Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients.

All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. The objectives are:

(a) To promote adequate development of responsible sexuality, permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals; (b) To ensure that women and men have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities.

Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies. . . . Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. Governments and communities should urgently take steps to stop the practice of female genital mutilation and protect women and girls from all such similar unnecessary and dangerous practices.

Reproductive health programmes

RESPONDING TO CAIRO

Case studies of changing practice in reproductive health and family planning

Nicole Haberland
Diana Measham
Editors

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The Population Council is an international, nonprofit, nongovernmental organization that seeks to improve the well-being and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources. The Council conducts biomedical, social science, and public health research and helps build research capacities in developing countries. Established in 1952, the Council is governed by an international board of trustees. Its New York headquarters supports a global network of regional and country offices.

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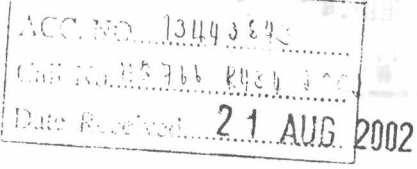

RESPONDING TO CAIRO

To Lila, Max, Michaela, and Sam

Foreword

The extraordinary recommendations of the International Conference on Population and Development, held in Cairo in September 1994, represent a sea change in the way population and reproductive health problems are conceptualized. A wide range of national population policy pronouncements, organizational changes, and program interventions in many countries have been guided by these recommendations in the ensuing years. The Programme of Action, signed by 179 governments, remains a landmark document. It provides a broad framework for a new approach to delivering reproductive health services in a comprehensive, user-friendly fashion, with respect for reproductive rights, and rejects the demographically driven, top-down approach that has been the hallmark of many family planning programs for the past four decades.

Since 1994 a major challenge has been to translate the Programme of Action into effective reproductive health services that satisfy the needs of women and men. This has often required removing demographic targets, overturning traditional patterns of family planning service provision, and introducing entirely new and comprehensive services to address many reproductive health concerns, such as sexually transmitted infections, violence against women, maternal mortality and morbidity, and abortion. It has been clear from the beginning that there is no simple road map, no single approach. Experimentation is essential, coupled with careful evaluation and monitoring.

These changes are not easily made. Governments must engage in sometimes-difficult debates to formulate and approve new policies. Decades of top-down, autocratic service systems cannot be changed overnight. Providers with deep-seated attitudes and behaviors regarding their clients need to be retrained and better supervised, and new categories of community health care providers must be created. Communities themselves need to be mobilized to become active participants in meeting their own reproductive health needs. Health officials must develop novel ways of evaluating the performance of workers who, in many cases, are no longer assessed according to the number of clients accepting contraceptives.

The case studies in this book represent the most comprehensive effort since the Cairo conference to examine in detail many of the most promising practical efforts to translate the Programme of Action into reproductive health programs and services that respond directly to the needs of women in the developing world. Their geographic and programmatic range is remarkable: from national policy and program changes in China and India to community-based projects in Peru; from shifts in national policy to grassroots projects on neglected issues such as postabortion care and involving men as partners; and from innovations in service delivery to efforts to challenge gender power norms in the community.

The case studies highlight the varied programmatic innovations that have been initiated throughout the developing world. Many demonstrate success in empowering women and communities to seek and obtain comprehensive reproductive health services. Major shifts in national policies have been encouraging. Yet the difficulties that remain in changing hierarchical and demographically driven policies and programs are enormous. The challenge to authority and tradition posed by women's empowerment remains at the heart of this resistance to change. The hopes and promises of the Programme of Action are gradually being realized, but no one should have illusions that all of its goals are in sight. These case studies offer hope, fresh ideas, and sobering insights into the challenges that lie ahead. They provide rich, practical information on both successes and failures.

Although each of the projects surveyed has been evaluated to some degree, evaluation in general remains a critical challenge. No longer can the traditional measures of contraceptive prevalence or fertility reduction adequately encompass the goals of the Cairo recommendations. Although work is proceeding on developing new indicators for assessing progress toward reproductive health goals, comprehensive evaluation methods remain elusive.

Another fundamental concern is that most reproductive health interventions are carried out on a small scale and are infrequently replicated or scaled up to the national level. Years of work lie ahead in advocating national policy changes, rethinking programmatic strategies, and implementing effective programs at the community level. Far more resources are needed, from both national and international sources. It will be an enormous challenge to maintain the commitment and dedication to the common goals of the Cairo conference throughout the world.

Yet, much has been accomplished, and it is evident that the broad concept of a client-oriented approach to reproductive health is increasingly accepted as the norm. As I look back over the four decades of my own work in this field, the change is truly remarkable. Beginning in Tunisia in 1964, I was engaged in helping establish national

family planning programs. In the 1960s many countries were beginning to focus on rapid population growth and the need to lower birth rates and were paying only lip service to women's health needs. Men, for the most part, were ignored. The immediate measures of success were acceptance of family planning services and contraceptive prevalence. It was inevitable that this top-down demographic approach brought little or no community involvement and no attention to maternal mortality, reproductive tract infections, and many other health problems. Women's empowerment was virtually an unknown concept, or was considered irrelevant.

Tunisia was an interesting exception. After independence in 1956, President Bourguiba initiated far-ranging social policy changes to improve the status of women by educating girls; liberalizing marriage, divorce, and inheritance laws; improving women's health services; and initiating family planning services that included access to abortion and sterilization, both unique in the Arab world at that time. The results were impressive, with increased age at marriage, higher levels of education for girls, and increased contraceptive prevalence.

I was lucky to start my reproductive health career in such an enlightened setting, although I confess that my own viewpoint, and that of my employer, the Population Council, were sharply focused on contraceptive acceptance and the introduction of the "hot" contraceptive of the day, the Lippes Loop IUD. We were less enlightened than Tunisia!

Curiously, Tunisia's example was not emulated in other countries. A single-minded focus on fertility reduction through increased contraceptive prevalence was almost universally the norm from the 1960s to the mid-1990s. Looking back, there is no doubt in my mind that, had the Tunisian model been applied more widely, the world would have achieved far more in improving the lives of women and men, and there would still have been a significant change in fertility behavior.

During the past four decades, policies and programs have gradually undergone a shift toward greater sensitivity to women's needs, improved quality of care, and the incorporation of a user perspective in family planning programs. I was fortunate to work closely with many colleagues at the Population Council and in sister institutions who initiated many of these changes. But the changes were slow and were sometimes reversed, and the underlying demographic paradigm remained. Improving quality of care was "too expensive," counseling and informed consent "too difficult," and attention to broader reproductive health needs "not feasible." Reproductive rights could not be addressed. Educating girls and improving the status of women were outside the purview of the family planning establishment.

The Cairo conference and the tireless efforts of women's health advocates leading up to it resulted in a profound and essential breakthrough. Reproductive health

and rights and improving the status of women became centerpieces of the new paradigm. It seems that a great hurdle has been overcome, and that there will be no turning back. And yet challenges remain. Efforts by conservative governments and groups to revise and even overturn elements of the Cairo agenda have been made repeatedly. Vigilance and persistence are critical in ensuring that the new paradigm will become a practical reality.

This book demonstrates how the international efforts initiated in the 1960s have been transformed in the new millennium. It provides a key benchmark in the long passage toward the achievement of a humane, client-oriented approach to reproductive health and rights, sexuality, and women's empowerment.

GEORGE F. BROWN
The Rockefeller Foundation

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This book is the realization of the extraordinary vision of Judith Bruce, director of the Population Council's Gender, Family, and Development Program. We thank her for serving as our inspiration and our compass, and for her steadfast support and friendship.

Transforming Judith's idea into a 23-chapter volume leaves us indebted to many, many people in almost 20 countries. First and foremost, we thank the policymakers, program managers, women's health activists, service providers, and women and men who conceived of and carried out these efforts to realize the goals outlined in 1994 in Cairo. We applaud their vision and tenacity in working to overcome the many remaining obstacles to change. We thank the passionate and patient authors of each chapter, who worked tirelessly to document their own efforts and those of their colleagues so that others may learn from their successes and their mistakes. We aimed to transcend the typical project reporting style commonly used in this field to bring readers a narrative tale, told from a range of perspectives and with a clear sense of what came before and what came after. We also wanted to convey a clear sense of what worked and what did not. Staying true to these goals required an extraordinary level of editorial collaboration, drafting, and redrafting—and in some cases original research. We are extremely grateful to all the authors for embarking on this journey with us and seeing it through to its conclusion.

We owe enormous thanks to Debbie Rogow for her creative vision and unwavering collegiality—her storytelling magic touched most of these chapters. Elizabeth McGrory and Judith Anderson Outlaw also played key roles in shaping several of the chapters. We are very grateful for their insight, good humor, and unsurpassed editorial skill.

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Finally, we thank our families. Our final review of the final chapter of this book was undertaken while Nicole nursed week-old Michaela and Diana allowed 18-month-old Lila to scribble on her pants with a pen. This moment crystallized for us the challenge of working motherhood, which began for us with the launch of this project. We gave birth to three beautiful children while conceptualizing and editing this book—Lila, Max, and Michaela—and five-year-old Sam was only a few months old when Judith first floated the idea. We thank them all—and our ever-patient and supportive husbands, Andrew and Ben—for bringing us so much joy and helping us keep things in perspective. Our parents—Peter and Anke, Tony and Carol—have also helped us navigate both our careers and our family life and have always been there to step in when the two collide. For this, and their unwavering support and guidance, we thank them.

February 2002

NICOLE HABERLAND
DIANA MEASHAM

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Introduction

Nicole Haberland and Diana Measham

The 1994 International Conference on Population and Development (ICPD) in Cairo codified views long advocated by women's health activists the world over. Their humanistic and feminist goals became cornerstones of Cairo's landmark accord, which recognized the rights of all people to reproductive health, called for special attention to women's empowerment and clients' needs, and repudiated reliance on contraceptive services as the tool for achieving demographic targets (United Nations 1995). The ratification of the ICPD Programme of Action marked a turning point in the history of the population field—one that brought reproductive health and women's rights to the forefront of the international population agenda.

Five years after the ICPD, reproductive health and population professionals reconvened at a follow-up conference, ICPD+5, to assess their progress toward implementing the ICPD agenda and lessons learned regarding how best to do so. While the ICPD drew attention to the limitations of service-delivery systems and outlined next steps in general terms, directions for implementation were vague. Given this fact and the many policy, funding, and programmatic measures that needed to be set in place to effect the changes called for in Cairo, few measurable improvements could be reported at ICPD+5. At both the ICPD and ICPD+5, calls were issued for the development of case material—concrete documentation of changes in the field.

This volume adds this new dimension of analysis to the body of material documenting efforts to realize the ICPD agenda. The case studies in this book examine past and present practice in a variety of settings, highlighting changes, however incremental they may be. Drawn from 22 projects in 18 developing countries, they present the stories of policymakers, program managers, health workers, health advocates, and clients. The case studies comprise a set of illustrative examples. Our belief is that by looking at noteworthy projects in depth, we can provide guidance to others grappling with how best to implement the ICPD agenda in specific settings. Have we made progress in implementing this agenda? The case studies profiled here indicate a quali-

fied "yes." Many challenges remain; at the same time, some seminal changes in policy and practice have taken place, notably the following:

- The two largest countries in the world, India and China, have abolished or modified population policies that were hostile to individuals'—especially women's—rights and freedom of choice. Nonetheless, strong pressures to achieve demographic goals by promoting contraceptive use persist in some settings.
- Decisionmakers in some settings have increased their willingness to regard sexuality as a legitimate part of reproductive health care and to incorporate attention to it into programs. However, mechanisms to address underlying issues of gender and power in the context of reproductive health care remain elusive, largely because attitudes, norms, and behaviors in this area are deeply entrenched. Concerted, long-term efforts are required to eliminate these ingrained obstacles to change.
- There is now widespread acceptance of the benefits of integrating and expanding services to meet a wider range of reproductive health needs. Efforts to broaden the content of services have met with considerable success, often at low or no additional cost. Progress in this area has been enhanced by some technological innovations (e.g., the development and distribution of manual vacuum aspiration) and has been hindered by some technological gaps (e.g., the lack of simple, low-cost diagnostic tools for most RTIs and of female-controlled microbicides for prevention of HIV and other STIs). Efforts to develop and improve reproductive health technologies must be accorded much higher priority and investment.
- The social and economic antecedents of women's reproductive health problems can be successfully addressed and overcome. Efforts to empower women as health care consumers, equal partners in sexual relationships, and important members of their families and communities are feasible and desired. To be effective, such efforts require working closely with women themselves and stepping outside clinic walls. Failure to address the socioeconomic underpinnings of reproductive health problems can prevent service-delivery interventions from fully achieving their goals.

Other themes and lessons learned post-ICPD abound. Many are detailed in this volume. Together, the case studies represent a rich and growing body of experience that can help to provide direction, fresh ideas, and cautions as we move forward.

OVERVIEW

The Cairo accord called for profound changes at multiple levels of systems, as well as in communities. Accordingly, this book is structured around five main themes. We

begin in Part I with government systems in which both subtle and overt changes in population and health policy have taken place. Chapters in this section address the field-level effects of national policy change in three countries that are important in terms of their size, history, and the scope of their reproductive health problems: India, China, and South Africa.

The chapters in Parts II–IV of this book focus on innovations in service delivery—the level at which most policy changes ultimately affect clients. These innovations encompass three critical areas: reorienting health workers to provide more client-centered services; expanding providers' capacity to deal with underlying issues of sexuality, gender, and partner relations; and broadening the constellation of services to include neglected reproductive health concerns.

In Part V we turn to the community level, where the objective is particularly daunting: changing the gender norms and power relations that lie at the root of many reproductive health problems. Despite the challenges, notable efforts have been made to empower women, to involve community members in designing and improving reproductive health services, and to combat violence against women and girls.

The remainder of this Introduction provides an overview of the book rather than a comprehensive summary of its chapters. We invite the reader to delve further into the richness of the case studies themselves.

Part I: Moving National Health and Family Planning Systems Toward a Client Center

Violations of women's reproductive rights have occurred throughout the world, but some of the most widely condemned took place in India under its contraceptive target system, in China under its birth planning program, and in South Africa under apartheid. Following the Cairo conference, policies that permitted abuse in these settings were abandoned or modified. In 1996 India abolished its contraceptive target system. In 1995 China initiated an experiment to improve quality of care, including the expansion of contraceptive choice. And in 1994 South Africa ended apartheid and in the ensuing years began restructuring its health care system to overcome decades of racism and neglect of primary care, including reproductive health care.

In each setting, change in national-level policy was necessary before meaningful change could occur in service-delivery systems. While national policy change sets the stage, responsibility for the details of implementation typically falls to officials at the state, province, county, and district levels. What techniques have been used to implement national policy changes? What has happened locally since these historic changes were initiated?