network
WHSMP	–	Women's Health and Safe Motherhood Project
WIDER	–	World Institute for Development Economics Research
WSSD	–	World Summit on Social Development

OTHER DAWN PUBLICATIONS PRODUCED FOR UN CONFERENCES

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WHO WE ARE

Development Alternatives with Women for a New Era (DAWN) is a network of women scholars and activists from the economic South who engage in feminist research and analysis of the global environment and are committed to working for equitable, gender-just and sustainable development.

DAWN'S VISION

We want a world where inequality based on class, gender and race is absent from every country, and from the relationships among countries. We want a world where basic needs become basic rights and where poverty and all forms of violence are eliminated. Each person will have the opportunity to develop her or his full potential and creativity, and values of nurturance and solidarity will characterise human relationships. In such a world women's reproductive role will be redefined : men will be responsible for their sexual behaviour and fertility. Child care will be shared by men, women and society as a whole.

We want a world where the massive resources now used in the production of the means of destruction will be diverted to areas where they will help to relieve oppression both inside and outside the home. This technological revolution will eliminate disease and hunger, and give women means for the safe control of their lives, health, sexuality and fertility.

We want a world where all institutions are open to participatory democratic processes, where women share in determining priorities and making decisions. This political environment will provide enabling social conditions that respect women's and men's physical integrity and the security of their persons in every dimension of their lives.