Implementing the ICPD's Message

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Commentary

Implementing the ICPD’s Message

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Progressive elements of the population establishment and of women’s groups managed to achieve a consensus at the International Conference on Population and Development (ICPD) in Cairo on how to stabilize the world’s growing population and, at the same time, improve women’s health and well-being. While the academic community will continue the sterile debate on the relative importance of development versus family planning programs for fertility reduction, the issue was put to rest, at least in the international policy arena, for the first time at the conference. Both the need for providing the means to reduce unwanted fertility and the importance of creating conditions favorable to promoting the desire for smaller families have been recognized. The main message constitutes two elements: Provide contraceptive methods within broader reproductive health services, and enhance women’s equality in education, health, and economic opportunity. These are tall orders for any government.

The implementation of the ICPD’s main message would require an ideological transformation both for the population and for the development establishments, and a realignment of turf within the national and international bureaucracies, which are used to working with sectoral mandates.

Implementation of a Broadened Population Policy

Traditionally, population policies, concerned with the reduction of population growth and fertility, have been implemented by means of organized family planning programs. A broadened population policy, concerned with improvements in gender equality, would, therefore, present a challenge to existing institutional mechanisms.

To bring about a reduction in gender disparities with regard to education, health, and economic opportunity would require implementation of gender-sensitive social and economic policies. Implementation of such policies, however, falls outside the purview of a country’s family planning program (designed for the population sector), but this is exactly what the entire development sector is supposed to do. About 98 percent of the funds allocated for all development activities are spent on sectors other than that of population. The efficiency of these expenditures must, therefore, be improved in order to promote women’s equality and to create conditions conducive to lower family-size preference. In brief, the mainstream development process must incorporate the reduction of gender disparities as its primary goal.

Not only do population and women’s groups have no leverage concerning the way funds for development are spent but also no bureaucratic mechanism exists to implement such an agenda. Within the United Nations system, for example, the United Nations Population Fund has no influence over the resources allocated for improving child health, female education, or economic opportunities for women. These funds are controlled by other UN agencies. Similarly, the Office of Population within the United States Agency for International Development and the departments of family planning in other national governments have no leverage over the funds required to empower women so as to create conditions favorable to a preference for smaller families. Some mechanism, therefore, must be created to make expenditures for development consistent with the objective of reducing gender disparities.

Reproductive Health and Family Planning Programs

Whether to provide reproductive health services is not an issue. The issues are: Who should provide and pay for these services, and why?

Since the ICPD, much discussion has centered around the question of how to integrate reproductive health and family planning. At one level, the solution
is simple: Because the spread of contraceptive use is expected to reduce the risk of pregnancy and, therefore, maternal mortality (and consequently can be viewed as a part of reproductive health), a simple computer program could be used to search for and replace the phrase "family planning" with "reproductive health" or with "reproductive health and family planning" in all official documents. This change, however, would not affect the scope of the services provided.

It can be argued that contraceptive services should be subsumed within reproductive health programs, which, in turn, would be subsumed within broader health services. The problem here is that reproductive health may not receive as high a priority among all health issues as its advocates wish. Moreover, both contraceptive and health services have their own separate constituencies and budgets; by contrast, reproductive health has some constituency but no independent budget. Thus, reproductive health advocates would have to work both with family planning programs and with health programs to ensure the delivery of all reproductive health services.

In order to design family planning programs that provide reproductive health services beyond those required to distribute contraceptive methods, we need to understand why these programs have not paid attention to health issues related to reproduction.

While the establishment of family planning programs has been guided by multiple rationales, the overriding intent of governments and donors has been to reduce fertility and population growth. By contrast, the reproductive health approach focuses on individual rights and well-being. Because of the demands made by reproductive health advocates, family planning programs are now being pulled in two directions: They are expected to improve individual well-being and to reduce a society's overall fertility. A focus on individual well-being would contribute to the achievement of the social objective by reducing unwanted fertility. In this respect, the two objectives are consistent. However, a focus on the reduction of population growth and total (wanted and unwanted) fertility has led some programs to use undesirable means, such as monetary incentives to clients and providers, method-specific quotas, and coercion. In this fashion, the two objectives, under certain circumstances, can be inconsistent.

Some managers and donors (internal as well as external) of family planning programs are likely to be concerned that a focus on only individual well-being may reduce funds for these programs. Moreover, a reproductive health approach would divert funds from contraceptive to reproductive health services. Under these circumstances, managers are likely to implement the reproductive health approach only if they think it is a cost-effective way to reduce total fertility or if the primary objective of family planning programs is redefined. A convergence of the interests of reproductive health advocates and family planning program managers is easy to envision in terms of the provision of services for safe abortions, because the availability of these services would reduce fertility, expand choice, and reduce maternal morbidity and mortality. However, no empirical evidence supports the idea that adding other reproductive health services, such as treatment for reproductive tract infections or sexually transmitted diseases, is a cost-effective way of lowering fertility. Furthermore, efforts to gather such evidence are unlikely to be productive.

What if empirical research shows that the addition of services to diagnose and treat such conditions is not as cost-effective in reducing fertility as are incentives to providers and clients? Moreover, since the objective of offering reproductive health services is to improve the health of individuals, provision of these services for the purpose of reducing fertility and evaluating their effectiveness based on their ability to attain that goal would not be justified.

In order to include reproductive health services within family planning programs, the primary objective of these programs should be defined in terms of empowering individuals to achieve their own reproductive intentions in a healthful manner. The first part of this objective maintains the link with fertility reduction by focusing on unwanted childbearing, and the second part extends the link with reproductive health services. A practical strategy could be designed so that those reproductive health services that interact directly to reduce unwanted childbearing safely are paid for and delivered by family planning programs, whereas other issues of reproductive health become the responsibility of health programs.

Acceptance of the proposed objective for family planning programs will have profound implications for the design of services, their costs, and the evaluation of their performance. One way to redesign contraceptive services from a reproductive health perspective is to deal with the contraindications of each method, by developing standards for screening, and focusing as well on diagnosis and treatment (including referral for treatment) of these conditions. Monitoring compliance and incorporating the occurrence and treatment of reproductive morbidities should also be part of the evaluation of these programs. The cost estimates of offering a method through a program with such an approach should include not only commodity costs but also the costs of screening for and diagnosis of contraindications, and treatment of such conditions, and the costs of diagnosis

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and treatment of adverse reactions to that contraceptive method. The impact of family planning programs could then be assessed in terms of their combined outcome, reflecting both the avoidance of unwanted and un-planned childbearing and associated reproductive morbidity. Such an assessment could be facilitated by an index called HARI, an acronym for Helping Individuals Achieve their Reproductive Intentions.¹

Suggested Role of the Population Sector

Implementation of the ICPD’s main message would require that we go about the tasks of development and family planning differently. What can the population sector do to facilitate the entire process? While the temptation may be strong for it to focus only on the scope of services, to neglect completely the development and implementation of a broadened population policy would be a mistake.

First, the population sector can promote the elements of the main message to a wider audience so that they may be endorsed at various national and international forums. Second, it must accept that the achievement of replacement fertility sooner rather than later will require more than organized family planning programs. Third, it should revise the primary objective of and the main evaluation criteria for family planning programs in such a way that serious attention is paid to reproductive health issues. Fourth, it should forge alliances with like-minded development professionals so that other development sectors increase their efforts to reduce gender and other kinds of inequalities in education, health, and economic opportunity. Fifth, the population sector must mobilize and devote the resources required to delineate these roles and responsibilities and to identify institutional mechanisms to implement the population and women’s agendas.

Note