Population and Reproductive Health: Where Do We Go Next?

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Since the 1994 International Conference on Population and Development (ICPD), analysts concerned about population growth have explained the Cairo paradigm shift as a triumph of feminist ideology over demographic analysis (see Presser1 for an overview). These analysts bemoan what they see as a dramatic shift away from demographic concerns, as a prescription of demographic targets, and as a downplaying of vertical family planning programs in favor of broader approaches to sexual and reproductive health that are premised on individual rights, especially women's rights. (Actually, the ICPD Programme of Action recognized national “population-related goals” as legitimate, but it proscribed the use of demographic targets to define service provider standards and priorities.) They assert that the ICPD’s approach to reproductive health, development, and rights is too complicated and too expensive to be implemented by resource-poor countries (see, for example, Lush et al.2 and Wheeler3).

The Cairo agenda is admittedly challenging. In formulating the agenda, however, the ICPD responded to women’s demand for better-quality health and family planning services. The ICPD also took into account the need to remove social barriers to access and the imperative to modify policies and programs to meet the demographic realities of the 21st century. Let us take each of these concerns in turn.

**Improved Health and Family Planning Services**

The ICPD recognized the critically important contributions of the first 30 years of contemporary “population” policy—that is, concentrated investment in the provision of contraceptives to the largest possible number of married women of reproductive age—and acknowledged the demographic impact of these conventional family planning services. Worldwide, contraceptive prevalence rates rose from less than 10% in the 1960s to 55% in 1998, and fertility rates have fallen. Some estimate that family planning programs have been responsible for as much as 40% of these changes. Certainly, many women benefited enormously from the investment.

There is still a long way to go, however, to ensure the minimum standard for high-quality family planning that was set a decade ago.4 That standard includes not only technical quality but informed consent, a range of contraceptive choices, health services in addition to contraception, and respectful, accurate communication between client and provider.5 In too many places, the ICPD agreements to end coercion, discrimination, and violence in population programs remain to be implemented. Furthermore, services need to be redesigned to meet the needs of a wider clientele than is represented in the “unmet need for family planning,” narrowly defined as the 100 to 150 million married women who desire to space or limit births but who are not using contraception.6 Monitoring progress toward improved services will also require new indicators—not merely of contraceptive use but of individuals’ ability to achieve their reproductive goals in a healthful manner.7

**Barriers to Access**

The ICPD recognized, as did the Third World Conference on Women in Nairobi in 1985, that although women have a right to control their own reproduction, numerous social barriers—not only poor quality or absence of family planning services—prevent them from doing so. Although these barriers vary across countries and often within countries, they generally include poverty, a lack of education, and the low social status accorded to women. They also have substantial demographic consequences, as noted by Sinding in this issue of the

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Policy and Programs

The diverse demographic realities of the 21st century pose new and varied challenges that cannot be met through the limited family planning approach of the last 30 years. These challenges are as follows:

• To ensure access to safe abortion and thereby eliminate 80,000 deaths and countless injuries annually
• To meet the demands of “demographic momentum,” that is, to provide the information and services needed by the unprecedented cohort of 1.2 billion adolescents entering their sexually active years, as well as by the children already born who are following close on their heels
• To eliminate persistent and avoidable mortality and morbidity directly related to sexuality and reproduction

Safe Abortion

The ICPD Programme of Action recognizes unsafe abortion as a major public health problem and requires that where abortion is legal, it must be safe. The United Nations’ 1999 five-year review of ICPD Programme implementation further specifies that health systems must train and equip providers and take other measures to ensure that legal abortion is safe and accessible. The ICPD Programme of Action requires that where abortion is legal, it must be safe. The United Nations’ 1999 five-year review of ICPD Programme implementation further specifies that health systems must train and equip providers and take other measures to ensure that legal abortion is safe and accessible.

Demographic Momentum: Adolescents

To address demographic momentum, the ICPD recognized that adolescents, especially girls, need sexuality education; sexual and reproductive health services; technologies that protect against disease, not just unwanted pregnancy; and broader life opportunities (education, vocational training, employment) on an unprecedented scale. Girls are currently at enormous risk for violent and unwanted sex, HIV/AIDS, botched abortion, and early or forced marriage. For their own well-being, they must be given the skills and the power to decide whether to have sex and under what conditions, when and whom to marry, when to begin bearing children, and how many children to have.

Their choices on these matters will also be the primary determinants of future population growth.

Conventional approaches to family planning simply do not serve adolescents well enough. Adolescent women, whether married or unmarried, have been excluded from services in most places. The methods most often promoted are inappropriate for teenagers. Currently, nearly 50% of women in the developing world who use contraception are protected by contraceptive sterilization and another 25% are using IUDs—both methods entirely unsuited to adolescents. Even hormonal contraceptives are inadequate, because they do not protect against HIV infection and other sexually transmitted diseases (STDs). Furthermore, as these young people are forming relationships, they need to acquire skills to ensure mutual respect and equality and to resist harassment and violence—an agenda wider than the “family life education” provided by population programs. Given that most of the future growth in the world population will come from the demographic momentum inherent in these young people, the ICPD’s strong emphasis on young people is both just and demographically imperative.

Morbidity and Mortality

The ICPD agreed on an agenda to address persistent and new health threats directly connected to sexuality and reproduction, namely, high and avoidable rates of maternal mortality and morbidity, the pandemics of AIDS and conventional STDs, and violence against women. Nearly 600,000 women die each year in poor countries because they do not have skilled attendance in pregnancy and at delivery or access to safe abortion. For each woman who dies, an estimated 17 more suffer severe morbidity, and young children die at high rates soon after they lose their mothers. The 1993 World Bank analysis of the global burden of disease estimated that 18% of the “disease burden” of women of reproductive age is due to pregnancy-related causes. Public health systems must be strengthened to provide essential obstetric care, and investments must be made in transport systems and education programs to ensure that women have access to that care.

The World Health Organization estimates that there are 330 million new STD infections annually and that 34 million people are now infected with HIV or living with AIDS. These diseases are decimating the productive populations of sub-Saharan Africa and are approaching catastrophic levels across Asia, too often because men refuse to practice safe sex. For example, in sub-Saharan Africa, the primary engine of the epidemic is men who buy commercial sex, refuse to use condoms, take multiple wives, or, increasingly, have sex with young girls in the belief that the girls are “clean” or will cure them of AIDS.

Conventional family planning programs do not deal with sexuality and have tended to exclude men. The ICPD Programme of Action and the commitments made in the ICPD 5-year review mandate programs to promote gender equality and responsible and respectful sexual relationships; among the goals of these programs is the involvement of men in preventing STDs (including HIV infection) as well as unwanted pregnancies. Both the Programme of Action and the 5-year review call for greatly increased investment in methods that women can control and that protect against STDs with or without contraceptive effect. (Such methods include microbicides, substances that, when inserted vaginally or rectally, kill viruses and bacteria or block their entry into cells.)

As for violence, the most recent survey of available data on the types of abuse dominant in the lives of girls and women around the world—coerced sex and the abuse of women within marriage and other intimate relationships—concludes that “at least one woman in every three has been beaten, coerced into sex, or, otherwise, abused in her lifetime . . . most often [by] a member of her own family.” As well as being a fundamental infraction of women’s rights, such violence inhibits women’s contraceptive use, constrains their access to health services, and often leads to high-risk sexual behavior and other health risks. Actions to prevent such violence, similar to those that address STDs and HIV/AIDS, are urgently needed.

Conclusion

Meeting the far-reaching “demographic” challenges of the 21st century requires implementing the comprehensive agenda agreed to in Cairo, repeated in the Fourth World Conference on Women in Beijing in 1995, and repeated again in the 5-year review of implementation of the Cairo Programme of Action in 1999.

The ICPD agenda is indeed complex and requires substantial human and financial resources. Enormous numbers of health and family planning workers, teachers, and policymakers need to be retrained and reoriented. In too many countries, health systems that have drastically deteriorated must be rebuilt. Changes in most places will be incremental. The changes will begin, at a minimum, with an essential service package of the widest possible range of contraceptive choices—always including condoms and, when they become
available, microbicides—as well as with essential obstetric care, safe abortion, and adolescent education and services. Within prevailing constraints, priority must also be given to improving the quality of family planning and health services. It is particularly important to invest in monitoring and accountability systems as a basis for advocacy and to ensure full participation by all stakeholders, especially women.

Regarding cost, the jury is still out. The World Bank concluded that 3 of the 5 most cost-effective interventions to reduce the disease burden of adults are contraception, treatment for sexually transmitted infections, and preventing maternal death. Further, many of the national health policies and programs negotiated since Cairo—in Bangladesh, for example—have emphasized an “essential service package” that is said to be “affordable.” While much has been made of the shortfall in funds that governments agreed in Cairo to provide (see, e.g., Sinding9), significant progress could undoubtedly be made by reallocating the resources we already have and by spending them more efficiently. Furthermore, many developing countries that have not yet met their Cairo commitments could do so if they reordered their priorities, redirecting funds away from military expenditures and corruption and toward social investment.

As Sinding notes, the old demographic arguments that generated population funding in the past are no longer as salient as they once were. We believe that the Cairo agenda can attract a very broad range of political support—not only from those concerned with population growth but from organized women whose primary concern is women’s rights, from human rights groups, from health professionals, and from HIV/AIDS activists and professionals. For 30 years, a relatively small number of committed advocates generated the political will required to appropriate funding for “population” issues. We can and should do no less to obtain the funding needed for the wider Cairo agenda.

References