

PN-ACA-421
93593

IMPLEMENTING REPRODUCTIVE HEALTH PROGRAMMES



ODA

Report of a Donor Workshop
co-sponsored by the
UK Overseas Development Administration
and
US Agency for International Development

New York
12 - 14 June 1995

Acknowledgements

This report was written by Lori S. Ashford of the Population Reference Bureau and edited and produced by the London School of Hygiene & Tropical Medicine.

USAID and UKODA gratefully acknowledge the technical assistance provided by the Secretariat of the Donor Workshop, George Brown, Beverly Winikoff, and Mary Beth Powers of the Population Council, and John Cleland of the London School of Hygiene & Tropical Medicine. Valuable support was also provided by Valerie Moulay-Omar and Louise Kantrow of the Population Council and Evelyn Dodd of the London School of Hygiene & Tropical Medicine.

December 1995

Table of Contents

I. Summary	2
II. Reproductive Health Programmes: Expert Presentations and Discussions	5
Priority Needs and Cost-Effective Interventions	5
STDs and HIV/AIDS	5
Family Planning	8
Safe Motherhood	10
Post-partum Care	12
Nutrition	13
Unsafe Abortion	14
Adolescents	16
Violence Against Women	18
Female Genital Mutilation	20
Cross-Cutting Issues in Programme Implementation	21
Vertical and Integrated Approaches	21
Public and Private Sector Roles	23
Research Needs	23
Health Policy Reform	24
Advocacy for Reproductive Health	25
III. Coordination and Monitoring of Donor Assistance: Donor Roundtable	26
Programme Development and Expansion	26
Programme Monitoring and Evaluation	27
Funding for Reproductive Health	28
Boxes:	
1. The ICPD Message on Reproductive Health	3
2. Defining and Operationalizing Reproductive Health	6
3. Mexico: From Mexico City to Cairo and Back	9
4. Bangladesh: Public/Private Partnerships in Reproductive Health	15
5. Ghana: Next Steps in Strengthening Reproductive Health Programmes	19
Tables:	
1. Cost-Effective Interventions for women aged 15-44, 1990	6
2. Estimates of Reproductive Ill-Health	7
Figure:	
1. Burden of Disease in Adult Men and Women aged 15-44 years	7
Appendices:	
1. ICPD Programme of Action, paragraphs 7.2, 7.3, 7.6	30
2. Statement by Dr. Nafis Sadik, Executive Director, UNFPA	32
3. Participant Contact Information	36

I. Summary

The Programme of Action adopted at the International Conference on Population and Development (ICPD), held in Cairo in September 1994, sets out an ambitious agenda for improving reproductive health. The Cairo programme articulates a comprehensive concept of reproductive health, including family planning and sexual health (see Appendix 1). It calls for universal access to services by the year 2015 and recognizes that reproductive health is closely interrelated with policies to empower women, strengthen families, stabilize population growth, and eradicate poverty. Governments, donors, UN agencies, and others are challenged to support actions that will achieve these goals.

The Donor Workshop on Implementing Reproductive Health Programmes, held in New York on 12-14 June 1995, sought to promote a better understanding of the strategies that will most effectively contribute to improving reproductive health and advancing the Cairo programme. The origins of this workshop go back to a November 1994 meeting of the Development Assistance Committee (DAC) of the OECD, in which DAC members agreed that it would be useful to explore further the operational aspects of implementing the Cairo agenda. The US Agency for International Development and the UK Overseas Development Administration proposed to co-host the workshop to help donors, assisted by technical experts, consider these issues. Participants included representatives from bilateral and multilateral donor agencies as well as several private foundations. (See Appendix 3.) The Population Council, in collaboration with the London School of Hygiene & Tropical Medicine, served as Secretariat.

The workshop consisted of a series of presentations and discussions on the key components of reproductive health, developing country experiences, and donor perspectives. Technical presentations addressed seven key areas of reproductive health:

- ▲ Sexually transmitted diseases (STDs) and HIV/AIDS;
- ▲ Family planning;
- ▲ Safe Motherhood, including prenatal and post-partum care;
- ▲ Unsafe abortion;
- ▲ Adolescents;
- ▲ Violence against women; and
- ▲ Female genital mutilation.

Country case studies were also presented by programme leaders from Mexico, Ghana, and Bangladesh. Discussions focused on the following questions of key concern to many donors:

- ▲ What are the essential elements of reproductive health?
- ▲ Which elements require more work in order to develop effective interventions?
- ▲ What research is needed?
- ▲ How can the donor community implement the proposed interventions and research and improve service delivery?
- ▲ What is the scope for concerted donor action in helping and working with countries in coordinating and implementing reproductive health programmes?

A number of cross-cutting themes surfaced in workshop discussions related to programme implementation.

The need to improve cost-effectiveness and accessibility of services is a top priority. Many questions were raised about how to organize and link programmes and their components so that they are both cost-effective and accessible to users. Strategies are needed to ensure that individual users - women and men - can easily access the reproductive health services that they need. When feasible, these services should be provided in a comprehensive, integrated fashion.

The private sector deserves greater help and encouragement. Private voluntary NGOs and the commercial sector already account for a significant share of services in some countries. Their contribution is vital in meeting growing reproductive health needs in an innovative and cost-effective fashion.

Adolescents represent a critical target group for reproductive health programmes. Today's one billion adolescents will affect future prospects for population stabilization and are key to improvements in reproductive health. Unfortunately, they represent the most underserved segment of the population.

A conducive policy environment in developing countries is essential. Donors have a critical role to play here. They, together with collaborating institutions, will need to support advocacy efforts to overcome sensitivities about the issues and to convince governments and communities that reproductive health is a priority. The influence of UN agencies is also of particular importance. In most countries, the development and funding of comprehensive reproductive health programmes will require reforms in the health sector as a whole.

Further research will be required to test alternative approaches. Different technologies and different programme strategies should be assessed in terms of effectiveness and relative cost. New survey instruments have to be developed to evaluate programmes. Evidence of programme impact will be necessary both to improve programmes and to convince officials in donor countries that reproductive health merits high priority as a development investment. Research will also be needed to bring hard data on reproductive health needs to the attention of policymakers, particularly in those areas of reproductive health that are politically and culturally sensitive.

The importance of donor coordination was stressed. The dilemma for a number of donors is that they are being called upon to expand their reproductive health activities at a time of resource constraints. Thus it is all the more important for each donor to identify its areas of comparative advantage and to find ways to collaborate with other donors. While each donor aims to improve the efficiency of its programmes and implement best practices according to local needs, some coordination and monitoring mechanisms are needed at the country and international levels. For example, some structured monitoring is needed of reproductive health programme inputs, the outputs and achievements of these programmes, as well as their effectiveness and value for money.

The workshop did not set out to seek consensus on the precise operational implications of the Cairo Programme of Action. Donors agreed that there is probably no single package that can be prescribed to meet all people's reproductive health needs and recognized that priorities are likely to differ. The important requirement is that people can access a range of services and be given the opportunity to make choices between service providers who meet quality of care standards.

The following sections of this report contain summaries of technical presentations and discussions on cross-cutting themes related to programme implementation and donor coordination. It is hoped that the report will serve as a useful technical reference for those involved in policy and programme management and, perhaps more important, that it makes a constructive contribution to efforts to achieve the goals set in Cairo in 1994.

Box 1 The ICPD Message on Reproductive Health*

Nafis Sadik, Executive Director, United Nations Population Fund (UNFPA)

The Programme of Action requires all of us to be strong and steadfast advocates for all aspects of sexual and reproductive health and rights, even though our direct financial support may be provided on a more selective basis. There are no standard models or blueprints for operationalizing reproductive health programmes. There are probably a variety of approaches that can work, just as there have been with family planning.

The tasks set out in the ICPD Programme of Action are beyond the capacity of any single organization; thus donors, governments, and NGOs will need to collaborate, and national programmes need to be made up of an appropriate mix of public, non-governmental, and private sectors.

Reproductive health has always included family planning—and indeed family planning will continue to be a central component of reproductive health programmes. It allows couples and individuals to meet their reproductive goals thus giving women the freedom and ability to participate actively in social and economic development. It is central to the reduction of maternal mortality and morbidity. It is central to preventing the need for recourse to abortion. And it enables women to have more control over their sexual lives and thus more control over the transmission of reproductive tract infections including sexually transmitted diseases (STDs) and HIV/AIDS.

**This statement is printed in its entirety in Appendix 2.*

II. Reproductive Health Programmes: Expert Presentations and Discussions

Priority Needs and Cost-Effective Interventions

Moderators: Margaret Catley-Carlson, President, The Population Council, and Allan Rosenfield, Dean, Columbia University School of Public Health

STDs and HIV/AIDS

Speakers: Peter Piot, Executive Director, Joint UN Programme on AIDS; Debrework Zewdie, Health, Nutrition and Population Specialist, The World Bank

World Bank data show that of the disease burden in women aged 15-44, maternal causes are the greatest, and STDs/HIV are the next most serious (Figure 1, page 7). The number of new cases annually of curable sexually transmitted diseases is estimated at 333 million worldwide (Table 2, page 7). Current transmission patterns show that adolescents must be given priority in prevention programmes. According to WHO, half of all infections to date have been in 15-24 year-olds, and in many countries 60 percent of all new HIV infections are in this age group, with a female-to-male ratio of two to one.

How do STDs, HIV, and AIDS fit into a reproductive health framework? It is most practical to view it at the service delivery level, using clients' needs as a starting point. The prevention strategies and technology for avoiding pregnancy and STDs overlap. Similarly, the prevention of mother-child transmission of disease, especially syphilis, overlaps with prenatal care. Yet, in spite of the theoretical overlap between these services—family planning, STDs/HIV, and prenatal care—opportunities for prevention of STDs and HIV are often lost in practice.

Interventions and actions

Alternative approaches exist for combating the spread of STDs and HIV/AIDS: Programmes can either maintain a special focus on STDs or integrate STD prevention and treatment with other services. No single, technical solution exists for the problem of STDs and HIV/AIDS. As complex problems, they require a combination of approaches. A number of interventions, service improvements, and actions are recommended:

- ▲ There is no simple dichotomy between prevention and care. To achieve greatest impact in preventing STDs in certain populations, services need to offer improved diagnosis and treatment as well.
- ▲ Simple, cost-effective interventions are available. Analysis needs to be made of the various levels where interventions can be made to improve health-seeking behaviour, i.e., among the general population, among those infected, or among those seeking care. A few fundamental things need to be done, such as providing sufficient equipment in hospital maternity wards to inhibit the spread of infections.
- ▲ Programmes need to accomplish more with the same resources. Improvements in planning, management, and training will be needed. Socio-economic conditions matter:

If providers are poorly paid and have poor infrastructure, additional training will have little impact.

- ▲ Communication campaigns will require tailor-made approaches. Priority should be given to social marketing of condoms; information, education, and communication (IEC) for vulnerable populations; and school sexual health education.
- ▲ Research is needed on new tools and technologies, including women-controlled technologies to prevent HIV and STDs, STD diagnostics, and strategies for management of asymptomatic infections. Operations research is needed in the areas of service delivery and communication.
- ▲ Special attention needs to focus on interventions for young women, and these cannot wait until broader strategies for empowerment of women succeed.
- ▲ A critical role for donors will be to ensure access to the best international practices and to create a supportive environment for policy, such as advertising of condoms.

Box 2 Defining and Operationalizing Reproductive Health

Mahmoud Fathalla, Senior Adviser, Biomedical and Reproductive Health Training and Research, Rockefeller Foundation

The revelation in Cairo was that the "population pyramid" was not just made up of numbers, but of people. By making their voices heard, the world's citizens succeeded in shifting the focus of the debate from demographic targets to individuals. Individual need is the basis for the concept of reproductive health. Reproductive health needs arise at consecutive phases of the lives of each individual; they are closely related, and they have impact on each other.

Individuals want the *ability* to have children and to avoid having children, and to have mutually fulfilling sexual relationships. They would like *successful* outcomes in terms of pregnancy and child survival, and they need *safety* in pregnancy and childbirth, in fertility regulation, and in sexual relationships.

Allocation of resources will need to be based on two criteria: the magnitude of the disease burden and the availability of cost-effective interventions. According to the 1993 World Bank Development Report, "Large disease burdens and cost-effective interventions coincide for only one group of adults, women aged 15-44." Of the five clusters of primary health care

interventions that the World Bank identified as costing \$50 or less per disability-adjusted life year (DALY)* saved in developing countries, three are in reproductive health: family planning; prenatal and delivery care; and case management of STDs. (See Table 1 below.) In other words, reproductive health is good value for money.

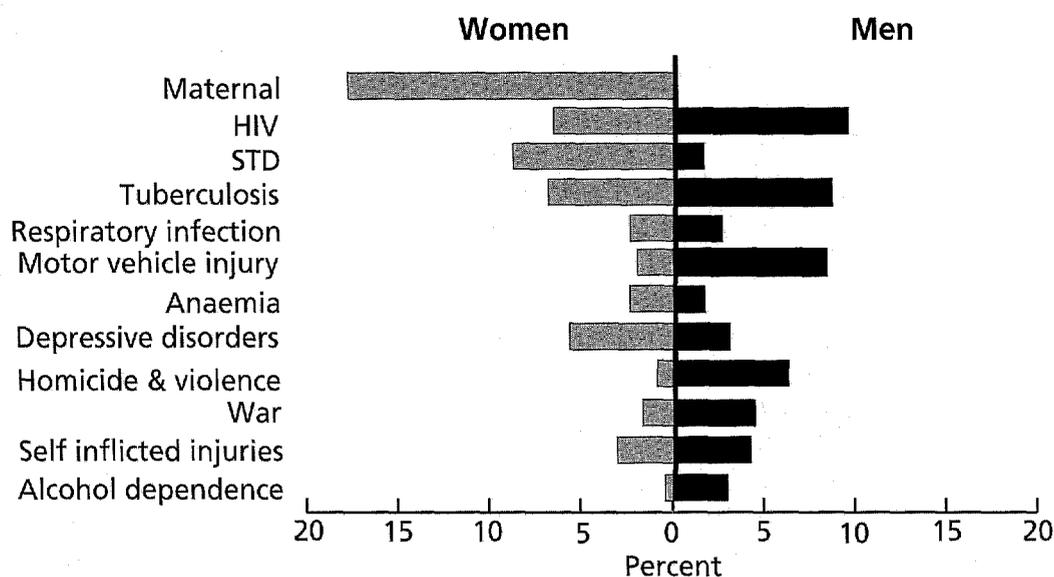
* DALY is the loss of disability-free life as a result of death, disease, or injury.

Table 1
Cost Effective Interventions for Women aged 15-44, 1990

Main causes of disease burden	Cost per DALY saved
<i>Unwanted pregnancy</i>	\$15-150
<i>Maternal causes</i>	\$60-110
<i>STDs</i>	\$10-15
<i>HIV</i>	\$3-5

Source: World Development Report, 1993

Figure 1 Burden of Disease in Adult Men and Women aged 15-44 Years in the Developing World, 1990



Source: World Development Report, 1993

Table 2 Estimates of Reproductive Ill-Health

Category	Millions (worldwide)
Couples with unmet family planning need	120
Unsafe abortion	20
Pregnancy complications	30
Maternal deaths	0.5
Perinatal mortality	7
Infants with low weight at birth	23
Curable STDs (new cases)	333
Cumulative total of HIV infections by the year 2000	35
Cumulative total of AIDS cases by the year 2000	15

Source: WHO/Family Health Division/95.6

Strategies for the prevention and treatment of STDs are not new. The challenge will be to bring them into the mainstream of reproductive health services. On one hand, it can be argued that vertical programmes are too expensive and reach too few people and that integrated services make the best use of common counselling skills and prevention technologies. Integrated services also avoid losing clients in the referral process. Some successful instances were cited of integrating syphilis treatment with maternal care and HIV/AIDS prevention with family planning. On the other hand, special (vertical) programmes at the international and national levels may be the best guarantee that such integration of services eventually takes place at the client level.

Donor representatives questioned the cost of various treatments for STDs and alternatives to the condom.

Simple tests for many STDs do not exist for resource-poor settings, and diagnostic tools are still imperfect. Syndromic management—identifying the best possible treatment based on symptoms—is being evaluated in many places and in high prevalence areas may be considered 60-80 percent effective. (However, it may be noted that many women present without symptoms.) Resources will be needed for drugs, and drug resistance may drive up the price of treatment. Microbicides combined with spermicides could be an effective dual-prevention technology; however, their development will require additional resources. In the meantime, programmes should continue to focus on increasing the use of condoms, especially encouraging their use inside and not just outside the home and marriage.

Family Planning

Speakers: Pramilla Senanayake, Assistant Secretary General, International Planned Parenthood Federation; Ayo Ajayi, Regional Director for East and Southern Africa, The Population Council

Family planning has been and will continue to be the centrepiece of reproductive health and therefore will continue to account for a significant portion of donor efforts and resources. Family planning is a preventive health measure: It reduces the frequency of ill-timed pregnancy and childbirth, saves the lives of millions of women and girls, and relieves the public sector of the high costs of hospital care and curative medicine for both women and children. Other aspects of reproductive health are vitally important for men and women at different times of their reproductive lives and according to their personal circumstances—but, above all, contraceptive advice and services are essential for sexually active couples from the onset to the end of reproductive life.

Unmet need

Based on Demographic and Health Survey (DHS) data from married women not practising family planning, unmet need for contraceptives ranges from about 14 percent of married couples in Brazil, Colombia, Indonesia, and Sri Lanka to more than 35 percent in Bolivia, Ghana, Kenya, and Togo. However, estimates of the unmet need for family planning based upon World Fertility Survey and DHS data are generally too low, since unmarried individuals and adolescents are not included.

Many under-served sectors of societies are still in need of family planning, especially the unmarried, adolescents, and men. Teenagers who are not physically and emotionally ready for motherhood constitute a high-risk group. Contraceptive use is very low among adolescents in sub-Saharan Africa. For example, in Senegal, only 2 percent of married women aged 15 to 19 use contraception, while maternal mortality among that age group represents 18 percent of all maternal deaths. Even in countries where contraceptive use is higher, the rate of use among adolescents is low. Finally, statistics on induced abortions provide yet another indication of unmet need for family planning. Often, women resort to abortions because of a lack of available services or a lack of satisfaction with existing services, including the failure of a contraceptive method.

Programme costs

The cost of family planning programmes varies widely between countries according to the services offered, the facilities available, and the extent to which cost recovery can be achieved through client fees and contraceptive sales. Global expenditures were estimated to be \$4.5–5 billion per year in the early 1990s. The ICPD Programme of Action recommends

Box 3 Mexico: From Mexico City to Cairo and Back

*Gregorio Perez-Palacios, Director General of Reproductive Health,
Ministry of Health, Mexico*

Mexico provides an excellent example of a country that has exercised the political will and the programme planning capacity to fulfill the commitments made in Cairo. Historically, Mexico focused its efforts on expanding access to and acceptance of family planning in response to a perceived population explosion in the 1960s. In 1974, the Constitution was amended to make family planning a right for all Mexicans. With that, the government established a population programme with two central driving factors: the impact of rapid population growth on the socio-economic development of the country, and the extension of the reproductive rights of each individual. As a result of the government's commitment and the concomitant efforts of non-governmental organizations, the total fertility rate in Mexico declined from 7 children per woman in the 1970s to 3 children per woman today.

Following the ICPD, the Government of Mexico adopted the broader concept of reproductive health. To implement the Cairo Programme of Action, the Ministry of Health began by merging the Maternal/Child Care and Family Planning Directorates into one new Directorate of Reproductive Health. The pillars of the National Reproductive Health

programme include: family planning, adolescents, safe motherhood, women's health, and sexually transmitted diseases, with an overall gender perspective. The new thinking in the family planning sector includes strengthening women's roles, highlighting men's responsibility in the reproductive process, and the prevention and management of infertility.

Advocacy, education, and communication efforts will be used to spread the message of reproductive health. Mass media are used to bring the concept of reproductive health to health workers, clients, and the general population. Mexico also targets adolescents with appropriate information, services, and social marketing programmes, and is implementing a nationwide no-scalpel vasectomy programme.

Mexico's success story is being shared with other countries through the Partners in Population and Development Initiative, which will support South to South transfer of experience. The recipe for the Mexican success can be found in more than 20 years of significant government efforts, and in viewing the ICPD as an opportunity to review their progress to date and to expand programmes to embrace a more holistic view of women's reproductive health needs.

that to make family planning universally available, global expenditures on family planning should reach \$10.2 billion annually by the year 2000 and \$13.8 billion by 2015, about one-third of which should come from the international donor community.

There is some disagreement on whether and to what extent high costs come down once demand for contraception is firmly established. Costs may decline as the number of users increases, but so far there has been little evidence that this is happening. Cost-cutting could be achieved through bulk purchase of contraceptives, distribution through the private sector, the elimination of unnecessary tests and follow-up clinical visits, and prescription by paramedical personnel instead of the more expensive physicians. Improving the quality does not always imply higher costs: more efficient clinic management and eliminating unnecessary tests can be achieved at zero or reduced costs. Experience also suggests that money spent on improving services, by increasing contraceptive prevalence and continuation, may cost less per client in the long run.

Relationships between family planning and other reproductive health services

The infrastructure of existing family planning programmes provides a unique mechanism to offer essential reproductive health services. Because family planning services are more advanced in many countries than other forms of reproductive health care—having been subject to exhaustive testing and scrutiny—they are an excellent starting point for developing more fully integrated health programmes. The experiences of family planning programmes in promoting quality of care, streamlining delivery systems, recruiting and training personnel, using indigenous health workers, and conducting research and evaluation are all relevant for reproductive health programmes. At the same time, limiting family planning services to the health care system is constraining, as many reproductive-age people are not in need of other health services.

Safe Motherhood

Speakers: Jon Rohde, Representative, UNICEF-India; Wendy Graham, Director, Dugald Baird Centre for Research on Women's Health, Aberdeen University

Complications related to pregnancy and childbirth are among the leading causes of mortality for women of reproductive age in many parts of the developing world. Yet despite efforts to date, most women in developing countries are not seen during pregnancy or delivery by a health worker who is able to educate her about care and nutrition or to identify and manage pregnancies with complications.

Even if other reproductive health problems are largely overcome by preventive services at the community level, maternal mortality will continue to be a significant public health problem in any country where women do not give birth in health facilities. Moderator Allan Rosenfield reported that a recently-held Interagency Task Force on Safe Motherhood—which convened donor agencies and NGOs—concluded that the problem of maternal mortality will not be resolved without access to essential emergency services for women who need them.

Traditional approaches to maternal mortality reduction have not been successful because, with the exception of unsafe abortion and severe anaemia, major maternal complications that lead to death are not amenable to preventive measures. The only truly effective prevention of maternal death is prevention of pregnancy; beyond that, complications cannot be predicted accurately.

The need for emergency obstetric care

A body of evidence shows the poor predictive value of obstetric history, age, and parity as maternal risk factors. Thus, the identification of high/low risk groups of prenatal women is not an effective strategy for reducing mortality. It often results in a false assurance to low risk women who may later develop life-threatening complications, and invariably identifies many women “at risk” who go on to have normal deliveries. This undermines the credibility of the health worker in the eyes of mothers. The early identification of complications, such as hypertension, bleeding, abnormal foetal position, and pre-existing disease is useful. However, much more emphasis is needed on overcoming barriers to seeking and accessing appropriate follow-up care.

- ▲ Once complications arise, medical intervention is required—in the majority of cases at a health institution with the capacity to provide medical and surgical obstetric services. Thus programmes must aim to move women with complications to appropriate facilities. In a number of countries, building or staffing more hospitals is not the best option. More lives can be saved by improving the quality, and ultimately the use of existing services. Facilities that could provide lifesaving care are often under-utilized for this purpose.
- ▲ It is important to forge strong linkages between institutions and the communities (reducing the “psychic distance” between women and services); increase accountability for referrals; and introduce service innovations such as changes in staffing patterns and improved stocking of equipment and supplies for blood transfusions, anaesthesia, and laboratory work.
- ▲ At the village level, emphasis should be on ensuring preparedness of families and health care providers to recognize problems when they arise and on the knowledge and motivation to take appropriate action, including referrals. Programmes should ensure that those who influence decisions, including local nurse-midwives and mothers, recognize the early signs of complications and know where and when to seek care.
- ▲ Programmes should mobilize communities to accept hospital care as a necessary and appropriate strategy for dealing with obstetric complications, and to arrange transport for medical emergencies. This may require greater interaction in the community and social pressure to encourage households to take appropriate actions.

Discussion focused on the level of health facility needed to provide emergency services and whether or not risk indicators should continue to be used. Where hospital infrastructure is non-existent, health centres should be equipped and serve as the first referral point for emergency services. Discussants also agreed that households are the appropriate level for IEC efforts and decision making. Transport may not be the only barrier facing households; families may also be reluctant to go to hospitals out of fear that they cannot afford to pay for a caesarean section or other emergency care.

Other prenatal and intrapartum interventions

Reducing maternal mortality does not necessarily imply reducing morbidity. About 100 acute cases of morbidity exist for each maternal death. Thus, reducing ill-health associated with pregnancy and childbirth must figure among donor goals. A balance must be maintained between providing for complicated cases and meeting the needs of women with normal, uncomplicated pregnancies.

What should be in the safe motherhood package? There are multiple points at which services can intervene. Apart from ensuring access to medical treatment for obstetric emergencies, discussed earlier, priorities for safe motherhood include the following:

- ▲ Reduce exposure to the risks of unwanted pregnancies, by providing accessible and acceptable family planning services and safe abortion services.
- ▲ Establish and improve other maternal health services, by equipping community maternities, training traditional birth attendants to refer and treat women with complications, improving prenatal care services, and establishing maternity waiting homes.

Prenatal care interventions of proven effectiveness include anaemia screening, iron/folic acid supplementation, iron treatment for anaemia, identification and treatment of hypertension, and screening and treatment for genital tract infections, all of which can be carried out at the primary health centre level. Only those interventions of proven benefit should be prioritized; those of unproven benefit must be subject to rigorous examination.

Measuring effectiveness is crucial to evidence-based policy and practice and should be given a higher priority within safe motherhood programmes and on the research agenda. Guidelines are needed for establishing the biological and operational effectiveness of prenatal, intrapartum, and post-partum care. Measures of effectiveness also need to be broadened beyond maternal mortality.

Certain problems are caused by avoidable factors: mismanagement and substandard care may contribute to, or even be the prime cause of, maternal morbidity and mortality. Quality of care and, in particular, procedures to identify and correct substandard care need to be built into services through a routine audit cycle. Quality of care is a pre-requisite for the optimal use of services.

With regard to linkages, a supermarket approach to providing services may be needed. A prenatal visit, for example, may be a key opportunity to enhance a woman's reproductive health. However, integrated reproductive health programmes need to maintain a balance in service provision between complicated and normal pregnancies. For the latter, programmes need to maintain referral systems to emergency services. Programme planners should also bear in mind that they may be loading services on to a small number of providers. Midwifery as a profession is varied in terms of skills and approaches, and thus efforts are needed to advance professional standards if midwives are to take on additional roles.

Post-partum Care

Speaker: Soledad Diaz, Directora, Instituto Chileno de Medicina Reproductiva (ICMER)

Post-partum health care should jointly address mothers' and infants' needs because the physiology of the mother and child are linked through breastfeeding and because the health and development of children is part of women's lives and fulfilment. There is a tendency on the part of health services to provide quality prenatal services, but as soon as a delivery takes place, providers' attention switches to the child. Thus, the continuity of women's reproductive health care is broken in a period in which women are particularly vulnerable, both from a physical and psychological perspective.

Adequate post-partum services, including contraceptive and breastfeeding services, may have a large positive impact on the health of women and infants, may contribute to prolonged birth intervals, and may increase the acceptability of family planning advice. They can provide the information and support that women need to have a fulfilling experience of motherhood. In addition, they offer the opportunity to include men in reproductive health care, if they are interested in the health and development of their children.

ICMER as a case study of post-partum care

The ICMER programme in Chile provides an example of a “woman-friendly” service—one that allows women to obtain information and services for themselves and their infants in one setting. The ICMER post-partum programme was initiated at the end of 1977 and more than 5,500 mothers have participated. The mothers belong to the lower socio-economic classes, are mostly literate, and have had normal pregnancies and deliveries.

The services at ICMER include: integrated maternal-child care, where mother and child are seen in the same visit and share a common clinical record; regular post-partum visits; counselling on and provision of contraceptive methods that are appropriate for lactating women; practical advice and counselling on infant care, including promotion of exclusive breastfeeding during the first six months post-partum; and provision of general health services, including screening for cervical cancers and gynaecological infections and paediatric examinations.

All of the health providers are trained in both breastfeeding and family planning so that they work as a team and provide consistent and reinforced messages to clients. The principal message conveyed to women is that they are responsible for their own health care and reproductive decisions; the role of the staff is to provide the needed information, services, and support.

The ICMER post-partum programme model has been evaluated both quantitatively and qualitatively. For women who remained in the programme for the first year post-partum, pregnancy rates range from 1 percent (long-term methods) to 2 percent (progestin-only pills), and the overall contraceptive continuation rate is around 98 percent. The proportion of women who are breastfeeding at 6 months (91 percent) has remained stable throughout the 15 years of the programme. Only one infant death in about 5,500 cases has been reported, and the rate of severe illnesses is extremely low.

Nutrition

Speaker: Gerd Holmboe-Ottesen, Associate Professor, Department of Preventive Medicine, Oslo University

Nutrition affects women’s health throughout their lives and particularly in the context of safe motherhood. A striking proportion of women in the developing world are malnourished. Anaemia, mostly caused by insufficient iron, is the most common nutritional disorder in the world today. Additionally, about 45 percent of all women in less developed countries are underweight—below 45 kg. Although nutrition is one of the single most important determinants of reproductive health, little research and few actions have been undertaken to address the problem.

Women’s nutrition is important for reproductive health outcomes. Women who are malnourished have a higher risk of death associated with pregnancy and childbirth than other women, and they are more prone to disease and reduced quality of life. Many of the immediate causes of maternal deaths—e.g., haemorrhage, infection, obstructed labour—can be associated with nutritional deficiencies, such as anaemia, malnutrition, and small stature. In addition, children of malnourished mothers have lower birth weights and are more likely to grow up malnourished, creating an inter-generational cycle of growth failure.

Women are exposed to additional reproductive stress owing to the overlap between pregnancy and breastfeeding, which is common in many developing countries. Women’s working conditions and family obligations add to reproductive stress and nutrition depletion.

A heavy work load, especially during peak labour seasons, may also have repercussions for pregnancy outcomes.

Solutions

To enhance women's reproductive health, donors need to focus more on the factors that determine women's nutritional status. By choosing programme strategies that improve the nutritional status of the mother, the nutritional status of children can also be improved.

Improvements in women's nutrition should ideally begin in childhood if optimum conditions for reproduction are to be achieved. At older ages, several strategies can be chosen, including increasing women's production and income-earning opportunities in general, and more specifically, supplementary feeding to pregnant and lactating women.

Special emphasis should be placed on anaemia, since it is the major nutritional problem for women in developing countries. Anaemia can be combated not only with iron supplementation, but with dietary improvements in general.

Unsafe Abortion

Speakers: Khama Rogo, Chairman, Centre for the Study of Adolescence, Department of Obstetrics and Gynaecology, University of Nairobi; Forrest Greenslade, President, IPAS

WHO estimates that approximately 70,000, or 13 percent, of the 500,000 maternal deaths that occur each year throughout the world (and as many as one-fourth in some countries) are the result of complications of unsafe abortion. Some 20 million unsafe abortions take place every year. This represents a ratio of one unsafe abortion in ten pregnancies, or one unsafe abortion in seven births.

Mortality as a result of unsafe abortions is highest in Africa, even though a smaller number of abortions take place in the region compared with Asia, Latin America, and the former Soviet Union. In a 1989 study of patients admitted to Kenyan hospitals suffering from unsafe abortion, the complications identified included pelvic sepsis, septic shock, haemorrhage shock, anaemia, and genital infections.

Abortion-related mortality is more preventable than some of the other direct causes of maternal mortality. Affordable and effective approaches exist that can reduce mortality and morbidity due to the complications of abortion—namely, family planning information and services (including emergency contraception), emergency treatment for the complications of unsafe abortions, and safe abortion services for termination of pregnancy when laws permit. Better linkages among these services are needed.

Barriers to addressing unsafe abortion exist at various levels: individuals and communities (knowledge, attitudes, and moral and religious opposition); national policies and legislation; and service delivery systems. Many service providers are lacking the technical skills, equipment, and funds to treat complications arising from unsafe abortion.

Box 4 Bangladesh: Public/Private Partnerships in Reproductive Health

Sadia A. Chowdhury, Director, Health and Population Programme,
Bangladesh Rural Advancement Committee (BRAC).

The first National Family Planning Programme in Bangladesh was initiated in 1965, and in 1975, the programme was broadened to include maternal and child health. Safe motherhood and family planning are the only elements of "reproductive health" that have received much attention in programming and research to date. Facilities for diagnosis and treatment of infertility are limited to a handful of physicians in urban areas. The number of clandestine abortions is high and appears to be increasing, although the reasons need to be studied further. The prevalence of STDs and reproductive tract infections are also likely to be high owing to lack of access to reproductive health information, unsafe hygienic practices, and non-existence of diagnosis and treatment facilities. In addition, while the spread of HIV is thought to be at an early stage, the potential for increase is great because of a lack of information and general taboos against talking about sexuality.

NGOs have been involved in family planning and maternal-child health activities since their inception in Bangladesh in the 1950s. With over 1,000 small and large national NGOs working in this field, much of the country is covered by private providers working alone or complementing public services. It is estimated that NGOs account for 37 percent of the distribution of modern contraceptive methods.

The Bangladesh Rural Advancement Committee (BRAC) is a national organization whose goal is poverty alleviation and empowerment of the

poor. BRAC works in 74 percent of the thanas, including the provision of health care in 13,000 villages. It has recently initiated a new partnership with the government to facilitate family planning and other reproductive health programmes in eight districts.

The political commitment to the partnership between the public and private sector was witnessed in the cooperative dialogue between government and non-governmental representatives in preparation for the ICPD. In addition, a number of working groups composed of private and public sector representatives exist to set programme and policy directions.

Within this framework of cooperation, and in response to the commitment to reproductive health coming out of the ICPD process, the following activities have been outlined to form the foundation of the more holistic approach to reproductive health services in the future:

- ▲ a baseline study on emergency obstetric services and a further study of knowledge, attitudes, and practices regarding emergency care;
- ▲ design of an emergency obstetric care intervention;
- ▲ establishment of a Mother Friendly Hospital Initiative;
- ▲ initiation of the Intersectoral Task Force to develop strategies for HIV/AIDS programmes;
- ▲ official involvement of women's health advocates in the policy process; and
- ▲ creation of "gender focal points" inside the Ministry of Health and Family Welfare.

Recommended donor actions

To address the reality of unsafe abortion, a checklist of actions to confront the problem and reduce maternal mortality and morbidity includes the following:

- ▲ A first step is to incorporate post-abortion care into existing health programmes. Post-abortion care includes the treatment of abortion complications, post-abortion family planning, and links to other reproductive health care services.
- ▲ Donors should work to strengthen the global consensus on the problem of unsafe abortion. They should frame discussions on unsafe abortion as a public health issue, and avoid inflammatory language.
- ▲ Donors need to inform field staff that unsafe abortion is a concern and solicit suggestions on ways to address it. Country assessment teams should be instructed to consider unsafe abortion as a component of the reproductive health needs to be addressed. Questions about the magnitude of unsafe abortion should be included in assessment forms and guidelines.
- ▲ Efforts to address unsafe abortion should be included as a component in existing programmes, for example, Safe Motherhood. Programmes that train health providers to manage other obstetric emergencies should include the management of incomplete abortions.
- ▲ The quality of care in treatment of abortion complications can be improved by: following WHO recommendations for decentralized care; providing manual vacuum aspiration instruments as part of safe delivery and emergency obstetric kits; “partnering” with donors who support these commodity purchases; and supplying the clinical reference materials to support high quality care.
- ▲ Since women who arrive at hospitals for abortion-related problems are likely to be non-users of preventive health services, the concept of “managing” incomplete abortion must be expanded to include other post-abortion care services, such as family planning, screening for STDs, and referrals for other health problems.
- ▲ In order to demonstrate the links between improved services and reductions in abortion-related mortality and morbidity, donors will need to measure programme outcomes differently and pay particular attention to the social and economic costs of unsafe abortion.

Manual vacuum aspiration (MVA) equipment, used to treat incomplete abortions, is a simple and safe technology that can be used in many clinic settings, as it does not require an operating theatre. In Kenya, one study estimated that health facilities could save 60-70 percent of service costs by shifting from dilation and curettage to MVA.

Adolescents

Speaker: Tirbani Jagdeo, Chief Executive Officer, Caribbean Family Planning Association

Current population data indicate that there are more than one billion young people between the ages of 10 and 19—possibly the largest cohort of teenagers ever on the planet. Thus, the future of reproductive health and population stabilization will depend on today’s adolescents. In fact, it may be the best example of where the two interests—reducing population growth rates and improving reproductive health—coincide. Unfortunately, adolescents make up the most underserved segment of the population.

About 15 million girls ages 15 to 19 give birth every year. Yet appropriate services for young people are seriously lacking in many countries, owing to controversy, ignorance, and lack of recognition of the serious health consequences that affect millions of sexually active teenagers. However, this is changing and could change even faster if some of the imaginative innovations aimed at young people could be replicated on a large scale. Family planning and reproductive health programmes for young people have been tested in a number of countries, but the experiences have not been shared in a comprehensive fashion.

Programme considerations

A number of issues related to adolescents' sexual and reproductive health were outlined for donors to consider:

- ▲ Programme planners and service providers need to understand how adolescents behave. Adolescent health problems are highly preventable; however, adolescents as a group do not believe that they have health concerns and therefore often do not seek care.
- ▲ There is no such thing as a universal adolescent community: adolescent needs vary with their age, culture, and social status. Adolescents from indigenous groups are at greater risk of reproductive health problems. These and other disadvantaged groups are more likely to have early and closely spaced pregnancies as well as sexually transmitted diseases.
- ▲ Evidence shows that contraceptive use among sexually active adolescents tends to be lower than among sexually active adults. As a result, teenage pregnancies have become common in many societies. Teenagers often postpone seeking health care, in part because of fears of the consequences of social disapproval of premarital sex.
- ▲ Experience shows that information and education works: young people who are exposed to information are more likely to use contraceptives than those who are not exposed.
- ▲ Mistimed pregnancies among teenagers are not a failure of technology but of policy. Special initiatives are needed to bring sex education into the schools and more widespread information and education on STDs and HIV/AIDS.
- ▲ Policy makers also need to consider adolescents' support systems, as evidence shows that young women are more likely to have early pregnancies if they are from single-parent homes.

Participants strongly endorsed the need for greater attention to adolescent needs, and some suggested that the donor community may need to consider a radically different service model for adolescents. However, programmes for adolescents raise many sensitivities, and ironically, the attitudes and behaviour of adults may undermine efforts to change behaviour in adolescents. One discussant suggested that adolescent health is not a "donor-friendly" area because it is closely linked to political, religious, and cultural issues. But others felt that donors have a duty to work with governments on the need to reach adolescents.

Recommendations for donors

Adolescents are the most critical group to be targeted for both prevention of pregnancy and STDs—in no other group do the two concerns overlap so clearly. In terms of needed technology, microbicides and barrier methods are suitable for adolescents in addressing both of these needs.

With regard to behavioural change, no standard models exist but there is adequate knowledge to move forward. Two promising initiatives that are proving useful in a range of different cultures are peer counselling and special clinics for adolescents, which create an atmosphere of trust and confidentiality. Many projects recruit young people themselves to find out what other young people know or want to know about sexuality. These initiatives are promising, although there is little hard evidence to prove their effect on adolescent reproductive health.

Discussants offered a range of options for addressing the reproductive health needs of young people:

- ▲ youth-friendly services;
- ▲ a supportive policy environment;
- ▲ development of national action plans;
- ▲ school health education packages (although it was noted that many children at risk are not in school after the primary grades); and
- ▲ use of media to provide constructive messages.

Violence Against Women

Speaker: Lori Heise, Co-Director, Health and Development Policy Project

Gender-based abuse is a widespread problem that poses obstacles to health and development and thus should be addressed as part of a reproductive health package. Until now, most family planning and reproductive health programmes have been designed on the premise that all sexual acts are consensual. Yet abuse and violence against women is a widespread phenomenon and should be of particular concern to donors because of its relationship to overall health status—HIV prevention, unwanted pregnancy, family planning, and safe motherhood. In addition, most governments have made moral and legal obligations to fight violence as part of their commitments under international law.

State of knowledge

Evidence indicates that gender-based violence—including rape, partner assault, and sexual abuse—constitutes a substantial health risk factor. U.S. studies repeatedly show that women with a history of sexual or physical assault seek more medical care than other women. Multivariate analysis suggests that victimization affects health care use indirectly through its impact on psychological and physical well-being.

Where studies have been conducted on the prevalence of sexual coercion and abuse, the results have been striking. In Uganda, for example, a study of 400 randomly selected primary school students (with an average age of 13.9) found that 49 percent of sexually active girls said they had been forced to have intercourse. In Jamaica, a study of 450 school girls ages 13-14 found that 13 percent had experienced attempted rape and an additional 3 percent had been raped, half before the age of 12.

Box 5 Ghana: Next Steps in Strengthening Reproductive Health Programmes

Henrietta Odoi-Agyarko, Director, Maternal-Child Health Division, Ministry of Health

Both before and since the ICPD, the Ministry of Health in Ghana has been making strides toward implementing a broader programme of health care services for women. While Ghana has had a family planning programme for over 20 years, less attention has been given to other areas of reproductive health. New efforts are now being undertaken in safe motherhood, prevention and treatment of STDs, post-abortion care, infertility, cervical and breast cancer, and female genital mutilation.

In the area of safe motherhood, current activities include training of traditional birth attendants, equipping midwives, and re-examining training curricula for doctors and midwives. Efforts are being made to prevent maternal mortality by involving private transport unions and individual vehicle owners to assist pregnant women in labour. In addition, the government will use a multi-media approach to dispel misconceptions and taboos regarding women's health during pregnancy, which often lead to delay or denial of care.

With national HIV prevalence in adults approaching 4 percent, the government is increasing its activities in the prevention of STDs (including HIV) and in training caregivers in home-based care of persons with AIDS. One challenge will be to engender political commitment by leaders at the national, regional,

district, and local levels. Under the circumstances, it is critical that a multi-sectoral approach be taken to slow the spread of HIV. Social marketing messages have proven effective: over 60 percent of respondents to the Ghana Demographic and Health Survey said that they received their AIDS information from the radio.

While 43 percent of married women in Ghana report having used family planning, there is a wide gap between knowledge and use. In order to expand access to a range of methods, the Ministry plans to train personnel and equip facilities to provide long-term methods, while encouraging the private sector to provide short-term methods like pills and condoms.

Special programmes are underway to gain the involvement of religious and traditional leaders in reproductive health and to alter the societal norms regarding family size. A challenge to improving use of condoms and other contraceptives will be religious concerns about advertising of modern methods on television.

While programme management and support issues remain to be resolved, the Ministry of Health is committed to the implementation of broader reproductive health programmes and has developed a medium-term plan, which should also be a basis for programming donor assistance. The challenge in Ghana will be to integrate the additional components into existing service delivery systems.

Gender-based abuse can have negative reproductive health consequences resulting from battering during pregnancy and coerced sexual relations. Battering during pregnancy can result in miscarriage, premature births, low birth weights, and other pregnancy complications. Coerced sexual relations interfere with contraceptive use (particularly condoms), thereby bringing about unwanted pregnancies and STDs. Sexual abuse in childhood has also been linked via multivariate analysis to early sexual initiation and increased risk of unwanted pregnancies and STDs in adulthood. Gender-based abuse also contributes to other gynaecological problems including chronic pelvic pain, vaginal discharge, and pelvic inflammatory disease.

Implications for reproductive health programmes

Victims of abuse often have reproductive health needs that presently go unattended; thus, providers need to be aware of how violence and gender power issues affect women's reproductive health and decision making. Provider attitudes can either facilitate safety and healing or "revictimize" clients through judgmental or indifferent behaviour.

Family planning and health providers are strategically placed to refer women to available support services. Also, sexuality and family life education and counselling programmes can be strengthened by adding elements that directly address myths about male/female sexuality, coercion, sexual communication and assertiveness.

Recommended donor actions

- ▲ Strengthen existing NGOs and channel funds for anti-violence programming through women's grant-making institutions.
- ▲ Fund baseline surveys on the nature, frequency, and severity of abuse in different settings.
- ▲ Fund research into the health and development consequences of sexual coercion and abuse.
- ▲ Fund research and demonstration projects to test pilot public health interventions against abuse.
- ▲ Encourage the application of lessons learned from HIV prevention to the challenge of changing social norms and behaviours toward gender-based abuse.
- ▲ Accelerate funding for female-controlled methods of STD/HIV prevention, such as microbicides.
- ▲ Increase provider awareness of the problem of gender-based abuse and incorporate questions to screen for abuse into routine reproductive health care. Support emergency contraception for rape victims.

Female Genital Mutilation

Speaker: Nahid Toubia, Executive Director, RAINBO

An estimated 130 million girls and women in the world have suffered female genital mutilation (FGM), and some 2 million are at risk every year—predominantly in Africa. Girls and women who have suffered from the procedure experience pain, trauma, and, frequently, severe physical complications, such as bleeding, infections, urine retention, and shock leading in some cases to death.

In addition to complications, which have obvious health effects, FGM has other sexual and reproductive health implications: subservience to male decisions; genital phobia; fear of infertility; inability to use vaginal and uterine contraceptives; and low self esteem. Reasons for limited action can be attributed to the fact that FGM has been a hidden problem; it is mainly limited to Africa; it centres around strong cultural beliefs; and is a difficult behaviour-change issue.

Areas of need

Documented evidence indicates that FGM is prevalent in 28 African countries, although there is wide variation in prevalence within and among countries. The five countries accounting for the largest number of cases (below) represent 75 percent of total cases reported in Africa.

	Estimated prevalence	No. cases (millions)
<i>Nigeria</i>	60%	36.8
<i>Ethiopia/Eritrea</i>	90%	23.9
<i>Egypt</i>	80%	21.4
<i>Sudan</i>	89%	9.2
<i>Kenya</i>	50%	6.3

Actions to be taken

With regard to laws and policies, international standards related to FGM are already in place. Most countries have ratified the UN Convention to Eliminate All Forms of Discrimination Against Women (CEDAW). Additionally, international conferences such as the 1993 Vienna Human Rights Conference and the 1994 ICPD have garnered government support for eliminating traditional practices that are harmful to women's health. Most relevant

UN agencies, bilateral and multilateral donors, and international NGOs have developed policies on FGM.

Resources and technical support are lagging behind policy. It is too early to say whether donors and governments will back their commitments with funding. Behavioural and operations research, programmes, monitoring and evaluation are all needed but still lacking. The most urgent need is in the area of technical assistance in operations research and the development of programme interventions that could bring about behavioural change. As a first step, cultural sensitivity is being broached through international dialogue and consensus. A few existing programmes, such as those in Egypt and Burkina Faso, include education and training, multi-media awareness campaigns, and resource centres. But it will take time to show impact on the incidence of FGM from this kind of intervention.

Donor participants noted that behaviour change related to FGM has been a neglected area, along with gender power issues in general. Where education and urbanization have increased, some changes have occurred. Where changes are slow to occur, information, education, and communication programmes are a key intervention for combating the practice. In Burkina Faso, for example, education efforts on FGM worked in the context of discussions on women's health and roles.

Cross-Cutting Issues in Programme Implementation

Vertical and Integrated Approaches

In a number of sessions of the workshop, both expert presenters and donor representatives raised questions about how best to organize programmes to make the most reproductive health services and information available to users at the lowest cost. In some settings family planning and other health programmes have developed as vertical, or separate, activities. At the same time, individual users of services have an array of reproductive health needs; they must be able to access services that address these needs. Where feasible, these needs should be met in a comprehensive fashion, through integrated services.

Some advantages of vertical programmes were highlighted. Vertical programmes have special goals, which enable them to develop technical norms, standards, and training programmes. Before setting up vertical programmes, testing and analysis is done to identify the most cost-effective service approaches. Support and monitoring for execution is also essential for programme objectives to be met. Programmes and clients thus benefit from more focused, technically sound, and carefully monitored vertical approaches. Also, controversial activities are less likely to be neglected in vertical than in integrated programmes.

In the area of STDs and HIV/AIDS in particular, opportunities for identification and prevention of disease are often lost, especially as service providers become overloaded with responsibilities. Thus, a special programme may be the best guarantee that a full range of services, including STD diagnosis and treatment, will be available to clients. If STD and HIV/AIDS services are merely viewed as an “add-on” to family planning, however, their effectiveness could be limited.

Discussants pointed out a number of advantages of comprehensive reproductive health services:

- ▲ the age group addressed is the same (women and men of reproductive age, including adolescents);
- ▲ common counselling skills and technologies are used (particularly for family planning and STDs);
- ▲ family planning services in some settings are more acceptable to clients when integrated with other health services;
- ▲ integrated programmes have synergistic and mutually reinforcing elements that contribute to reductions in mortality and morbidity;
- ▲ integrated services are more convenient to users (e.g., mothers can get care for themselves and their children at the same time); and
- ▲ integrated approaches can reduce overall costs and enhance sustainability.

One discussant made a distinction between programmes and services; that is, a family planning, STD, or safe motherhood programme may be vertical in terms of its funding sources and objectives, but integrated at the level of services to the end user.

Opinions differ on the gains and losses from integrated services and much more work needs to be done to identify and resolve the constraints that may arise in combining health components that have previously operated separately under their own management structures.

In settings where public sector infrastructure is weak, the comprehensive primary health care approach may be unrealistic. Thus donors need to know more about those strategies and interventions that offer the best potential; this will require testing approaches that enable women and men to have an array of reproductive health needs addressed at the same time.

Donors may wish to obtain the benefits of both vertical and integrated approaches. Many vertical programmes exist today as a result of donors’ and governments’ interests and past investments. The challenge now is to bring them together to create a reproductive health approach.

Donors are not in agreement as to whether services should be entirely integrated—nor is such an agreement necessary. On the other hand, donors need to understand each other’s differences about priorities. Participants agreed that individual users should be able to access the information and services that they need, when they need it—whether it be from one or multiple services.

Public and Private Sector Roles

The private sector already provides substantial service coverage in many countries and has considerable potential for making a greater contribution, with appropriate government support. The private sector typically includes NGOs, private practitioners, clinics, hospitals, and commercial outlets such as pharmacies and shops.

Reproductive health programmes can benefit from an expansion of the private sector's role because of the resources, flexibility, and efficiency of private agencies. They can make tactical changes quickly, shift resources, and recruit and retain high quality staff. However, the private sector depends on supportive government policies and direct assistance for some activities, such as serving low-income clients. At the same time, if clients value the services, many will pay for them.

Discussants agreed that NGOs will play an important role in service delivery for the foreseeable future. NGOs have long been involved in family planning and STD prevention because many governments have preferred to steer clear of sensitive issues. NGOs can be flexible and work in innovative areas that might otherwise be unexplored by governments. The strength of NGOs lies in their ability to pioneer, demonstrate, experiment, and innovate. They can also serve as models or set benchmarks for government services.

Some participants questioned whether NGOs would be in a position to expand to offer a broader range of reproductive health services, or carry the weight of a national programme. On the other hand, Profamilia in Colombia was cited as an example of a national, NGO service provider that makes available a whole range of reproductive health services, and that directly or indirectly serves the majority of the population. Participants noted that, even if NGOs do not directly serve a large number of clients themselves, they may provide training or help meet other needs of government programmes.

Programme sustainability is a critical issue for many donors. Many believe that the public sector should be responsible for bringing about long-term sustainability. Governments must be able to define and determine clearly their roles in ensuring that reproductive health needs are met. The question, then, is how can public-private partnerships be fostered to maximize the role of both sectors? One donor representative suggested that donors should assist in the development of market solutions. Since only a handful of governments and multilateral agencies have large amounts of resources to invest, the private sector will have to be engaged and encouraged to play its part in finding solutions to global problems.

Research Needs

Research is a first step to bringing culturally and politically sensitive issues, such as adolescent sexuality, unsafe abortion, and gender abuse, to the attention of policy makers. Hard data are needed to convince policy makers of the need to act, even when proven interventions already exist. In the area of gender-based abuse, interventions are lacking in part because of a lack of information on the magnitude of and reasons for the problem.

In addition, fresh research designs and methods need to be developed. New survey instruments, for example, will be valuable in identifying needs and in planning reproductive health programmes. Better diagnostic tools are needed to combat the spread of STDs and HIV/AIDS in resource-poor settings. In the area of safe motherhood, research is required on the most effective interventions, so that evidence-based practice becomes the driving force behind programmes.

While some basic epidemiological research will be necessary, most donors prefer programme-oriented research because it allows programme planners and policy makers to focus concretely on how to bring about change. A number of research-related recommendations were put forth:

- ▲ Investigation is needed of different service models for reproductive health: expanding existing services; integrating services; and/or testing new models with added interventions.
- ▲ Research must be field-based and participatory. Priority issues should be decided in the field and research studies designed to answer programme managers' and fieldworkers' questions. Programme managers and staff, not researchers, should design intervention packages.
- ▲ Increased use of methods from outside the medical/public health research community, e.g., market research, may be useful. Market research techniques could be particularly useful in measuring changes in knowledge and awareness of reproductive health issues. UNFPA and other donors are also exploring the potential for simple survey research methodologies to complement those already in use.
- ▲ Operations research is needed on how to involve local constituencies; how to integrate, evaluate, and determine cost-effectiveness of services; and how to retrain workers. It was suggested that the impact of shifting away from demographic targets for field workers should be studied further.

Health Policy Reform

Policy change is needed in developing countries if governments are to place greater emphasis on reproductive health in their own programmes and budgets. One donor suggested that in many developing countries, reproductive health does not constitute a priority for the ministries of health and therefore few project proposals are put forth to donors. Another donor stated that the economic justification for reproductive health investments needs to be more fully developed apart from the public good rationale that has justified population programmes.

A number of speakers reminded participants that in order to address the complex array of reproductive health issues, donors may have to deal with problems in the health care system as a whole. Donors have a critical role in supporting health sector reform to encourage optimal allocation of resources. This may include emphasizing preventive care over costly curative care, and ensuring that inefficient parallel structures do not exist for service delivery.

Donors need to address issues of broad reform in their dialogue with governments, and be prepared to use their resources as "venture capital" to support the process of change. This is particularly important because programme managers and service providers face a multitude of day-to-day challenges and constraints and thus may not change directions on their own. Moreover, because health providers focus on managing the consequences of unhealthy behaviour, they often have an inability to act on policies that deal with the causes. In many countries, a range of policies, laws, and regulations pose barriers to the implementation of goals agreed upon in Cairo.

Advocacy for Reproductive Health

Just as family planning and STD prevention programmes faced resistance in past decades, many reproductive health concerns being discussed in international fora today will have to overcome political and cultural sensitivities at the local level. Difficult topics, such as female genital mutilation, unsafe abortion, and adolescent sexuality, will require data (and courage) for advocacy efforts to be effective. Advocacy will also be needed to encourage men to take more responsibility for reproductive health and family life.

Advocacy will be needed on the part of donors, NGOs, and collaborating institutions to convince recipient governments, particularly financial authorities, that reproductive health is a priority. South-south collaboration and involvement of women's and grass-roots organizations can help to increase the visibility and political will devoted to implementing the reproductive health goals of the ICPD.

III. Coordination and Monitoring of Donor Assistance: Donor Roundtable

Moderator: Mahmoud Fathalla, Senior Adviser, Biomedical and Reproductive Health Training and Research, Rockefeller Foundation

To ensure that limited funds for reproductive health are spent wisely, donors need to set priorities, make tough choices, and closely monitor programme implementation in the field. Some cost-effective reproductive health interventions are well-known, yet others are still new. For example, family planning programmes have been demonstrated to be effective. Programmes in the area of STDs and HIV/AIDS prevention, safe motherhood, emergency obstetric care, and post-abortion care still need further validation. Areas such as gender-based violence are still lacking viable interventions.

In all areas, there is a need to document those programme approaches that are most cost-effective, sustainable, and practical. Donors will need to exchange experiences about what works, and work with developing country governments in defining priorities among a range of reproductive health interventions. While the focus of the workshop was on programmes linked to health care systems, all participants recognized that it is also critical to increase women's control over resources and other forms of empowerment.

WHO and UNFPA representatives presented their institutions' approaches to addressing reproductive health. WHO defines priorities in reproductive health to be family planning, safe motherhood, and STD prevention and management. Groups in need of targeted assistance include families, adolescents, men, and refugees/displaced persons. UNFPA activities will be concentrated in three core areas: reproductive health (including family planning and sexual health); population policy development; and advocacy in sexual and reproductive rights (including gender equality). An important message for the donor community is to ensure that in any given country, each of the key elements—family planning, STDs/HIV, and safe motherhood—is supported by at least some donor or the government. All donors and governments should consider the need to invest in young people, and should engage in dialogue and coordinate efforts.

Programme Development and Expansion

A number of donor representatives emphasized that programmes must be a national responsibility, not donor driven. Planning for reproductive health programmes should take place at the local level, with broad social participation. Decentralized planning should be promoted whenever possible, resulting in local development plans with specific inputs and interventions.

At the same time, all donor agencies—and especially those that manage large programmes—must have a set of priorities to guide programme planning and resource allocation. Donors need to work with countries to identify and agree upon common goals, objectives, and responsibilities, and help define roles that offer the best prospects for improving reproductive health.

Several approaches exist for developing and coordinating reproductive health programmes among governments and donors. At a minimum, donors need to exchange

information regularly. It is clear that donor coordination has been more effective in some countries than in others. In some countries, governments can coordinate donor inputs into relatively well-developed programmes. Elsewhere, consortium approaches involving donor co-financing or donor parallel financing, such as that led by the World Bank in Bangladesh, may offer an effective way to coordinate donor inputs. In other countries, such as Kenya, more ad hoc coordination has worked effectively. Donors with limited staff are often receptive to close coordination with those who have more.

In developing new interventions, donors need to collaborate in specifying and testing alternative technologies and approaches. Finally, donors must identify and build on their comparative advantages—whether working through bilateral assistance or multilateral agencies. Ideally, a complementarity of priorities will be achieved, such that all needs are ultimately addressed. Coordination among bilateral and multilateral donors has worked increasingly well in such areas as commodity procurement for family planning programmes, and should be equally encouraged in other areas of reproductive health. UNFPA, WHO, and the World Bank have all been reviewing their strategies in reproductive health and will all play critical roles, as will UNICEF in relation to its mandate. Just as it is important for bilateral donors to collaborate, it is essential that these key multilateral agencies coordinate their resources and inputs effectively.

Programme Monitoring and Evaluation

As a follow up to the ICPD, donors will need to track reproductive health expenditures and develop better indicators for measurement of reproductive health outcomes. Donors will need structured monitoring of:

- ▲ the amount spent by donors on each element of reproductive health;
- ▲ the outputs and achievements of these interventions;
- ▲ the value for money (or cost-effectiveness) of these investments; and
- ▲ advocacy undertaken on reproductive health and its effectiveness.

Tracking of reproductive health expenditures poses particular problems within as well as between donor agencies. Within any one agency, difficulties arise in identifying which health and family planning expenditures can be grouped as “reproductive health.” Between agencies, comparability will be difficult if they choose to support different programme elements of the reproductive health package.

A third problem arises in tracking expenditures over time: the time series data developed and used by international organizations such as the Development Assistance Committee of the OECD and UNFPA will become confused as definitions of programmes broaden. One danger is that pre-existing funding for health programmes will be regrouped as reproductive health and double counted, creating a false impression of increased donor funding.

Donor representatives therefore called for agreed-upon categories for reproductive health expenditures, so that bilateral programmes can be compared to each other. It was noted that the basic guidance for tracking expenditures is already provided in Chapter 13 of the Cairo Programme of Action. However, systems for tracking spending on specific elements of reproductive health also need to be developed. Bilateral donors will look to UNFPA to track reproductive health inputs globally for both donors and host countries and to maintain

as well as possible consistency with earlier series. Reporting to the UN Commission on Population and Development will be an essential element of this process.

Monitoring and evaluation efforts will need to be strengthened within each donor agency and will also benefit greatly from inter-agency collaboration. Evidence of programme outcomes is needed both to improve the quality of programmes and to demonstrate effectiveness to ensure future resource flows.

Measuring programme outcomes

To evaluate reproductive health programmes, donors will need new indicators, systems for measurement, and syntheses of lessons learned. Measuring programme impact will be critical for guiding programme planning and resource allocation.

USAID has begun work in several areas, the results of which will be circulated to donors:

- ▲ a handbook of reproductive health indicators;
- ▲ operations research to test strategies for linking family planning with other aspects of reproductive health;
- ▲ an expert panel study of reproductive health by the National Academy of Sciences; and
- ▲ a comprehensive review of data collection efforts with the assistance of the National Academy of Sciences.

Several participants noted that Demographic and Health Surveys (DHS) are a useful but incomplete mechanism for measuring reproductive health outcomes. For example, DHS data do not provide reliable maternal mortality trends, nor can they indicate programme costs. Modifications in DHS and other types of surveys and data collection methods may be needed to track progress in some special areas of reproductive health.

Donors need to become more efficient in their own efforts and implement “best practices” according to country needs. At the same time, coordination and monitoring mechanisms are needed that serve the collective needs of the donor community. Some of these mechanisms exist already, such as the functions that UNFPA is increasingly performing in commodity procurement and tracking expenditures. Some additional functions may have to be created, and further exploration will be needed about what form these should take. One donor representative suggested that an important task is to distil expenditure data and evidence of outcomes into short policy-oriented summaries. In this way domestic audiences in donor countries can be better informed about the value and impact of work in this area.

Funding for Reproductive Health

A number of donor representatives expressed concerns about whether funding would be adequate to meet the reproductive health needs of growing numbers of individuals of reproductive age. Donor agencies will be challenged to present these needs before their directors, ministers, or parliaments and make a convincing case for using taxpayers’ funds to achieve the goals laid out in the ICPD. A working definition of reproductive health is useful for this purpose, as is a simple categorization of needs into six or seven key areas. And, above all, donors need evidence that programmes are working.

The ICPD was a success in that the concept of reproductive health was adopted not only by technical experts but by politicians. Many policy officials are strongly in favour of the new concepts and goals articulated at the ICPD, but are now asking how they will be implemented. Reproductive health goals therefore need to be articulated in more operational terms so that they can be fully funded.

In the wake of the political commitments made at Cairo, donors will need to articulate clearly to domestic constituencies what reproductive health is, and to "sell" reproductive health to policy officials. The most convincing case, according to one donor, is that reproductive concerns touch all individuals at some point in their lives and thus "reproductive health is a problem of 6 billion lives."

Appendix 1

Programme of Action of the International Conference on Population and Development

Chapter VII (excerpts)

A. Reproductive rights and reproductive health

Basis for action

7.2. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

7.3. Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of their right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programs in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women

32

and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

Actions

7.6. All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, *inter alia*, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health-care programmes.

Appendix 2

Statement by Dr. Nafis Sadik, Executive Director of the United Nations Population Fund

at the Donor Workshop on Implementing Reproductive Health Programmes
12 June 1995

Thank you very much for inviting me here this morning. It is a great pleasure for me to be with you on the first day of this workshop and to have the opportunity to share ideas with friends and colleagues from so many countries.

We are meeting today to exchange information on how to go about implementing the Programme of Action of the International Conference on Population and Development. It is hard to think of a more important topic than the role of the international community in assisting all developing countries, as well as countries with economies in transition, in the tremendous challenge that lies ahead. The ICPD took a critical step in endorsing both a holistic, primary health care approach to reproductive health, including family planning, and a set of goals by which our collective success will be judged.

The Programme of Action also requires all of us to be strong and steadfast advocates for all aspects of sexual and reproductive health and rights, even though our direct financial support may be provided on a more selective basis. I will return to this later.

We know from experience that practically all countries have accepted the concept of reproductive health, and that they are now examining their programmes as to how to adapt them to provide a wider array of services in an integrated manner. Nevertheless, several countries are also having some difficulties with the new terminology, particularly in translating the term reproductive and sexual health to different languages. We thus need to assist countries in both moving operationally in the direction laid down in the ICPD Programme of Action, and in gradually adopting the terminology as well.

I am reminded here of the situation in sub-Saharan Africa as recently as the early 1980s when the term "family planning" was unacceptable, and yet the concept and the practice of child spacing, particularly for the health of mothers, caused no difficulties, and within a relatively short period of time led to the widespread acceptance of both family planning and population issues.

We need to be clear that reproductive health always *includes* family planning, and indeed family planning will continue to be a central component of reproductive health,

- ▲ since it allows couples and individuals to meet their reproductive goals, thus giving women the freedom and ability to participate actively in social and economic development
- ▲ since it is central to the reduction of maternal mortality and morbidity;
- ▲ since it is central to preventing the need for recourse to abortion;
- ▲ and since it enables women to have more control over their sexual lives and thus more control over the transmission of reproductive tract infections including STDs and HIV/AIDS.

34

There are no *standard* models or blueprints for the operationalization of reproductive health programmes in the context of primary health care, and we should not waste any time looking for them. There are probably a variety of approaches which can work, just as there have been with family planning, and we need to encourage countries to try out what seems most appropriate, and to learn from their own experiences and from the experiences of others.

However, all new approaches must continue to pay special attention to improving the quality of care, for example, in regard to the training and reorientation of primary health care workers in order to enable them to provide quality services. Furthermore, a participatory approach, involving all appropriate constituencies, in the design of reproductive health programmes will be essential to their ultimate success.

In our efforts to assist countries in improving the reproductive health of their peoples, certain over-riding issues need to be remembered.

First, our ultimate goal should be to develop comprehensive and integrated systems of reproductive health care that offer the full range of services, as outlined by WHO in its recent report to the World Health Assembly entitled "Reproductive Health: WHO's role in the Global Strategy." However, this will best be achieved, in practice, through an incremental approach which builds on existing primary health care infrastructures. We need to identify gaps and inadequacies, and strengthen links between programmes which are currently addressing one or more of the components of reproductive health.

Second, we should continue to stress that operational programmes should respond to the reproductive health needs of individuals, and therefore must be based on an identification, assessment and prioritization of such needs on a country by country basis. We need to rapidly assemble the best tools and methods to undertake reproductive health needs assessments, side-by-side with instruments to assess the capacity of current institutional structures to meet those needs.

Third, we need to continue in our efforts to ensure that women, women's organizations, and other groups working for women's needs are fully involved in the planning, implementation and monitoring of reproductive health services and programmes. Women will necessarily remain the focus of reproductive health activities since the burden of sexual and reproductive ill-health affects women to a much greater extent than it does men.

We should also not forget that the empowerment of women is a fundamental prerequisite to sound reproductive health. This requires that women have increased access to resources, education and employment, and that their human rights and fundamental freedoms are promoted and protected so that they are enabled to make choices free from coercion or discrimination. Family life education and public information for young people that encourages responsible sexuality, respect for women, and gender equity are also fundamental to improving the status and role of women in society.

All organizations and agencies need to advocate for the promotion of gender concerns, as well as for issues relating to the girl child and the education of girls as necessary prerequisites for reproductive health.

Fourth, the Tasks set out in the Programme of Action are beyond the capacity of any single organization. We need to strengthen collaborative and coordination arrangements with WHO, UNICEF and other partners in the UN system, the International Financial Institutions, as well as bilateral agencies and relevant NGOs.

At the inter-country level, WHO, in collaboration with the Joint United Nations Programme on HIV/AIDS, should provide an overall framework to operationalize reproductive health programmes and should define policies, give technical guidance, and set norms and standards for the full spectrum of reproductive health activities. International,



non-governmental organizations can assist in a number of areas such as the testing of operational approaches, and research activities, for example, in regard to new and improved contraceptive methods. Together, we all need to better ensure links between global research and development activities and operational programmes. Global agendas must be driven by the needs of countries, and if we assure this, it will facilitate the incorporation of the results of this work into programmes at country level.

Fifth, at country level the implementation of Reproductive Health Programmes is also beyond the capacity of any single organization. *National* programmes need to be made up of an appropriate mix of public, non-governmental and private sectors, each according to their comparative advantage and market segment. NGOs have an important role in developing and testing innovative approaches and in monitoring both quality of care and progress towards national goals. In supporting the strengthening of national reproductive health programmes, we, as a family, must ensure better co-ordination at country level.

In this regard, the Inter Agency Task Force Working Group on Reproductive Health, which will convene on June 29 in Geneva, will provide further guidance as to how to strengthen this process. I sincerely hope that, in the future, your bilateral activities at country level will be conceived and implemented within an overall nationally coordinated framework.

Let me now turn to some even more specific issues.

The ICPD Programme of Action gave us a global menu for reproductive health, and I have already said that the menu to be adopted by any particular country should be determined by the reproductive health needs of their populations. However, since needs are always greater than resources, some prioritization is inevitable, and we would be derelict in our duty, if we did not provide some indication of priorities from a global perspective and from the perspective of those interventions which are liable to have the greatest impact on sexual and reproductive health.

Reproductive health programmes must give priority to family planning; maternal and neonatal care; and reproductive tract infections including STDs and HIV/AIDS.

I have already indicated why family planning must continue as a central component of reproductive health. Next comes maternal care, including abortion care as specified in the Programme of Action, since this too is almost a universal need throughout the world, and since so much mortality and morbidity related to pregnancy, unsafe abortion, and child birth is preventable by technologies which are currently available. Reproductive Tract Infections and sexually transmitted diseases, including HIV/AIDS, need to be addressed at country level according to their epidemiological patterns, their incidence, and the population groups in which they are most prevalent. All countries require prevention programmes in this area to one extent or another.

Our Expert Consultation on Reproductive Health, held last December, pointed out that if these priority areas are addressed, we will thereby prevent the occurrence of many other women's reproductive health conditions including secondary infertility.

Finally, harmful practices, such as female genital mutilation, need to be addressed in those countries where they exist. But, as was also concluded at our Expert Consultation, we also require more information on the underlying socio-cultural causes of such practices in order to develop better strategies for their education.

Let me conclude by mentioning a number of very important issues.

The Programme of Action clearly calls upon us all to address squarely the issue of adolescent sexual and reproductive health. In many countries, over one-half of adolescents are married. However, whether married or single, all adolescents need access to reproductive health information, education and services. We need to advocate for, and support, country-specific, culturally appropriate, accessible information and services for adolescents that

recognize the important linkages between human sexuality, family planning and the transmission of sexually transmitted diseases including HIV/AIDS. We need to involve adolescents in the planning, implementation and monitoring of adolescent reproductive health programmes, and we need to utilize approaches that have been shown to be effective such as peer counseling.

The Programme of Action also calls for much greater attention to the roles and responsibilities of men in reproductive health. Men must be urged and supported to take responsibility for their sexual and reproductive behaviour. Once again we all have an important advocacy role in this area, as well as a duty to support initiatives to explore how the needs of men for sexual and reproductive health services can best be met, and how their roles can most appropriately be supported.

Emergency situations - refugees, displaced persons, natural disasters and armed conflicts - put women in even more acute need of sexual and reproductive health services, and in addition expose women to a greater degree to the threat of sexual violence. As a community we must always be ready to respond immediately when emergencies occur. UNFPA is currently developing with UNHCR, in cooperation with WHO, UNICEF and a number of Non-Governmental Organizations, technical guidance for the provision of sexual and reproductive services in such situations.

Finally, let me reiterate that in everything we do we should be guided by the needs of individuals; we should be guided by all the principles of the Programme of Action; we should be guided by the objective of improving the effectiveness and efficiency of reproductive health programmes at country level; and we should be guided by the over-riding goal... "to make accessible through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible, and no later than the year 2015."

Thank you.

Appendix 3

Participant Contact Information

Ayo Ajayi

Regional Director for Sub-Saharan Africa
The Population Council
P.O. Box 17643
Nairobi, Kenya
phone: 254-2-713480 fax: 254-2-713480
e-mail: pcnairobi@popcouncil.org

Lori Ashford

Deputy Director, International Programs
Population Reference Bureau
1875 Connecticut Avenue, NW
Suite 520
Washington, DC 20009, USA
phone: 1202-483-1100 fax: 1202-328-3937
e-mail: lashford@prb.org

Jose Barzelatto

Director of Reproductive Health and Population
The Ford Foundation
320 East 43rd Street
New York, NY 10017, USA
phone: 1212-573-4920 fax: 1212-697-7354

G. Benagiano

Director, Special Programme of Research,
Development and Research Training in Human
Reproduction
World Health Organization
1211 Geneva 27, Switzerland
phone: 41-22-791-33-80 fax: 41-22-791-41-71

Yves Bergevin

Senior Specialist, Health and Population, Policy
Branch
Canadian International Development Agency
200 Promenade du Portage
Hull, Quebec, Canada K1A 0G4
phone: 1819-997-7870 fax: 1819-997-6356
e-mail: Yves_Bergevin@ACDI-CIDA.GC.CA

Marit Berggrav

Head, Health Division
Norwegian Agency for Development
Cooperation
P.O. Box 8034 Dep.
N-0030 Oslo, Norway
phone: 42-22-314-400 fax: 42-22-314-401

Michael Bohnet

Deputy Director General
Federal Ministry for Economic Cooperation and
Development
Friedrich-Ebert-Allee 114-116
53113 Bonn, Germany
phone: 49-228-535-3750 fax: 49-228-535-3755

Loretta Brabin

Senior Lecturer in Women's Health
The Liverpool School of Tropical Medicine
Pembroke Place
Liverpool L35QA, United Kingdom
phone: 44-151-708-9393 fax: 44-151-707-2885

George Brown

Vice President, Programs Division
The Population Council
One Dag Hammarskjold Plaza
New York, NY 10017, USA
phone: 1212-339-0600 fax: 1212-755-6052
e-mail: gbrown@popcouncil.org

Margaret Catley-Carlson

President
The Population Council
One Dag Hammarskjold Plaza
New York, NY 10017, USA
phone: 1212-339-0501 fax: 1212-755-6052
e-mail: mcatley-carlson@popcouncil.org

Sadia Chowdhury

Director, Health and Population Programme
BRAC
66 Mohakhali C/A
Dhaka 1212, Bangladesh
phone: 8802-884-180 fax: 883542 or 883614

John Cleland

Professor of Medical Demography
Centre for Population Studies
London School of Hygiene &
Tropical Medicine
99 Gower Street
London WC1E 6AZ, United Kingdom
phone: 44-171-388-3071 fax: 44-171-388-3076
e-mail: j.cleland@lshtm.ac.uk

Barbara Crane

Policy Adviser, Office of Population
Center for Population, Health and Nutrition
U.S. Agency for International Development
SA-18, Room 711
Washington, DC 20523-1819, USA
phone: 1703-875-4634 fax: 1703-875-4693
e-mail: bcrane@usaid.gov

Nils Daulaire

Senior Health and Population Adviser
Bureau for Program and Policy Coordination
U.S. Agency for International Development
SA-18, Room 811
Washington, DC 20523-1819, USA
fax: 1202-647-9747

Soledad Diaz

Directora
Instituto Chileno de Medicina Reproductiva
Jose Ramon Gutierrez 295 - Depto. 3
Correo 22, Casilla 96
Santiago, Chile
phone: 562-632-1988 fax: 562-633-6204

Nicholas Dodd

Chief, Reproductive Health/Family Planning
Branch
UNFPA
220 East 42nd Street
New York, NY 10017, USA
phone: 1212-297-5211 fax: 1212-297-4917

France Donnay

Senior Adviser for Women's Health
UNICEF
3 UN Plaza, East 44th Street
New York, NY 10017, USA
phone: 1212-326-7313 fax: 1212-326-7336
e-mail: f.donnay@unicef.org

Mahmoud Fathalla

Senior Adviser on Reproductive Health
Training and Research
The Rockefeller Foundation
P.O. Box 30
Assiut, Egypt
phone: 20-88-334-820 fax: 20-88-337-333

Duff Gillespie

Deputy Assistant Administrator
Center for Population, Health and Nutrition
U.S. Agency for International Development
SA-18, Room 811
Washington, DC 20523-1819, USA
phone: 1703-875-4708 fax: 1703-875-4693
e-mail: dgillespie@usaid.gov

Wendy Graham

Director, Dugald Baird Centre for
Research on Women's Health
Aberdeen University
Aberdeen Maternity Hospital
Foresterhill
Aberdeen AB9 2ZD, United Kingdom
phone 44-1224-681818 ext.53924
fax: 44-1224-404-925
e-mail: wgraham@aberdeen.ac.uk

Forrest Greenslade

President
IPAS
303 E. Main Street
P.O. Box 100
Carrboro, NC 27510, USA
phone: 1919-967-7052 fax: 1919-929-0258

John Haaga

Director of Committee on Population
National Academy of Sciences
2101 Constitution Avenue, NW
Washington, DC 20418, USA
phone: 1202-334-3167 fax: 1202-334-3768
e-mail: jhaaga@NAS.EDU

Lori Heise

Co-Director
Health and Development Policy Project
6930 Carroll Avenue, 4th Floor
Takoma Park, MD 20912, USA
phone: 1301-270-1182 fax: 1301-270-2052
e-mail: lheise@igc.apc.org

Gerd Holmboe-Ottesen
Associate Professor
Department of Preventive Medicine
Oslo University
P.O. Box 1130 Blindern
0318 Oslo, Norway
phone: 4722-850-632 fax: 4722-850-620

Robert E. Howells
Programme Director
Wellcome Trust
183 Euston Road
London NW1 2BE, United Kingdom
phone: 44-171-611-8569
fax: 44-171-611-8237 or 8528

Kiyoko Ikegami
Senior Program Officer, International
Department
JOICFP
Hoken Kaikan Bekkan
1-1, Ichigaya Sadohara-cho
Shinjuku-ku, Tokyo 162, Japan
phone: 813-3268-5875 fax: 813-3235-7090

Kaoru Ishikawa
Director, Technical Cooperation Division
Economic Cooperation Bureau
Ministry of Foreign Affairs
2-2-1, Kasumigaseki
Chiyoda-ku, Tokyo 100, Japan
phone: 81-3-3581-3866 fax: 81-3-3580-6249

Dr. Tirbani Jagdeo
Chief Executive Officer
Caribbean Family Planning Association
Factory and Airport Road
P.O. Box 419
St. John's, Antigua, West Indies
phone: 1809-462-4170 fax: 1809-462-4171

Harumi Kitabayashi
Deputy Director, First Medical Cooperation
Division
JICA
P.O. Box 216 Shinjuku Mitsui Bldg.
No.1-1, 2-Chome, Nishi-shinjuku
Shinjuku-ku, Tokyo 163-04, Japan
phone: 81-3-3346-5219 fax: 81-3-3346-5474

Marjorie Koblinsky
Director
MotherCare
John Snow, Inc.
1616 N. Fort Myer Drive
Arlington, VA 22209, USA
phone: 1703-528-7474 fax: 1703-528-7480

Romaine Kwesius
Assistant Director
Health and Population Section
Australian Agency for International
Development
P.O. Box 887
62 Northbourne Avenue
Canberra ACT 2601, Australia
phone: 616-276-4652 fax: 616-276-4870

Jacques Laruelle
Public Health Specialist
Belgian Administration for Development
Cooperation
G61/13: Office for Specialized Agencies
6, Rue Brederode
1000-Brussels, Belgium
phone: 32-2-500-62-52 fax: 32-2-500-65-85

Ginevra Letizia
Ministry of Foreign Affairs
Directorate General for Development
Cooperation
Via S. Contarini, 25
00194 Rome, Italy
phone: 396-3691-4621 fax: 396-324-0585

Elizabeth Maguire
Director, Office of Population
Center for Population, Health and Nutrition
U.S. Agency for International Development
SA-18, Room 811
Washington, DC 20523-1819, USA
phone: 1703-875-4505 fax: 1703-875-4413
e-mail: lmaguire@usaid.gov

Ellen Marshall
Senior Coordinator for Population
Bureau for Population, Refugees and Migration
U.S. Department of State
2201 C Street, Room 5824
Washington, DC 20520, USA
phone: 1202-647-9718 fax: 1202-647-8162

Guillermo Martinez-Correcher
Deputy Director Technical Cabinet
Spanish Agency for International Cooperation
Ministry of Foreign Affairs
Avenida Reyes Catolicos, 4
28040 Madrid, Spain
phone: 341-583-8508/8147 fax: 341-583-8141/
8450

Per-Ola Mattsson
First Secretary, Multilateral Division
Dept. of Technical Cooperation,
Ministry of Foreign Affairs
P.O. Box 16121
10323 Stockholm, Sweden
phone: 46-8-405-1000 fax: 468-723-1176

Tim McIvor
Multilateral Aid Officer
Development Cooperation Division
Ministry of Foreign Affairs and Trade
Wellington, New Zealand
phone: 64-4-472-8571 fax: 64-4-473-9311

Thomas Merrick
Senior Population Adviser
Population and Human Resources Department
The World Bank
1818 H Street, NW
Washington DC 20433, USA
phone: 1202-473-6762 fax: 1202-522-3235
e-mail: tmerrick@worldbank.org

Eduardo Missoni
Ministry of Foreign Affairs
Directorate General for Development
Cooperation
Via S. Contarini, 25
00194 Rome, Italy
phone: 396-3691-4154-3236-900
fax: 396-324-0585

Claudia Morrissey
Reproductive Health Adviser
Office of Health and Nutrition
Center for Population, Health and Nutrition
U.S. Agency for International Development
SA-18, Room 811
Washington, DC 20523-1819, USA
phone: 1703-875-7281 fax: 1703-875-4686

David Nabarro
Chief Health and Population Adviser
Overseas Development Administration
94 Victoria Street
London SW1E 5JL, United Kingdom
phone: 44-171-917-0107 fax: 44-171-917-0107

Henrietta Odoi-Agyarko
Director
Maternal Child Health Division
Ministry of Health
Accra, Ghana
phone/fax: 233-21-226-739

David Oot
Director, Office of Health and Nutrition
Center for Population, Health and Nutrition
U.S. Agency for International Development
SA-18, Room 811
Washington, DC 20523-1819, USA
phone: 1703-875-4456 fax: 1703-875-4686

Aagje Papineau Salm
Coordinator, DST/TA
Directorate General for International
Cooperation
Ministry of Foreign Affairs
Bezuidenhoutseweg 67
P.O. Box 20061
2500 The Hague, The Netherlands
phone: 3170-348-4894 fax: 3170-348-5956

Gregorio Perez-Palacios
Director General of Reproductive Health
Ministry of Health
Insurgentes Sur 1397, 6 Piso
Delegacion Benito Juarez
03920 Mexico, D.F., Mexico
phone: 525-598-5617 fax: 525-598-6528

Ines Perin
Medical Consultant
Directorate General for External Economic
Relations
Commission of the European Union
Rue de la Loi 200
B-1049 Brussels, Belgium
phone: 322-299-2031 fax: 322-299-1063

Peter Piot
Executive Director
Joint United Nations Programme on AIDS
c/o World Health Organization
CH - 1211
Geneva 27, Switzerland
phone: 4122-791-2111 fax 4122-791-0746/0317

Mary Beth Powers
Consultant
The Population Council
One Dag Hammarskjold Plaza
New York, NY 10017, USA
phone: 1212-339-0600 fax: 1212-755-6052

Khama O. Rogo
Chairman, Centre for the Study of Adolescence
Dept. of Obstetrics and Gynecology
College of Health Services
University of Nairobi
P.O. Box 30588
Nairobi, Kenya
phone: 2542-220-754 fax: 2542-562-901

Jon Rohde
Unicef Representative
United Nations Children's Fund - India
73 Lodi Estate
New Delhi, 110003, India
phone: 91-11-469-0401
fax: 91-11-462-7521 or 469-2601
e-mail: jer@uncdel.ernet.in at internet

Allan Rosenfield
Dean
School of Public Health
Columbia University
617 W. 168th Street, Room 319
New York, NY 10032, USA
phone: 1212-305-3929 fax: 1212-305-1460

Nafis Sadik
Executive Director
UNFPA
220 East 42nd Street
New York, NY 10017, USA
phone: 1212-297-5000 fax: 1212-297-4911

Claudine Sauvain-Dugerdil
Consultant to Swiss Development Cooperation
University of Geneva, Labo Demographie
Rue Dancet 2
CH-1211 Geneva 20, Switzerland
phone: 41-22-705-7108 fax: 41-22-320-9125

Jacques Schwartz
Adviser, Population Research Unit
Sub-directorate on Health and Social
Development
Ministry of Cooperation
1 bis, Avenue de Villars
Paris 75700, France
phone: 331-47-830166 fax: 331-45-515964

Pramilla Senanayake
Assistant Secretary General, Technical Services
International Planned Parenthood Federation
Regent's College, Inner Circle
Regent's Park
London NW1 4NS, United Kingdom
phone: 4471-487-7864 fax: 4471-487-7865

Steven Sinding
Director, Population Sciences
The Rockefeller Foundation
420 Fifth Avenue
New York, NY 10018, USA
phone: 1212-869-8500 fax: 1212-852-8278

Jyoti Singh
Deputy Executive Director
UNFPA
220 East 42nd Street
New York, NY 10017, USA
phone: 1212-297-5211 fax: 1212-297-4915

Patience Stephens
Specialist in Population Analysis and Research
Population Division, United Nations
DC-2 UN Plaza, East 44th Street
New York, NY 10017, USA
phone: 1212-963-8390 fax: 1212-963-2147

Anne Tinker
Senior Health Specialist
The World Bank
1818 H Street NW
Washington, DC 20433, USA
phone: 1202-473-3683 fax: 1202-522-3235

Nahid Toubia
Executive Director
RAINBO
915 Broadway Suite 1603
New York, NY 10010, USA
phone: 1212-2477-3188 fax: 1212-477-4154

42

Tomris Turmen

Director, Division of Family Health
World Health Organization
1211 Geneva 27, Switzerland
phone: 4122-791-2111 fax: 4122-791-0746

Elini Visuri

Counsellor, Adviser on Social
Development and Population
Ministry of Foreign Affairs, Department for
International Development Cooperation
P.O. Box 176
FIN - 00161 Helsinki, Finland
phone: 358-0-1341-6437 fax: 358-0-1341-6428

Carl Wahren

Head, AID Management Division
Organization for Economic Cooperation and
Development
2, rue Andre Pascal
75775 Paris Cedex 16, France
phone: 331-4524 9072 fax: 331-4524 1997

Beverly Winikoff

Program Director, Reproductive Health
The Population Council
One Dag Hammarskjold Plaza
New York, NY 10017, USA
phone: 1212-339-0623 fax: 1212-755-6052
e-mail: bwinikoff@popcouncil.org

John Worley

Population and Reproductive Health Specialist
Health and Population Division
Overseas Development Administration
94 Victoria Street
London SW 1E 5JL, United Kingdom
phone: 44-171-917-0139 fax: 44-171-917-0174
email: hpd0jmw.vs4@oda.gnet.gov.uk

Inese Zalitis

Head of Section
Health Division
Swedish International Development Agency
S 105 25 Stockholm, Sweden
phone: 468-7285439 fax: 468-6126380

Debrework Zewdie

Population, Health and Nutrition Specialist
The World Bank
1818 H Street NW
Washington, DC 20433, USA
phone: 1202-473-9414 fax: 1202-522-3235

Copies of this report can be obtained from Lori Ashford, Population Reference Bureau, or from John Cleland at the London School of Hygiene & Tropical Medicine.