International Dialogue
Population and Sustainable Development

Reproductive Health:
The International Community's Poor Relative?

Berlin 2002 June 20

Conference Proceedings

Deutsche Stiftung
WELTBEVÖLKERUNG

gtz
Deutsche Gesellschaft für
Technische Zusammenarbeit (GTZ) GmbH

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Editorial

Corporate social responsibility – a formula which has been of growing importance for companies in the past years. For Schering, corporate social responsibility has long been a tradition. For more than 40 years, the company has been supporting projects of family planning organizations in over 120 countries of the world. Worldwide, one out of two pregnancies continues to be unwanted. Every minute 40 abortions are carried out under conditions that jeopardize the mother's and the baby's health although safe contraception methods exist. Religious and social constraints often play a role here. But a lack of information also prevents women from actively shaping their family planning.

As early as 1961 Schering started social marketing activities in India and Columbia. Today, the company contributes to an empowered family planning of women all over the world. For this reason, Schering teams up with international institutions like UNFPA (United Nations Fund for Population Activities), IPPF (International Planned Parenthood Federation), World Health Organization (WHO), European Union (EU) and the World Bank. Our partners also include the Federal Ministry for Economic Cooperation and Development (BMZ), the KfW Entwicklungsbank and the German Agency for Technical Cooperation (GTZ). Based on market studies, contraceptives are sold to women from the social middle classes at affordable prices in many countries of Asia, Latin America and Africa. It is our objective to increase the acceptance of contraceptives in these classes.

Even in places where women cannot afford contraceptives, they do not have to completely forego them because they are handed out free of charge in an cooperative effort with international organizations. The quality of these products does not differ from those being sold in Germany or any other European country. The package insert is written in five languages. It also contains pictograms to also enable illiterate women to collect the information.

So if Schering, together with important representatives from political life and from civil society, invites to an international dialogue on the topic of „Population and sustainable development" and raises the question if "reproductive health (is) the international community's poor relative?", this is being done before the backdrop of 40 years of commitment and experience.
The conference in Berlin helped to forge new alliances. There was agreement that it is high time to create new partnerships to tackle the great challenges of our times, which definitely include the demographic development and the related matter of efficient and humane family planning. The delegates also agreed that Public Private Partnerships can be a landmark model in this respect: in close partnership – private industry and social groups – and focused on a common objective.
Schering is happy to say that the participants judged the conference positively. Publications in the media reflect the impulse that the conference has given. We want to continue to stir the public's interest for this issue which is so important for mankind, and we hope that we have been able to lay the foundations for interesting events in the future with this international dialogue.

Dr. Ulrich Köstlin
Member of the board of the executive directors,
Schering AG

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Preface

One of humanity's most explosive problems of the coming centuries is the constantly growing world population. In preparation of the UN summit in Johannesburg politicians, experts from the sector of international development, and medical pundits and economists, came together at the conference "Reproductive Health1: the international community's poor relative?". The conference was organized by state institutions, private organisations and partners from industry, it was an example for public private partnership.

This was the only relevant meeting of its kind in Germany in 2002 where experts discussed the topic of Reproductive Health. Population development and related to this, contraception, sexual rights and sexual health are only topics of marginal importance in Western Europe. Although, 10 years ago at the UN Earth Summit in Rio, the world community had defined population development as an important factor of sustainable development.

At the International Conference on Population Development in Cairo, in 1994, it was the defined goal of the 179 nations to implement Reproductive Health as a universal right by 2015. It would thus be the right of every individual to enjoy a satisfying and safe sexual live. Furthermore, every individual should be free to decide on their fertility and the number of their children. This decision however, requires more than simply a "universal provision of contraceptives". What this really means is: information and consultation must be made available especially for women, free access to contraception, choice of type of contraceptive, and protection against and treatment of sexually transmitted diseases. Access to contraception has generally improved. In the Sixties, only ten percent of the population in developing countries were using contraceptives. Today, this number has increased to 60 per cent, representing up to 525 million people. However, it is estimated that 350 million couples still maintain sexual relationships without access to contraception. There are currently 6.2 billion people who live on this planet. Only a decade ago, this figure was almost one billion less.

Pundits from Africa, Asia, Latin America and Europe discussed the problems related to this topic. A number of questions were raised, e.g. what has been achieved as far as sustainability is concerned during the implementation of the Cairo Action Programme? Are the suggestions made in Cairo still relevant? Do we need to formulate a new set of perspectives? Do we need new alliances between state institutions, NGOs and partners from industry?

Ingar Brueggemann, Director General, International Planned Parenthood Federation (IPPF), London, spoke about poverty and the development of family planning. Lynette Injette Ochola, German Foundation World Population (DSW) gave an analysis of the dreams and realities concerning contraception in Africa. Shiv Khare, Executive Director, Asian Forum of Parliamentarians on Population and Development (AFPPD), spoke about cultural norms that limit free decisions in India, Pakistan and Bangladesh. José Luis Corral presented the committed work of CELSAM, a Latin American NGO that designs information campaigns on various types of contraception for women aged 15 to 49. The Social Marketing concept provides access to contraceptives for poor population groups. Practical approaches to solutions were given in the general presentation by Prof. Dr. Rolf Korte, German Agency for Technical Cooperation (GTZ). In the workshop "World Population and Development Financing", Dr. Hans Fleisch, Executive Director, DSW, spoke about the financing gaps in family planning and how to bridge them. Dr. Wolfgang Bichmann of the Reconstruction Loan Corporation (KfW) focussed on Social Marketing of contraceptives. In the workshop "World Population and Sustainability", Siddhartha B. Bajracharya presented a development project in the mountains of Nepal's Annapurna region. Annette Gabriel of the GTZ spoke about special "reproductive health" services provided by African family planning services. The difficult role of the Catholic Church in family planning in Latin America was looked into by Alfonso López Juárez from the family planning organisation MEXFAM. The experts used the workshops to draw up recommendations for the UN Environmental Conference in Johannesburg in 2002. Dr. Hans-Peter Schipulle from the Federal Ministry for Economic Cooperation and Development (BMZ) presented an outline of the discussions concerning matters of world population within the framework of the preparations for the World Summit in Johannesburg.

International Dialogue
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Reproductive Health:
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Programme

Thursday, 20 June 2002

10.00 a.m.
Opening address
Albrecht Graf von Hardenberg
Executive Director, Center of Cooperation with the Private Sector, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

10:15 a.m.
The more people the more
poverty?
Reproductive health poverty
and development
Ingar Brueggemann
Director General, International Planned Parenthood Federation (IPPF), London

Challenges, Perspectives and Regional Peculiarities
Presentation: Gabriele Heuser, Sender Freies Berlin inforadio

10:50 a.m.
Africa – contraception:
Wish and reality
Lynette Injette Ochola
German Foundation World
Population (DSW), Kenya
11:15 a.m.
Asia – free will – cultural norms
Shiv Khare
Executive Director, Asian
Forum of Parliamentarians
on Population Development (AFPPD)
11:40 a.m.

Investing in health programmes-
the concept of CELSAM
José Luis Corral Ruiz
Executive Director, Centro Latinoamericano Salud y Mujer (CELSAM)
César Loboguerrero
Medical Expert, Centro Latinoamericano Salud y Mujer
(CELSAM), Colombia
12:00 a.m.
Discussion

12:30 p.m.
Lunch

Approaches in Practice
Presentation: Gabriele Heuser, Sender Freies Berlin inforadio
1:30 p.m.
Successful approaches – repro-ductive world-wide health support
Prof. Dr. Rolf Korte

Head of Department of Health, Education, Nutrition,
Emergency (GTZ)
2:15 p.m.
Workshop 1 “World population and financing of development”
Presentation: Holger Scholz, Global Cooperation, GmbH
Inputs
More contraceptives for everybody – presentation of a world-wide campaign
Dr. Hans Fleisch
Executive Director, German Foundation World Population (DSW)
Member of the International Initiative on Reproductive
Health Supplies (IIRHS)
Social marketing: Successful financial cooperations with developing countries in the fields of contraceptions, Africa and Asia
Dr. Wolfgang Bichmann
Director of Department for Social Infrastructure Socio-Political Cross-Section Tasks, Environmental Protection, Kreditanstalt für Wiederaufbau (KfW)

2:15 p.m.
Workshop 2 “World population and sustainability“

Presentation: Walter Bock, Global Cooperation, GmbH
Inputs
More forests, less births – an integrated
development project in Nepal
Siddhartha B. Bajracharya
Annapurna Conservation Project Nepal (ACAP
Improved use of family services through
better incentives - examples from Africa
Annette Gabriel
Co-ordinator Nationwide Sector-Project Reproductive Health (GTZ)
Pope versus pill and condom- many ways to circumvent Rome - country focus: Mexico
Alfonso López Juárez
Executive Director Mexican Family Planning Organization (Mexfam)

4:00 p.m.
Coffee break

Evaluation and Recommendations
Presentation: Gabriele Heuser, Sender Freies Berlin inforadio
4:15 p.m.
Summary of workshops and
recommendations

4:45 p.m.
Population queries at the world summit in Johannesburg –
Recommended action
Dr. Hans-Peter Schipulle
Deputy Director General, Policy and Global Issues, Federal Ministry for Economic Cooperation and Development (BMZ)
5:00 p.m.
Reception

Summary
Keynotes, Discussions and Workshops

Opening and Introduction
Gabriele Heuser (SFB), facilitator of the event, outlined the importance of the family planning and sustainable development especially with regard to the World Summit for Sustainable Development in Johannesburg.

In his opening address, Albrecht Graf von Hardenberg, Executive Director of the German Agency for Technical Cooperation's (GTZ) Department of Cooperation with the Private Sector, raised the question of how we can form the future through new forms of cooperation. He thinks that faster, better and less expensive results can be achieved with partners from the private sector.
Ingar Brueggemann, Director General, International Planned Parenthood Federation (IPPF), discussed the term "reproductive health". This term does not only encompass the aspects of contraception and abortion, but also other dimensions, e.g. maternal mortality, child mortality, poverty, and human rights. She explained how the subject "world population development" had been discussed at the different World Summits since the first international conference on population was held in Rome in 1964. Ms Brueggemann emphasized the positive developments that took place between 1984 and 1994. She talked about the benefits and deficiencies in family planning and reproductive health, reporting the positive results in the area of family planning in Thailand, Indonesia, Japan and the Republic of Korea. Nonetheless, Ms Brueggemann said, it should be remembered that in the areas of maternal mortality, child mortality and human rights there still is a long way to go.

Challenges, Perspectives and Regional Characteristics
Based on extensive statistics, Lynette Ochola, German Foundation World Population (DSW), illustrated the current situation regarding contraception in Africa (main focus: Kenya). According to her, accessibility to and use of contraceptives largely depend on the degree of poverty. The estimated requisites for contraceptives are opposite a declining donor support, resulting in a contraceptives funding gap that is intensified by corruption. In general, the women were willing to use contraceptives. The question, though, was the affordability. Moreover, Lynette Ochola mentioned the increasing shortfall of condoms. The insufficient supply had disastrous consequences, as demonstrated by declining indicators, so that an increase in the number of pregnancies, abortions, child mortality cases, infant mortality cases and HIV infections had to be noted. On the other hand, Lynette Ochola stressed Kenya's lower fertility rate as a positive result owing to the growing use of contraceptives. At the same time, however, she pointed out that this success had to be seen in its context, e.g. the fact that the contraceptive prevalence now stagnated. The insufficient supply really had to be taken seriously. As reasons for the unmet needs of African women, Ochola named poor access, low quality of service, lack of information and men opposing family planning. To counter these aspects and to achieve greater empowerment of women, better governance and changes in the education sector were needed. An important factor, however, was the price of contraceptives.
Shiv Khare, Executive Director, Asian Forum of Parliamentarians on Population and Development (AFPPD), gave an overview of the population trends in the Asia-Pacific region. By way of example for the negative consequences of a society dominated by men, he named China and India (discrimination of female offspring, lack of empowerment of women). In this region, especially the sub-region South Central Asia, great challenges prevail in the areas infant mortality, maternal mortality and life expectancy. Many countries of the region were still far from meeting the aims set by the ICPD. In the area of female illiteracy, primary school enrolment and HIV/AIDS, the countries of the sub-regions South Central Asia and South East Asia still have a long way to go to reach the reviewed ICPD goals set for 2005 and 2010 respectively. However, there are great differences in the above-mentioned indicators in the different regions of Asia. The main goal of AFPPD is to strengthen the mobilisation of the parliaments in the industrialised countries in order to increase financial resources, or better said, to make them fulfil their financial commitments so that corresponding programmes can be implemented. He criticised formerly far-sighted governments like India who now followed the argumentation of the USA, maintaining that population development policies were no longer as important as before.

In his presentation, José Luis Corral, Executive Director, Centro Latinoamericano Salud y Mujer (CELSAM), described the contrasts between urban and rural areas. Despite all the differences between the countries of South America, there was still one thing they have in common: the void created by the withdrawal of the governments in many areas. Therefore, CELSAM's goal was to contribute to the sexual and formal education of women by providing options and information about contraception, reproductive health and family planning in order to improve women's health conditions and quality of life, which in turn would eventually facilitate a more comprehensive social development. The main instruments to achieve this purpose were mass media like journals, radio, magazines, TV and seminars. CELSAM covered the whole of

Latin America and, in Corral's opinion, was regarded as a credible disseminator, because the organisation didn't pursue political or commercial goals and its members only worked on a voluntary basis. CELSAM's activities were funded through different sources from the public and private sectors, e.g. Schering AG. César Loboguerrero, a CELSAM representative, extended the information about CELSAM's work by giving examples of the programmes implemented in Colombia. Furthermore, he presented the present activities and future intentions in and for this country.

Discussion
Several participants voiced their thoughts and questions: It was asked to what extent the different population densities presented a credibility problem. Are the industrialised countries allowed to impose regulations on developing countries regarding their population development policies, thereby taking into account that the industrialised countries claim the right to stop their population decline? With regard to this problem, Ingar Brueggemann stated that the main point was that no country had the right to dictate over another country. It remained open to discussion to what extent the influence of the industrialised countries was legitimate. She was sure that it was wrong to impose specific regulations. It was important for each country to find its own balance. External influences were no longer an important factor, the developing countries themselves were eager to change the situation. Each country's population had to decide for itself which population density would be the optimum, and convert the decision into political actions.
In one statement it was noted that population was not the main problem but that the momentum of the changes overtaxed the society's capacity to cope with them.
Another question referred to the necessity of increasing the awareness of the population. According to Ingar Brueggemann this was up to the media. Unfortunately, she added, the problem was almost non-existent in the media and it ought to be emphasized.

It was also stated that teachers could be important disseminators to raise the students' awareness.

Approaches in Practice
In his presentation, Prof. Dr. Rolf Korte, head of the Department of Health, Education, Nutrition, Emergency Assistance, German Agency for Technical Cooperation (GTZ), showed successful approaches for the promotion of sexual and reproductive health. He stressed the interdependency between reproductive health and the environment. Financial sustainability could be reached through self-sustaining service systems and Public Private Partnerships. Contributions in the field of technical cooperation are the establishment of consultancy services, cooperation with international organisations and support of the coordination between donors and regional recipients. Dr. Korte reported on more than 100 GTZ health projects with S&RH components. He presented a Community Based Services (CBS) programme in Kenya as an example for sustainability and quality. As a successful example for Public Private Partnership, he mentioned the creation of a HIV/AIDS task force in cooperation with DaimlerChrysler in South Africa. He concluded that men and women in developing countries must be provided with the same standards and possibilities of reproductive health services that we in Europe deemed normal. The existing problems, e.g. reduced contraceptive prevalence, could be overcome with the help of private investors.

Workshops
A team of facilitators presented the way the afternoon's discussions were to be structured. It was the purpose of the workshop to create recommendations for goals and strategies, to find a cross-section of experts, and to focus on specific topics: The conclusions would serve as recommendations for the UN conference in Johannesburg 2002.

Input presentations Workshop 1:
World Population and Development Financing
Dr. Hans Fleisch, Executive Director, German Foundation World Population (DSW), member of the International Initiative on Reproductive Health Supplies (IIRHS), reported on the contraception crisis that currently affects 63 countries and will intensify until 2015, due to a lack of resources (widening gap for contraceptive supply). As a consequence, the number of unwanted pregnancies, abortions, cases of maternal mortality and infant mortality would increase. In his opinion, the causes for the crisis are to be found in the increasing population, increasing demand, logistic problems, lack of coordination of the donor organisations and the diminished generosity of the donors. Dr. Fleisch gave information about the IIRHS whose goal it is to mobilise human, institutional and financial resources in order to overcome the supply crisis. In order to reach this goal, it was necessary to coordinate and consolidate all stakeholders (procurers, governments, donors, NGOs, etc.).

In his presentation, Dr. Wolfgang Bichmann, Director of the Department for Social Infrastructure, Socio-Political Cross-Section Tasks, Environmental Protection, Reconstruction Loan Agency (KfW), talked about Social Marketing of contraceptives and successful financial cooperation with developing countries in Africa

and Asia. The main focus of KfW's financial cooperation in the reproductive health sector were preventive programmes designed to fight poverty. Bichmann stressed that information on contraception, sexual behaviour and sexually transmitted diseases had to go hand in hand with easier access to contraceptives for the target group. In order to reach this goal, KfW financed a package of measures with three components: procurement and supply of contraceptives by using the existing supply channels of the private industry (the retail price depended on the spending power of the low-income target group); information and communication campaigns (using TV products like soap operas and movies) as well as sexual education and training events for consumers and distributors; gender-specific sexual education, product advertising and market research. These Social Marketing Programmes were mainly implemented by autonomous Social Marketing Agencies (SMA), but in many cases national and international NGOs took over this function. Owing to the estimated financial need in the future, KfW saw an increased need for un-bureaucratic donor cooperation, simultaneously, the use of the resources had to be controlled in a transparent way. The cooperation of financing institutions with NGOs that increasingly often receive remuneration for their work was seen as a workable model. Especially suitable for this kind of cooperation were some social marketing approaches. New partnerships in this area definitely had to be strengthened.

Results of Workshop 1:
Five working groups defined the most important results for the area "world population and development financing". Everybody agreed that governments should start to apply a cross-departmental approach to the family planning and reproductive health sector instead of solely allocating it at the Ministry of Health. Social Marketing Programmes ought to be drawn up specifically for young people.
The working groups made the recommendations that

- the big donor governments should provide more funding for the reproductive health sector;
- more discussion platforms on the topic of "reproductive health" should be created around the world;
- Social Marketing approaches should be increasingly applied, including dance and theatre projects, via the media, soft drinks, cosmetics and partnerships with parents, pupils and health personnel;
- the public in the donor countries should receive information about the future problems of the country and the world. To achieve a lasting effect, this information is to be provided by the press, PR campaigns and the media. The public, the political parties and lobbying groups need to be approached in order to mobilize sufficient funds.

Input presentations Workshop 2:
World Population and Sustainability
Siddhartha B. Bajracharya, Annapurna Conservation Area Project (ACAP), presented an integrated approach to conservation and development in his example of ACAP. The project demonstrates how to balance ecological problems and the needs of the population as most people in Nepal still depend on their environment (e.g. forest) to cover their basic needs (food, shelter). The project's issues of concern were the lack of basic infrastructure, rapid degradation of land and resources, increase in non-biodegradable waste, human population growth and unmanaged backpack tourism. Bajracharya stressed the importance of empowering people by instructing them and facilitating their possibilities to associate. In his eyes, the best way to reach and educate people was informal education and counselling, thereby focussing on adolescents as they were the most vulnerable group. He stressed the importance of trust and knowledge about customs and said that after a gradual process and better access to resources, the use of contraceptives has gradually increased. In conclusion, he said that the integration of reproductive health in the conservation aspect helped finding a workable balance.

Annette Gabriel, Coordinator Nationwide Sector-Project Reproductive Health, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), focussed on the problems of reproductive health service providers for whom the GTZ had developed various training programmes. These programmes were directed at people who work in the health sector, social workers and managerial staff of governments and NGOs. Those persons were often confronted with a multitude of problems, without having adequate resources and the capability or method to find solutions for specific situations.

Alfonso López Juárez, Executive Director, Mexican Family Planning Organization (Mexfam), concentrated on the fight of the catholic church against contraception. Latin America is the last stronghold of the catholic church. In Mexico, more than 88 per cent of the people are catholic, so the church concentrates on Mexico, strongly opposing the work of people like Juárez. Due to a dramatic increase in the use of contraceptives, Mexico's fertility rate has declined. This was achieved through a strong civil society movement, an Amendment of Constitutional Law in 1973 (every person has the right to choose, in an informed and responsible way, the number and spacing of his/her children), decided action by government health institutions and strong support from the media. The initial movement started with organizations like Mexfam and other institutions that began their work in the early sixties, external support from IPPF and UNFPA to

establish family planning and efficient lobbying of government agencies. The current battle front Mr. Juarez said, was sex education, emergency contraception and safe abortion, all of which were condemned by the church.

Results of Workshop 2

In the second workshop three working groups defined their recommendations. For the participants it was especially important that

- strategies were found to link the various stakeholders, i.e. government and industry;
- dogmas and prejudices need to be overcome;
- pragmatic solutions are required at the local level;
- the position of women in the social, cultural, economic and legal decision-making processes need to be strengthened at all levels of society;
- information constitutes an important basis for a sustainable change of behaviour;
- the HIV/AIDS problem and family planning need to be integrated into other activities of development cooperation (e.g. education, water, agriculture, infrastructure, environment).

Evaluation and prospect

The workshop teams presented their thoughts and the resulting recommendations. Afterwards, the participants were invited to discuss the results and ask questions. Following the discussion, Dr. Hans-Peter Schipulle, Deputy Director General, Policy and Global Issues, Federal Ministry of Economic Cooperation and Development (BMZ), gave a résumé of the current debate regarding reproductive health. He stressed the fact that the problems of the developing countries in the health sector could not be solved via command and control structures. It was important to eliminate the causes, i.e. malnutrition and unsafe water; this could be achieved, e.g., within the framework of prevention and self-help or through the construction of sustainable basic health care systems.

With regard to the UN Conference in Johannesburg in 2002, he said that the conference would not introduce new programmatic points and promises, but that the previous points and promises would be converted into concrete actions.

He gave an overview of the contribution of the German development cooperation in the health care sector. In this respect he stressed the fact that the concept of reproductive health and reproductive rights was based on the principle of voluntary population development measures.
Additionally, he explained the current situation in the reproductive health debate during the preparation of the World Summit. In his opinion, the main problems were the positions of the U.S.A. and India who had been hesitant in openly discussing the issue of reproductive health during the Bali Conference. This attitude resulted in decreased financial support.

He hoped that today’s conference would contribute to a successful conference in Johannesburg. He cordially invited the NGOs to submit further propositions to the respective contact persons at the BMZ and the Federal Ministry for Environment, Nature Conservation and Nuclear Safety (BMU). In conclusion, he stressed how important it was to take advantage of the offers that the industry had made in Doha and Monterrey. It remained to be seen what Public Private Partnerships (PPP) could achieve. The positive experiences gained in cooperation with industry demonstrated that there could always be win-win situations.

Albrecht Graf von Hardenberg
Director Public Private Partnership (PPP) Office, GTZ, Germany

Welcoming Address

I would like to welcome you very cordially here in the building of the German Agency for Technical Cooperation (Deutsche Gesellschaft für Technische Zusammenarbeit – GTZ). We are honoured that you have followed our invitation. We, being players from the field of development policy, i.e. the Reconstruction Loan Corporation (Kreditanstalt für Wiederaufbau – KfW), the German Foundation World Population (Deutsche Stiftung Weltbevölkerung – DSW), International Planned Parenthood Federation (IPPF) and the GTZ and also German industry, represented by Schering AG. The topic of partnerships is increasingly being raised in the fields of development policy and economic policy as well. We at the GTZ call those partnerships Development Partnerships with Industry or Public Private Partnerships (PPP). It is so much faster, better and cost-efficient to achieve development policy goals – including family planning – in cooperation with the players from civil society and private industry. On behalf of the German government, the GTZ is thus trying to establish contacts with companies that participate in projects that improve people's living conditions. An increasing number of examples for this approach can be found in the health sector.

The Secretary General of the United Nations, Kofi Annan, has recently honoured the most prominent example. It is the joint fight against HIV/AIDS and its consequences in the environment of the factories of DaimlerChrysler South Africa. Other examples of our work include AIDS prevention and medical treatment of AIDS patients together with Heineken International Corporation in Kinshasa/Ndolo or the dissemination of knowledge concerning modern contraceptives and their regular use in Bolivia together with Schering AG. Also included is the training of multipliers in emergency aid by Incentive-Med at the fire station in Lima, and the introduction of a hospital information system for French-speaking Africa together with EPO Health Consultants in Senegal, and the establishment of a PPP-AIDS Fund – together with Volkswagen South Africa and others – to help provide co-financing for interested South African companies for the development and implementation of their anti-AIDS strategies. The fight against malaria by Aventis CropScience, now Bayer CropScience, in South Eastern Anatolia or malaria-specific training measures in Uganda together with Aventis for their local staff and for the public health systems should also be mentioned.

I would be very glad if today's event could provide new ideas and perspectives for a consolidated cooperation. We are ready.

Ingar Brueggemann
Director General,
International Planned Parenthood Federation, London
More people – more poverty?
Reproductive Health, Poverty and Development:
An Overview

Introduction
The issue of population growth and its dialectical relationship with social development including cultural, economic and political development, has long been the subject of an ongoing, highly contested debate. Let me mention some reasons.

The success of family planning and other influential factors in preventing mothers and babies dying in childbirth and to reducing population growth, have led many voices to claim that the population problem has ceased to be a problem.

Whilst various inputs have led to reducing the total fertility rates in most continents, Africa and South-Asia are still experiencing high fertility rates and low contraceptive prevalence. However, the impact of the HIV/AIDS epidemic is used by some to argue that HIV/AIDS will replace family planning programmes as a catalyst in curbing population growth in Africa and South-Asia.

During the years 1990 to 2000, many commentators have argued that overseas development aid has not achieved its expected results and that international assistance has not been well coordinated, due to its fragmentation among so many micro-projects, formulated in the headquarters of donor agencies.
Those who are involved in population and its related sexual and reproductive health implications are witnessing a number of critical phenomena. For example:

- Instead of strengthening donors' commitment to reproductive health, the International Conference on Population and Development held in Cairo in 1994, may have actually watered down aid to population and family planning programmes by way of burying them in the bottomless pit of overall health needs.
- The recent politico-economic phenomena emphasising a disengagement of the state from public sector provision, which started inter alia with Prime Minister Thatcher in the United Kingdom in the late 1970s, has now been adopted by centre, centre-right and centre-left governments in the majority of donor countries. These policies have also been reflected in the approach to overseas development aid (ODA) with the imposition of structural adjustment policies (SAPs). The resulting negative impact on spending for social development and health has been evident, and may add to the worries of those who believe that family planning and reproductive health have, compared with other health interventions, the highest strategic impact which is not clearly recognised, on overall development of the balanced growth of population in relation to the resources available. 'Smaller families cope better!'
- Many donor governments are now turning their attention to Sector-Wide Approaches (SWAps) and other reform initiatives as a means to better deliver development. Whilst the intention behind such reforms is in a positive direction, many remain in their early stages and their ability to address sensitive issues, such as young people's sexual and reproductive health, gender equity and gender based violence, is not yet convincing. Since governments find it hard to address these issues, experiments relating to such sensitive matters may be better initiated by non-governmental organisations to start with. Needless to say, the lessons of such experiments can eventually only be effective, if governments pick up these responsibilities to guarantee broad coverage.

This is the context in which I would like to deal with the issues under consideration. It is obvious that addressing the population issue contributes to achieving the wider agenda of sustainable development.

Population and Development
The status of population growth
Humanity has exceeded the six billion benchmark. Let me repeat the figures with which most of you are familiar: it took two million years for world population to reach the first billion, 130 years to reach two billion, 30 further years to reach three billion, 15 years to reach four billion and 12 years to reach five billion, and in only another 7 years we reached 6 billion. With the current population growth rate of 1.5 per cent per annum, it takes approximately one year to add the equivalent of the population of Mexico i.e. 100.4 million or approximately three years to add the equivalent of the population of the U.S.A. i.e. 285.9 million.
At the current rate of population growth, the populations of the least developed countries will double in 37 years and that of Africa will double in 25 years so those who say that the population problem is no more, will wear a heavy burden if their argument wins the day in donor countries.

More to come: from six to nine billion
If it took humanity two million and 194 years to add six billion people to 'Adam and Eve', it will take less than 70 years to add the next three billion before the world population stabilises at nine billion, (excluding any horror calculations of nuclear wars).
During the following four decades, it has been estimated that the world will add approximately the following millions per decade.
2000 – 2010: 750 million
2010 – 2020: 730 million
2020 – 2030: 650 million
2030 – 2040: 550 million
2040 – 2050: 450 million

Recent estimates put the world population in 2015 varying from 7.83 billion to 7.9 billion. In 2050, the world population will range from 8.80 billion to 9.30 billion. One may take some comfort in the argument of those who say, or rather who worry, that fortress Europe will not witness any population growth; but the same people are also reluctant to envisage a Europe, which has a double standard regarding human rights. All this calls for a redoubling of the efforts aiming at consolidating successes in providing family planning services and covering the unmet sexual and reproductive health needs of the additional billions over the next few decades.

Dealing with population growth
From Rome to Cairo by way of Bucharest and Mexico
While the first international population conference in Rome, in 1964, was partly dominated by scientific discussion about demographic analysis, the issue of population policies occupied the agenda of the second held in Bucharest, 1974. At this conference, two ideological and somehow simplistic standpoints confronted each other. Whilst the North (or was it the West?!) saw population growth as a threat to political, economic and social stability and therefore to be countered by family planning, the South considered family planning as an imperialist plot and close to neo-colonialism, and advocated development as the best contraceptive pill. Both China and Algeria declared that the strength of the Third World lay in its manpower, yet by the time of the international population conference held in Mexico in August 1984, the ideological positions mentioned above had changed.

In China, the post-Mao leadership realised that without curbing population growth, the available investments would have to be used to cover the needs of additional mouths. Similarly, the Algerian Minister of Social Development who led the delegation of her country to the conference in Mexico was outspoken in her defence of family planning. By contrast, the representative of President Reagan (Mr. Buckley), declared, to the dismay of USAID, that population was a neutral factor in development.

A number of developments took place between the Population Conferences in Mexico (1984) and the one in Cairo (1994):
- Women's organisations throughout the world advocated the need to take into account women's health globally and not just to concentrate on the contraceptive side.
- Research had shown that informed choice had more success than mandatory demographic targeting in convincing people about the positive impact of family planning on their reproductive behaviour, resulting in smaller families.
- Family Planning NGOs distanced themselves from the dictat and quotas set by states, by advocating the human rights foundation of their programmes, rejecting any coercion of women.

In a sense it was this intellectual revolution, which led to the IPPF Vision 2000 Strategic Plan (October 1992), and to the Cairo ICPD Programme of Action (September 1994).

Family Planning and Reproductive Health:
Achievements and Deficits
In order to review the achievements which were accomplished in the fields of family planning and other aspects of reproductive health, one has to note that the major modern contraceptive breakthrough (the pill) occurred only fifty years ago and any systematic family planning programmes in most of the developing countries on the basis of modern contraceptives were set up less than forty years ago. Why do we maintain that these programmes had over time a considerable success, which we cannot claim for many services in development?

Fertility reduction leading to faster demographic transition
While the demographic transition from high fertility (six to eight children per woman) to low fertility (two children per woman) took from 50 to 100 years in today's developed countries, experiences from the recently industrialising countries like the Republic of Korea, Thailand and Indonesia show that organised family

planning programmes (FPP), help achieve the transition in 25 to 30 years. In the case of Korea, FPP were responsible for 40 per cent of the country's fertility decline between 1963 and 1973, only ten years.
For many quite unnoticed, in Islamic societies, where the demographic transition has not been completed yet, FPP have helped reduce the total fertility rate from seven to three children per woman. At the global level it has been cautiously estimated that, FPP have been responsible for avoiding between 400 - 700 million births so far.

Family planning benefits
Like in any evaluation, it is not easy to assign correctly, which interventions lead to which results. However, for women, the newborn and for human rights in general, there has been progress over time. Nevertheless:

- Maternal mortality – Death in birth is still 20 times as likely to occur for each birth in developing countries as in developed countries. Maternal deaths per 100,000 live births is 21 in developed countries and 400 in developing countries. Preventing a pregnancy can go a long way in preventing maternal death. Reducing fertility by 50 per cent would also reduce the risk in childbirth by almost 50 per cent. Let us not forget that:

  One woman dies every minute of every day from pregnancy and childbirth causes.

  In addition, treating the issue of (unsafe) abortion in a rational manner would also contribute to reducing the maternal death of the millions who die through unsafe abortion every year.
- Child mortality – All of the major global fertility surveys from the world fertility survey of the 1970s to the demographic and health surveys of the 1980s and 1990s, have reached the same conclusions that women in developing countries have always known: that delaying the first pregnancy and lengthening the space between pregnancies, increases the chances of child survival. The infant mortality rate per 1,000 live births ranges from 8 in developed countries to 94 in sub-Saharan Africa. In developing countries with a successful FPP, infant mortality can be as low as 46, whilst the figure rises, for example, to 112 in Côte d'Ivoire.
- Human rights – women's empowerment – poverty reduction - In addition to the benefits of family planning in the areas mentioned above, there is an everlasting benefit which remains after the end of the reproductive cycle and which helps in creating a sense of control over one's external environment: the ability of the woman to decide her reproductive choices, in this way being enabled to contribute to the well-being of the family and herself and ultimately break the vicious cycle of ignorance, multiple child birth, ill health and poverty.

Deficits and Challenges – Stemming from the Poverty Condition
Despite the achievements relating to family planning and reproductive health within the field of population stabilisation and reductions in maternal and child mortality, a number of challenges still have to be faced.

Current and future unmet needs, for women and youth
It is estimated that between 10-40 per cent of women still do not even have access to reproductive health services, including contraceptives. These statistics do not cover the total picture as in some countries; only unmet needs of married women of reproductive age are counted. To these one should add the growing number of un-married people whose sexual and reproductive health needs are met with hostility on the part of society and the government.
In addition, at present more than a third of the world's population are young people under the age of fifteen, who will soon begin their reproductive life cycle. Even though young mothers belonging to this group will have fewer numbers of children compared to their mothers, the total number of children born will still be larger, due to the size of the new generation (the largest ever in human history). It is estimated that in order for countries of the world to reach population stabilisation, contraceptive prevalence among individuals and couples needs to reach 70 per cent. The UNFPA's 1998 assessment, estimates that current use is around 58 per cent (all methods) and 50 per cent (modern methods). However, there are wide variations in modern contraceptive use among the world's sub-regions:

Region CPR (%)*
Africa 16 (range: 3-46)
Asia 55 (range: 26-82)
Latin America / Caribbean 58 (range: 52-60)

Source: Levels and trends of contraceptive use as assessed in 1998, UNFPA, New York, 1999, p.7
*CPR: Contraceptive Prevalence Rate

Needless to say that it is in the least developed countries where expenditures on health and other social sectors are the lowest, that more efforts are needed to generalise the use of modern contraception in order to achieve the goals of reducing maternal and child mortality and to arrive at a level of fertility rate which would free women to have access to education and employment.

The HIV/AIDS epidemic is becoming one of the most pressing sexual and public health issues confronting people in developing countries as well as in developed ones. Whilst the world at large has internalised the scope of the problem and the G8 have turned their attention to this issue, there is a danger, if most of the effort is placed on the side of curing and not enough on prevention of transmission. As a result, NGOs, who generally speaking have been instrumental in legitimising family planning since the 1960s, through counselling and face-to-face advocacy, are not fully mobilised in helping governments in preventing the spread of HIV/AIDS, which depends on systematic counselling and the relevant information and provision of condoms.

On the financial side, most developing country governments are unable to increase financial support to family planning and reproductive health due to budgetary pressure on the one hand and the demands of their meagre resources on the other. Similarly, global international assistance has decreased since the adoption of the Cairo Programme of Action. If the ICPD target of reaching a 70 per cent contraceptive prevalence rate (CPR) is to be met, the cost of FPP in developing countries would be around US $17 billion, which should not be unachievable.

The figure of $17 billion was an estimate, arising out of the ICPD, thought to be sufficient to cover the cost of FPP by the year 2000. Out of the $5.7 billion, which was assigned to donor countries, only $2 billion have been provided. 70 per cent of this amount was given by just four donor countries (U.S.A, Japan, U.K, Germany).

FPP costs are relatively modest: between $1 and $1.25 per capita, per annum. This translates into $10-20 per contraceptive user per year. If we compare the cost of a prevented birth with the costs associated with raising a child until it reaches working age, then the family planning costs are dramatically lower. For instance, in Zimbabwe the government spends about $19 per annum, per contraceptive user, whilst it spends $120 per primary school child.

In the lack of financial commitment to the ICPD Programme of Action, one can sense the possible return to ideas prevalent amongst economists in the 1980s and 1990s, that economic policies, more than family planning programmes, determine poverty reduction. But we can see that family planning is not only affordable, it can also make a big contribution to the fight against poverty: it reduces the birth rate, reproductive health diseases and illnesses and infant mortality. Family planning empowers women, and by providing them with education and rendering the relevant services, it gives them the opportunity to make their own decisions concerning their fertility. Thus, family planning triggers off a positive cycle. This is outlined when the children born of women who were able to choose the timing of their pregnancy (i.e. avoiding unintended or excess fertility), are during adulthood more able to plan their families effectively and provide education for their children, therefore giving them improved life chances.

At the societal level, recent research has found that when “fertility begins to decline, the process creates…a demographic window of opportunity during which increased personal savings and investment become possible”. Although the debate between these schools of thought will certainly continue, observation on the ground concludes to the necessity of combining poverty reduction efforts with family planning programmes. An evaluation in Malawi has concluded that such a combination had directly improved women’s reproductive health whilst at the same time improved women’s status in the family and community.
A further case in point is the assessment of the potential for economic growth in the Côte d’Ivoire. The Côte d’Ivoire, which rejected the introduction of any official family planning programmes until 1997, saw its population soar from 2.5 million in 1955 to 15.5 million in 2001 and witnessed a decrease of per capita income by more than fifty per cent in the same period. The assessment resulted in three scenarios which all involved family planning, with the objective to curb population growth, as a catalyst for socio-economic growth.

Conclusion
While 180 governments subscribed to the Cairo Programme of Action in 1994, which adopted specific reproductive health targets, unfortunately, at the financial level as shown, developed country governments have not fulfilled the commitments they made. In addition, a number of events and practices which occurred after the Cairo+5 celebration in The Hague (1999), may lead one to ask whether the Cairo Programme of Action can still be considered valid.

Significant among these is the increasing emphasis by donor governments on the social development agenda encompassed by the Millennium Development Goals of the United Nations, which prioritises: poverty alleviation, reduction of under five mortality, education, gender empowerment, maternal health, combating HIV/AIDS, Malaria and other major diseases, sustainable development and partnerships. It is clear that

IPPF's Vision 2000 Strategic Plan is in alignment with such goals and that through its family planning and reproductive health programmes, IPPF has a major contribution to play in helping to deliver this agenda.

I would like to close by highlighting four key questions, which have emerged at the turn of the millennium, the answers to which will be important regarding the future debate on the place of sexual and reproductive health in development:

- Has 'population' lost its political appeal and significance as a result of incorporating the issue of family planning into a broader concept of sexual and reproductive health?
- Will family planning and reproductive health lose its 'privileged' status by being 'dumped' with the other neglected areas of public health?
- Is the move to the Millennium Development Goals of the UN, which do not refer to family planning or the population issue as such, one way of avoiding any conflict with those who argue that the Cairo Programme of Action of 1994, has legitimised abortion under the disguise of reproductive health?
- Will 'poverty alleviation' replace 'population stabilisation' as a motor for development? Will it have political clout? (The absence of most world leaders at the recent UN Food Summit at FAO in early June 2002 in Rome was not a sign of strong political will to tackle global poverty nor do the preparations for the forthcoming Summit on Sustainable Development in August 2002 in Johannesburg give much hope, that the relevance of the population issue will find its proper place in the debate. Social justice, I believe.)

I believe that we are making a mistake for which there is no political and moral excuse if we continue to exclude the people from the discussions on sustainable development.

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Wish And Reality

The slogan of my presentation is poor, powerless and pregnant. The usage of and access to contraceptives has a lot to do with poverty and money, but not exclusively. According to the recently launched New Partnership for Africa's Development, in short NEPAD, half of Africa's population live on less than US $1 per day. The United Nations Population Fund (UNFPA) estimates that this year alone funding requirements for contraceptive commodities for family planning and condoms for preventing sexually transmitted infections (STIs) and HIV/AIDS amounts to US $946 million. Requirements for contraceptives for family planning amount to US $657 million. Contraceptives are paid mainly from three sources:

- Developing country national budgets,
- Donor contributions and
- From private and individual sources.

National governments in sub-Saharan Africa with tight national budgets, inherent corruption and ineffective logistical management are unable to supply a steady supply of contraceptives. On the other hand, a growing number of poor people in the region find it difficult to afford the contraceptives at commercial prices. On top of that, the contributions by donors to contraceptive costs, traditionally at 41 per cent, have decreased to under 25 per cent. This gloomy picture for the contraceptives funding shortfall is even more exacerbated by the ever-growing demand for contraception estimated at a cost of US $1.8 billion by 2015 due to population growth and the ever larger number of women wishing to use contraception.

The funding shortfall in many parts of sub-Saharan Africa has lead to a contraception related crisis with alarming consequences. Since 1999 francophone Africa has experienced overall contraceptive shortages, Ethiopia and Tanzania have experienced lack of injectable supplies and intrauterine devices. Most recently Tanzania was hit by a condom shortage when a batch of 10 million condoms was found to be defective and had to be returned to the supplier, leaving only 1 million condoms in the national stock, sufficient only for one month. This continuing condom shortage in many parts of sub-Saharan Africa has consequences. In Tanzania for instance HIV/AIDS is on a steady increase. Countries like Tanzania have actually stagnated or in some cases even regressed in key reproductive health indicators over the years.

UNFPA estimates that each US $1 million shortfall in reproductive health commodity supplies will result in 360,000 more unwanted pregnancies, 150,000 additional induced abortions and 800 maternal deaths, 11,000 infant deaths and 14,000 additional deaths of children under five.
Growth rates in Africa's population are still high. Sub-Saharan Africa has the highest total fertility rate (TFR), that is, the number of children a woman would have in her lifetime. It is 5.1 in Africa, 3.2 in Asia and 2.7 in Latin America.

As we can see in the graph above, there is a close correlation between TFR and contraceptive prevalence. Today, the population growth in Kenya has slowed to 2.7 per cent. This decline is partly due to the fact that the country has undergone a revolution in reproductive behaviour. Contraceptive use has grown from 7 per cent in 1978 to 33 per cent in 1993. In the late 1970's, women averaged 8 children; today the number is 5.3, one of the fastest declines in the world. UNFPA envisages the TFR to drop to 2.1 in 2015. However Uganda, Tanzania, and Eritrea still experience high TFR of 6.9, 6.1 and 5.9 and register a low contraceptive prevalence of below 10 per cent.

Africa's demand-supply gap for contraceptives is high. On average in sub-Saharan Africa less than 10 per cent of women use contraceptives. For example in Sweden and Italy 78 per cent and 91 per cent of women use contraceptives. Kenya has been dubbed a success story in family planning. Why so? The trend of contraceptive use over the past twenty years showed an increase from 29 per cent to 49 per cent for use of modern and non-modern methods. In the same period the use of modern methods increased from 11 per cent to 39 per cent though this is still less than half of that in Europe. The success in Kenya is due to the fact that programmes were developed at an early stage and political commitment has been continuous.

A study in Kenya revealed that main source of family planning information for male adults was the radio, that is up to about 78 per cent, and for adult women were health workers and family planning providers. For adolescent boys and girls, 60 per cent of information was from the radio, 45 per cent school and 37 per cent was from friends. In general there are low levels of knowledge about pregnancy prevention, with adolescents knowing less than adults. Knowledge about the variety of modern family planning methods is also limited. Adolescents mostly only knew of the condom or the pill. The female condom for instance is still widely unknown, and where available unaffordable for the majority.

The quintessence is that the affordability of family planning methods is very important in the African context. Data on unwanted pregnancies and unsafe abortions are a good indicator for the contraception crisis in Africa. In most African countries abortions are illegal and are only permissible to save the mother's physical and/or mental health if endangered.

Data on abortion is thus scant as most of the abortions are carried out illegally. The only available information is of women who end up in hospitals for post-abortion complications. For instance, at Kenyatta Hospital, Kenya, 90 per cent of the admissions to the gynaecological ward were for incomplete abortions; 40 women a day undergo dilation and curettage as a result of induced abortions. 8 per cent are youth under age 21. In Ethiopia illegal abortions account for 54 per cent of obstetrical deaths. In three hospitals in Abidjan 70 per cent of maternal deaths were due to abortions that had been performed at home.

Abortion is very common among adolescent girls, particularly schoolgirls. For instance in Togo, 23 per cent of secondary school girls had abortions at least once. In Kinshasa 15 per cent of women with one pregnancy had at least one abortion, with great variations according to education level, 13 per cent for women with only two years of primary education and 33 per cent for those with at least six years of education.
At Maputo Central Hospital in Mozambique, most of the patients admitted for abortions were women under 30 years of age, still unmarried and often still at school. The motivation for an abortion was mostly due to economic difficulties and the wish to go on with their education and not to lose opportunities. In addition, it is all too often culturally not acceptable to be pregnant, and especially young women do not want to be stigmatised.

In some countries abortion is so widespread that it had an effect on the fertility rate. In Côte d'Ivoire TFR dropped from 5.7 children per woman in 1994 to 5.2 children in 1999. In the same time period however, contraceptive practice only increased from 6 per cent in 1994 to 10 per cent in 1999, and 29 per cent of all women expressed an unmet need for family planning.

In Abidjan it was found that the reduction of number of children per woman due to abortions was 10 per cent and 15 per cent for young women. The above shows that women in Africa, especially young women, would like to manage their fertility, but unfortunately have to turn to abortions as their family planning needs are not met. This is further enhanced by the findings from Abidjan, where the abortion experience has set women to seek to control their fertility through contraception: The non-users of contraceptives declined from 60 per cent to 35 per cent. This shows how urgent family planning programs and access to contraception are, also focusing on adolescent girls and improved quality of service.

Safe motherhood is another indicator to measure reproductive health commodities security in Africa. Women in sub-Saharan Africa face the highest risk of maternal mortality and morbidity of any region of the world. For instance in Ethiopia, less than 10 per cent of births are attended by skilled personnel, and one out of seven women will die from complications of pregnancy. In Italy by contrast, skilled personnel attend nearly all births and the likelihood of a woman dying from a pregnancy related cause is only one in 6000. The average figure for Africa is one in 15, in Ethiopia as much as one in seven.

In sub-Saharan Africa still more than a quarter of pregnant women do not receive prenatal care and nearly half deliver without help from skilled health personnel. Two thirds of our population consists of youth. There is an urgent need to focus on the reproductive health needs of adolescents. Today many youth become sexually active at younger ages. A survey of youth in Zambia found that over 25 per cent of ten-year-old children and 60 per cent of 14 year old youth reported already having sexual intercourse. However, health workers in Africa feel it inappropriate to provide contraceptives to adolescents. A study in Kenya found that three fourths of family planning workers were unwilling to provide contraceptives to young women. African adolescents cite lack of knowledge, inaccessibility and safety concerns as primary reasons for not using contraception. In Nigeria and Madagascar less than 50 per cent youth know about contraception. A GTZ study in Mwanza, Tanzania, confirmed that only a minority of sexual active young people, less than 30 per cent, used a condom to prevent pregnancy or HIV.

Births to teenage girls are highest in Angola, Niger, Congo, Liberia and Sierra Leone, where one of five girls aged 15 to 19 give birth each year. School drop-out rates due to pregnancies are extremely high in Kenya. Teen mothers face twice the risk of dying from childbirth than do women in their twenties, and also have far more birth complications, as their bodies are not as developed. The question is thus not whether adolescents require reproductive health education, but what kind of education. Next to urgently addressing the issue of providing adolescents with access to reproductive health information, services and commodities there are social issues which also have to be tackled urgently.

Sexual exploitation of young people is frequent in Africa due to lack of economic power and job opportunities. In Addis Abeba, Ethiopia for instance, 30 per cent of prostitutes are women in the age group of 12 to 26 years. In Kenya studies reveal that 50 per cent of girls admit receiving gifts in the form of money, ornaments and clothes from their partners in exchange for sex.
In Ghana, 70 per cent of mothers interviewed admitted to encourage young girls to engage in premarital sexual relationships.

Forced marriages of younger girls to older men and indulging in unprotected sex are still common in Africa, and leave the girls pregnant and with no social or economic power. In general there are low levels of knowledge about pregnancy prevention, with adolescents knowing less than adults. Knowledge about the variety of family planning methods and prevention of HIV/AID and STDs is also limited. In Northern Ethiopia the mean age for first marriage is 13.5 years for girls and 19.5 years for boys. Still many countries in Africa have an average age of first marriage of between 16 and 21 years.

The widespread issue of young girls´ early sexual experiences due to force by adults, such as teachers cannot be touched upon due to time constraints. In South Africa 30 per cent of girls report that their first sexual intercourse was forced. In rural Malawi 55 per cent of adolescent girls report that they have been forced to have sex. In a district of Uganda 31 per cent of schoolgirls and 15 per cent of boys reported having been sexually abused mainly by teachers. HIV/AIDS poses one of the largest challenges for the African continent. Around 70 per cent of all HIV infections were located in sub-Saharan Africa in 2001, that is 28.1 million adults and children. It is estimated that half a million African youth aged 15 to 24 will die from AIDS by the year 2005. Half of all infected people acquire HIV before 25 and die by the time they turn 35. In Tanzania the age group 15 to 21 accounts for 20 per cent of the population but accounts for 60 per cent of all new HIV infections.

UNFPA has stated again that condoms have an important role to play in preventing the spread of HIV. Africa where the pandemic is gravest has to rely most heavily on donor support. Should donors wish to cover 100 per cent of the condom requirements of the continent they would have to double their 1999 level of support. This re-emphasizes the crisis of contraction shortage. Current donor support makes available on average three condoms per man in sub-Saharan Africa.

Closing the demand-supply gap for contraceptives in Africa does not just require additional financial resources but also capacity building, improved governance and country level commitment to better manage the reliable supply of contraceptives. This however also has to be supported by education and awareness campaigns aimed at changing behaviour, as well as empowering women and adolescents. The time for action is now.

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Status of the implementation of the ICPD in Asia An overview

Introduction

This paper intends to provide an overview of the status and challenges in Asia in relation to the International Conference on Population Development (ICPD). It focuses on population and reproductive health, including family planning, gender issues, reproductive health, and HIV/AIDS. It is based on the most recent data, as provided by United Nations Population Fund (UNFPA), Economic and Social Commission for Asia and the Pacific (ESCAP), and others.

Section I reviews the ICPD, ICPD+5, their goals and indicators. In Section II, a brief overview of population data and trends is given. This is followed by some environmental trends in Section III. In Section IV-VII, the regional situation in terms of recent trends and developments in some key areas is described, including mortality, gender equality, and reproductive health. When possible, the data will be compared against the background of benchmark indicators that were adopted at the 1999 General Assembly Special Session. In section VIII some considerations concerning resource mobilization will be listed. The final section summarizes the major conclusions and challenges with respect to the implementation of the ICPD in Asia. The rough data on which most of this report is based can be found in the annex.

I: ICPD and ICPD+5: Goals and Indicators

International Conference on Population and Development (ICPD)
At the 1994 International Conference on Population and Development (ICPD), 179 countries agreed that population and development are inextricably linked, and that empowering women and meeting people's needs for education and health, including reproductive health, are necessary for both individual advancement and balanced development. Advancing gender equality, eliminating violence against women and ensuring women's ability to control their own fertility were acknowledged as cornerstones of population and development policies. Concrete goals centred on providing universal education and reproductive health care, including family planning, and reducing infant, child and maternal mortality.

The Programme of Action (PoA) of ICPD of 1994 is widely acclaimed as a landmark multi-country agreement, signifying the dawn of a new era in how the world community views the interface between population and development. The overriding objective of the Cairo PoA is to raise the quality of life and individual well-being, and to promote human development by recognizing the complexity of interrelationships between population and development policies and programmes. The ambitious aim is to achieve poverty eradication, sustained economic growth in the context of sustainable development, wider access to education, especially for girls, gender equity and equality, the reduction of infant, child and maternal mortality, the provision of universal access to reproductive health services, including family planning and sexual health, sustainable patterns of consumption and production, food security, human resources development and the guarantee of all human rights, including the right to development as a universal and inalienable right and an integral part of fundamental human rights.

The PoA recognizes that the goal of empowering women to give them greater autonomy and to improve their political, social, economic and health status is very important and is a prerequisite for national sustainable development. The right to education, especially of women and the girl child, must be promoted to meet basic human needs. In particular, the PoA calls for the elimination of all practices that discriminate against women and affirms that advancing gender equality and equity and the empowerment of women, and the limitation of all forms of violence against women, are the cornerstones of all population and development-related programmes. The ability of women to control their own fertility is an important and strategic human right and is highlighted throughout the PoA.

The PoA affirms that reproductive rights embrace certain human rights that 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. The following indicators and threshold levels were suggested
Indicators and threshold levels of achieving goals of the ICPD Programme of Action by the year 2005.

Indicators
Threshold levels
Goal: Access to reproductive health

Proportion of deliveries attended by trained health personnel
60 per cent
Contraceptive prevalence rate
55 per cent
Proportion of population having access to basic health services
60 per cent
Goal: Mortality reduction
Infant mortality rate
50 infant deaths per 1,000 per live births
Maternal mortality ratio
100 maternal deaths per 100,000 live births
Goal: Universal primary education
Gross female enrolment rate at primary level
65 per 100 eligible population
Adult female literacy rate
50 per cent

Source: United Nations Population Fund (1996)
ICPD+5

A 1999 review of progress since the Cairo Conference ("ICPD+5") has provided growing evidence that the ICPD agenda is practical and realistic, and that despite all obstacles, it is being put into practice. The review included reports on national implementation efforts, global expert meetings and an international forum at The Hague, organized by UNFPA; it culminated in a special session of the United Nations General Assembly, from 30 June to 2 July 1999, which identified key actions needed for further implementation of the ICPD Programme of Action and new benchmarks [see below] for measuring progress towards ICPD goals.

Benchmark Indicators Adopted at the ICPD+5 Review
The ICPD Programme of Action recommended a set of interdependent quantitative goals and objectives. These included universal access to primary education, with special attention to closing the gender gap in primary and secondary school education; universal access to primary health care; universal access to a full range of comprehensive reproductive health care services, including family planning; reductions in infant, child and maternal morbidity and mortality; and increased life expectancy. The national achievements in these areas will be assessed against some of these benchmarks in sections IV-VII.

II: Population Trends
With a total population of nearly 4 billion, the Asia-Pacific region remains the most populous area worldwide and its population is still growing by 1.2 per cent annually (see annex).
China and India, together, account for 61 per cent of Asia's population, and for 38 per cent of the world population. China's relatively low growth rate of 0.9 per cent has largely been achieved through the controversial "one-child policy", which has resulted in a skewed population structure in favor of boys. India's annual growth rate of 1.5 per cent has been achieved through promotion of family planning. In both countries, there are reports of related sex-selective abortions and infanticide.
By sub-region, South and Southwest Asia has the highest growth rate, with Pakistan and Bangladesh as examples of populous countries with growth rates of higher than 2 per cent. "At these growth rates, south-central Asia will have to cope with over 2 billion people by 2025, many of them desperately poor." In Southeast Asia, Cambodia and Lao PDR have relatively high growth rates. Of the larger Pacific Island countries, Papua New Guinea stands out with a growth rate of 2.3 per cent per year.

The "youth bulge"
Apart from prolonged population growth, the large proportion of young people in Asian populations has sparked other concerns. Between 1960 and 2000, the number of young people (15-24) doubled or more than doubled in every Asian country, except China, Japan, North-Korea, and Kazakhstan. This rapid growth of youth populations has created pressure to expand education, health, and employment aimed at this age group. Furthermore, measures to curb rising levels of smoking, drinking, drug use, and unprotected sex, particularly amongst young people, are required in many Asian countries.

Ageing
Declining fertility and mortality, owing to better health care technologies and nutrition, is leading to population ageing in the region. On average, the size of population older than 65 increased by 3.35 per cent per year. South-Korea, Bhutan, Kazakhstan, Singapore, and China all have proportions of those aged older than 64 of higher than 10 per cent. ESCAP ranks selected countries by descending percentage change, 1990 and

2000. The Republic of Korea scores highest with an increase of 6.0 per cent (5 per cent in 1990 versus 11 per cent in 2000). Other countries high on the list include: Singapore (5.0 per cent increase), China (4.5 per cent), Sri Lanka (4.1 per cent), Thailand (3.8 per cent), Indonesia (3.7 per cent), and India (3.3 per cent). These countries represent the vast majority of the region's population.
Asian governments need to look ahead to the needs of their growing populations and move quickly to put the necessary pension schemes, health-care programmes, and other institutional and financial arrangements in place.

III: Environmental Trends in Asia and the Pacific
Asia, with 29.5 per cent of the world's land area, supports more than 60 per cent of its population. High population densities and widespread poverty are putting enormous stress on the environment. Major challenges include:

Land degradation: At least 1.3 billion people (39 per cent of the region's population) live in areas prone to drought and desertification. More than 350 million hectares are already desertified. About 20 per cent (around 550 million hectares) of Asia's vegetated land is affected by soil degradation. In India, Iran and Pakistan, water and wind erosion are major contributors to soil degradation. In India, as much as 27 per cent of the soil has been affected by severe erosion. China, India and Pakistan all suffer from land salinization resulting from excessive groundwater irrigation. Excessive agrochemical inputs are also responsible for land degradation in many countries of this region.

Deforestation: Forest cover has been receding rapidly across Asia, largely due to the unsustainable exploitation of timber reserves and unchecked agricultural expansion. Six countries (China, Indonesia, Malaysia, Myanmar, the Philippines, and Thailand) account for three quarters of recent deforestation in the region. Many forests, such as those in the Mekong Basin, have been logged to the point that they are of critically low quality. Illegal logging amplifies the pressure on forest resources in several Asian countries. Fuelwood harvesting, irrigation schemes, hydroelectric power projects, urbanization, infrastructure development, natural disasters and fires also contribute to deforestation. Wars denuded forest cover in Viet Nam and Laos, while forest fires were a significant factor in Indonesia. The adoption of sustainable forest and agricultural management policies has slowed forest depletion in Thailand, Viet Nam and Cambodia.
Water resource depletion: Agriculture accounts for a larger percentage of freshwater usage in Asia than in any other part of the world and freshwater will be the major limiting factor to producing more food in the future. Dams and groundwater irrigation have disrupted the natural hydrological cycle, reducing river levels, depleting wetlands and aquifers, and salinizing agricultural lands. Dirty water and poor sanitation claim more than 500,000 infant deaths a year. Asia's rivers contain three times as many bacteria from human waste as the world average. One in three Asians has no access to safe drinking water, often as a result of contamination of groundwater and surface water reserves by sewage and industrial waste. A study of 15 Japanese cities, for example, showed that chlorinated solvents from industry contaminate 30 per cent of all groundwater supplies. Agrochemical inputs are a growing source of water contamination as nitrates leach into freshwater bodies. Salt-water intrusion also threatens the water supply in many areas; in Madras, India, for instance, salt water has rendered many irrigation wells useless as far as 10 kilometres inland.
Biodiversity depletion: Indonesia, India, and China are among the countries with the most threatened species of mammals and birds, according to the World Conservation Union (IUCN). Indonesia has the highest number of threatened mammals (135 species), followed by India (80) and China (72). The Philippines have more critically endangered birds than any other country in the world.

Air quality and carbon emissions: Air pollution is now becoming a part of the region's environment, causing deaths. In China, for instance, smoke and small particles from burning coal cause more than 50,000 premature deaths and 400,000 new cases of chronic bronchitis a year. Led by China and Japan, emissions of carbon dioxide increased at twice the average world rate of 2.6 per cent per year during 1975-1995.
Urbanization: Asia has 160 of the world's 369 cities with more than 750,000 residents. Growing populations have frequently outpaced the development of urban infrastructures, and slums and shanty-towns are growing in many cities. In Colombo, for example, some 50 per cent of the urban population resides in slums and squatter areas. The urban population of the region, now about 35 per cent of the total population, grew by 3.2 per cent a year between 1990 and 1995, compared with 0.8 per cent a year for the rural population. In most countries, the urban population is likely to grow threefold in the next 40 years. China alone is expected to have 832 million urban residents by 2025.

GEO-2000 reports that "some governments are now taking action to reconcile trade and environmental interests through special policies, agreements on products standards, enforcement of the Polluter Pays Principle, and the enforcement of health and sanitary standards for food exports."

IV: Child Mortality, Maternal Mortality and Life Expectancy

Infant mortality
The goal set by ICPD was 50 per thousand live births by 2005. For the whole of Asia, infant mortality stands at 53, compared to 55 for the world as a whole. By sub-region, South Central Asia has the highest infant mortality (69) with an extremely high rate in Afghanistan (161) and high rates in Pakistan, Nepal, Bangladesh, and India. In other sub-regions, Lao PDR, Myanmar, Cambodia, and Papua New Guinea all have rates above 60.

Maternal mortality
The ICPD goal was 100 per 100,000 live births by 2005. Asia as a whole has a mortality ratio of 280, compared to 21 for the "More developed regions", 440 for the "Less developed regions", and 1,000 for the "Least developed countries". Nepal (830) and Afghanistan (820) have extremely high rates and Lao PDR, Bangladesh, Cambodia, Bhutan, Indonesia, and India all have rates higher than the world's average of 400. Clearly, the target of 100 by 2005 is still a long way and will not be reached by any of the countries mentioned above.
Life expectancy
During the second half of the 20th century, life expectancy in Asia as a whole increased by more than 25 years, from 41.3 to 67.7. With an average life expectancy of 65.8/69.2 (M/F), Asia scores slightly higher than the world's average of 63.9/68.1, with Japan scoring very high, and Hong Kong, Macao, and Singapore not far behind. Countries with a substantially lower life expectancy -defined as below 55/60- include Lao PDR, Myanmar, Cambodia, Nepal, and Papua New Guinea. Again, Afghanistan stands out with an extremely low life expectancy of 43.0/43.5.

V: Education
Female illiteracy and primary school enrolment
The 1990 illiteracy rate for women and girls should be halved by 2005; and by 2010, the net primary school enrolment ratio for children of both sexes should be at least 90 per cent.
The State of World Population, UNFPA, 2001, provides recent data on (female) illiteracy (>15 years) in Asia (see table 1 in Annex). By sub-region, South Central Asia has the highest rates of illiteracy; Afghanistan (77 per cent), Nepal (75 per cent), Yemen (73 per cent), Bangladesh (69 per cent), Pakistan (68 per cent), and India (54 per cent) stand out with female illiteracy rates of higher than 50 per cent. In these countries, male illiteracy is substantially lower; average 39 per cent versus 69 per cent for women and girls. In South-eastern Asia and the Pacific, Lao PDR (65 per cent), Papua New Guinea (42 per cent) and Cambodia (41 per cent) have the highest female illiteracy rates.

ESCAP compares youth literacy rates (people aged 15-25) in 1990 and 1999. The following improvements are noted (in bold, the 2005 target if the ICPD goal were applied to youth: Bangladesh (44 to 50 per cent, 2005 target: 72 per cent), Nepal (46 to 59; 73), Pakistan (49 to 63: 75), India (64 to 72; 82), Cambodia (46 to 58; 73), Lao PDR (55 to 69; 77) and Papua New Guinea (69 to 75; 85).
By 2001, gross primary school enrolment was still below 80 per cent in several countries in the region, including Afghanistan (M/F: 64/32 per cent), Bangladesh (77/66), and Pakistan (87/42). The "old" goal of 65 per cent female enrolment by 2005 will probably have been reached by almost all countries. Clearly, the countries mentioned above still have a long way to go to reach the reviewed ICPD goals set for 2005 and 2010 respectively.

VI: Gender Equality and Empowerment of Women
Violence Against Women
The report on the Asian "Intercountry Workshop on Parliamentary Advocacy for the Elimination of Violence Against Women", held in Bangkok 19-21 June, 2001, provides a situation analysis of violence against women: the regional picture, including domestic violence, rape & sexual assault, prostitution, trafficking of women, and sexual exploitation of women in armed conflict situations. The following is taken from that report:
- The most endemic form of VAW is wife abuse or physical harm inflicted by male partners. Researchers suggest that questionnaires requiring women to identify abuse generally underestimate the physical violence in intimate relationships. This situation is attributed to the women's socialization of accepting physical and emotional chastisement as a husband's marital prerogative limiting the range of behaviour considered as abuse.
- Rape and sexual assault may be perpetrated by strangers although a high percentage of rapists are acquaintances, friends, relatives and those in positions of trust or power. The most frequent type of rape occurs within the family - very often perpetrated by the father on the daughter.
- Although prostitution is widely prevalent in the region, the issue has not been adequately documented. The illegal or underground nature of the sex industry renders it difficult to determine its actual size. Estimates are that between 0.25 and 1.5 per cent of the total female population in Indonesia, Malaysia, the Philippines and Thailand are engaged in prostitution. Problems and concerns related to the

demographic, health and criminal aspects of prostitution raise the issue of whether it should be criminalized, prohibited, legalized or deregulated.

- It is estimated that nearly one-third of the global trafficking trade, or about 200,000-225,000 women and children, come from South-East Asia. In recent years, trafficking has become highly organized with the involvement of international criminal networks attracted by the lucrative profits. Across the sub-region, some national laws on the suppression of trafficking are in place.

Female literacy and women in parliament

In the table below, two indicators are introduced here to gauge gender equality: Ratio of literate females to males of 15-to-24 year-olds, 1990 and 1999, and the proportion of seats held by women in parliament, 1992, 2000.

Available data suggest that in South and South-West Asia - with exception of Sri Lanka - the gap between young men and women remains quite high. In South-East Asia and China the situation looks much better, whereas in countries such as Mongolia and Papua New Guinea there is still a lot of room for improvement.

VII: Reproductive Health

The proportion of births attended by skilled health personnel

ICPD+5: At least 40 per cent of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80 per cent globally, by 2005; these figures should be 50 and 85 per cent, respectively, by 2010; and 60 and 90 per cent by 2015.

ESCAP reports the percentage of births attended by health staff in 1990-1991, as compared with 1995-2000. Nepal (8 versus 9 per cent), Bangladesh (7-13), Lao PDR (? -14), Bhutan (16-15), and Cambodia (47-34) report percentages of lower than 40 per cent and very high maternal mortality rates (>500/100,000 live births). Of these countries, only Bangladesh shows an improvement. It seems unlikely that these countries - with a possible exception of Cambodia - will reach the target set for 2005.

Papua New Guinea (53), Indonesia (56), Myanmar (56), and Philippines (56) remain under 60, (Pakistan unknown, yet 40 per cent in 1990-1991) with high maternal mortality ratios of 170-390/100,000 live births.

Adolescent fertility rate and contraceptive prevalence

The threshold of <50 /1000 live births is not likely to be reached by many countries in the region. The State of World Population, UNFPA, 2001 shows extremely high birth rates by women aged 15-19 in Bangladesh (125/1000), Nepal (124), Afghanistan (111), Cambodia (97), Lao PDR (91), and Papua New Guinea (84). Contraceptive prevalence is extremely low in Afghanistan at 2 per cent. Prevalence rates of usage of modern methods are below 25 per cent in Cambodia (7 per cent), Lao PDR (15), Pakistan (17), Bhutan (19), and Papua New Guinea (20).

HIV/AIDS

ICPD+5: HIV infection rates in persons 15-24 years of age should be reduced by 25 per cent in the most affected countries by 2005 and by 25 per cent globally by 2010.

Adult HIV prevalence rates are highest in the following countries: Cambodia (4.04) Thailand (2.15), Myanmar (1.99), India (0.70), Malaysia (0.42), Nepal (0.29), Viet Nam (0.24), Papua New Guinea (0.22), Brunei Darussalam (0.20), and Singapore (0.19). Similarly, HIV prevalence rates among youth (15-24 years old, M/F) are highest in Cambodia (2.36/3.51), Thailand (1.18/2.32), Myanmar 1.04/1.72), India (0.36/0.61), Malaysia (0.57/0.09), Singapore (0.22/0.16), Nepal (0.14/0.20), and Papua New Guinea (0.08/0.25). With exception of Malaysia and Singapore, these rates are substantially higher for young women than for young men.

A word of caution is in place for China's situation. Based on these data, China has nowhere been mentioned as a country with severe problems, yet, given the size of its population, the absolute numbers can be extremely high. For example, in the case of HIV/AIDS prevalence amongst young people, a rate of 0.07 per cent (0.12/0.02) represents many more people than the 2.94 per cent (2.35/3.51) of Cambodia. Certain areas of China - with larger population than many of the listed countries - appear to have rather high HIV prevalence rates.

VIII: Resource Mobilization

Resources needed for reproductive health and population programmes worldwide were estimated to be US $17 billion in 2000. While developing countries are providing most of their share, support from international donors was less than half of the US $5.7 billion called for. Over the last 10 years, Net Official Development Assistance (ODA) as a percentage of Organisation for Economic Co-operation and Development / The Development Assistance Committee (OECD/DAC) donors' gross national product, has generally been declining. Only Denmark (1.01 per cent), Norway (0.91 per cent), Netherlands (0.72 per cent), and Sweden (0.7 per cent) reach the proportion of 0.7 per cent that the rich countries have committed to provide. If the rich countries were to honour this commitment, current ODA levels would almost triple.

At the International Conference on Financing for Development, held at Monterrey, March 2002, several

countries including the USA and The European Union (EU) have pledged additional resources for the developing countries. A good part of these should be destined for the developing countries of Asia and the Pacific region. In a separate effort, the one country that stands out in virtually all indicators covered in this paper, Afghanistan, is currently receiving aid through various channels.

IX: Conclusions and Challenges

The Asia-Pacific is vast region with large sub-regional and national differences. Most South Central Asian countries still have a long way towards reaching the ICPD goals. Afghanistan scores extremely low on all indicators and is finally receiving the aid it had needed for a long time. Nepal, Pakistan, Bangladesh, and India are also scoring low on many indicators, especially on maternal mortality and female illiteracy. Sri Lanka appears to be quite successful at reaching the goals set by ICPD.

In South-eastern Asia, Cambodia, Lao PDR, and Myanmar have serious problems in the field of mortality, education and reproductive health, including HIV/AIDS. In addition, Thailand has a big HIV/AIDS problem that has led to increased funding by UNFPA and others.
Although the Pacific Islands are generally doing relatively well, Papua New Guinea appears to have great difficulty at reaching any of the ICPD goals.

As a region, Asia has seen both remarkable improvements and shocking deteriorations. A recurring barrier to the successful implementation of the ICPD in many countries is lack of concepts such as reproductive rights, gender equity and women's empowerment among providers, legislators and community members alike. Several countries are going through health and educational sector reforms in an effort to make services client friendly, of high quality, and affordable. It is still too early to gauge the effects of these efforts. In their latest publication "Asia-Pacific Population and Policy" (Number 59, April, 2002) the East-West concludes the following: "In many countries today, women still have more children than they want. Policymakers in these countries and international donors need "a second wind" to continue providing consistent, long-term support for family-planning programmes. In addition, reproductive health and risk-reduction programmes need to reach out more vigorously to young people."

In terms of resource mobilization, UNFPA estimated a world wide deficit in resources by the year 2000 compared to the ICPD targets of US $2.1 billion in the most optimistic scenario. Consequences include: more potential family planning users without contraception, more unwanted pregnancies, more abortions, more unwanted births, more deaths and injuries resulting from pregnancy, and increased infant and child mortality. Clearly, there is an important role and duty for government agencies and donors to mitigate these consequences.

José Luis Corral Ruiz
Executive Director, Centro Latinoamericano Salud y Mujer (CELSAM), Mexico
Investing in health programs
The concept of CELSAM

I am honoured to have the opportunity to present CELSAM Latin America. CELSAM is a non-profit civil organization conceived to contribute to society by educating and informing women, creating awareness and producing data giving accurate answers to their needs.

To explain our organization, CELSAM has an executive board, and a scientific committee formed by opinion leaders from all Latin America, and a technical committee, formed by international agencies, local NGOs same as governmental institutions supported and lubricated by an executive director in charge of the general organization and communication process. Our current coverage is whole Latin America. We have a regional CELSAM in each country; and through two of these countries, we cover Central America and the Caribbean. In total we have one regional and 12 local CELSAM.

CELSAM promotes a Latin-American consensus of different contraceptive methods and solutions to punctual reproductive health information needs.
CELSAM disseminates its conclusions through media and by mingling with physicians' associations, private and public organizations, respecting their independence.
With our contacts, Know-how experiences, technical assistance, actualisation, and our members' personal experience and presence, we have something that is very important for the final user: it is credibility.
CELSAM is the name but our last name is the most important thing, our last name is conformed by all CELSAM members.

Our studies have shown that Pharmacy is one of the first ways of obtaining contraceptive methods for women in Latin America. How do these women get their information? How do these women get their medical advise and revision? There are three groups of women in reproductive stages: teenagers, the women over 25 years and elderly women. They all receive information through different sources. There are the religious, and the traditional ones, that means those received through the physicians. Besides there are other sources: governmental ministries of health, institutions - private and public - and NGOs. I call them the "information wall".

This is due to the fact that the people in these institutions are supposed to deliver all kinds of information about reproductive rights as contraception – but they don't do it. They only drop information to women and they don't know how to use it, or what to do with it, even though there are so many ways of spreading information. Let's talk about some information channels: radio; more or less 90 per cent of the women in Latin America have radio. Magazines: teenagers love to have these magazines. It's an important source of information for urban teenagers. Also TV: many people believe whatever they see on TV whether it is true or not. There are other important sources: Friends and family. Let's assume, a woman obtains the required information. What will she do? Will she go to the physician? I don't think she will do so. Normally she goes to the pharmacy and asks for a method, asks for a solution. But there are some questions now: is this the right way? Regarding compliance: Will these women use contraceptives for a long period? What happens if they present any side effect, even though it is a minor one? Are they going to use it for a long period of time? What happens if one of these new users is not an eligible person for hormonal products?
Imagine: there is a pamphlet, a booklet or a message on TV, that says the pill does not increase your weight. Maybe it is true, maybe not. If it is connected with a brand, nobody will believe it, because they feel that we want to sell them a product. But it is different when the message is sent by a NGO supported by opinion leaders, international agencies, other national and international NGOs and governmental institutions. Now this information becomes true.

CELSAM disseminates recommendations and conclusions throughout the region. It contributes to create a public opinion within a society and the medical community. We are non-commercial and non-political. The experts that collaborate in this project share their experience and vision to inform and educate Latin American women. They don't receive any pay for this. It's voluntarily. We use media relations as a tool, we train journalists, we do media seminars, send press releases, info papers, information lines and we run our web pages in alliance with the big portals in Latin America. We have a research project, a survey on the perceptions and use of birth control methods in Latin America, in fourteen countries. We have a lot of printed materials for communication purposes in many different areas. We also have collateral materials brochures, conclusions, B-rolls, videos, etc.

We have numbers that show that more than 118 million people last year have received our information

through media. CELSAM activities are funded through different sources coming from the public and private sectors. In the private sector Schering AG has funded some of its projects since the beginning. CELSAM received also technical assistance from other organizations like Pathfinder, United Nations Population Fund, Family Health International and the American Government development agency USAID, through the Centers of Medicare and Medicaid Services (CMS) and catalyst. With information and education women in Latin America will apply their right to decide. And with these decisions we are preventing unplanned pregnancies and abortions by increasing the use of modern contraceptive methods.

César Loboguerrero
Medical Expert, CELSAM, Colombia
A working team
The Colombian case

Let me give you some figures referring to the population structure in Colombia. The total population is 43.070.703. Women represent the majority with 50,6 per cent. Women aged 15 to 45 reache 10.613.794. Most of them, 7.355.707, live in urban areas. 40 per cent of the Colombian population is between 10 and 29 years old. Average age of first sexual encounter is 13 years. The Demography and Health Survey of "Profamilia" has shown that 1 of every 3 adolescents under 19 years old have been pregnant at least once. The mother's age has an important impact: infant mortality increases when they are under 20 years (31 per 1000) and diminishes when the mother is between 21 and 29 years old (21 per 1000).
There is also a strong relation between education and fertility rate.

The average rate in the country is 2,6. In women with less than 5 years of formal education, the rate is 4.8 children and drops to 2.4 children when women have 8 or more education years. There is also a gap between rural and urban areas. The rate in urban areas is 2.6, while in rural areas it is 4.4. The risk of new natal dead is five times higher in non-educated women. 42 per cent of the interviewed women (source: Demography and Health Survey Profamilia, 2000) did not have any information about sexually transmitted infections and it also proved that if undesired childbirth could be avoided, fecundity rate would be 1.8 and not 2.6.

Let's have a look at some prevalence rates in Colombia for contraception methods. But we have to be aware, because these rates do not include adolescents when their marital status is single. In 2000, 52.8 per cent of the women were using contraception methods. 17.5 per cent were sterilized, 5.5 per cent used condoms, and 8 per cent preferred the pill.

So what is CELSAM doing in Colombia?
We are developing educational activities where feminine population is predominant advising them in the adequate method. We are looking for new places to work and try to strengthen those already existing, generating close relations with decision making staff in order to obtain commitment, fidelity and partnerships. Our customers should conceive prevalence work as a service product. CELSAM Colombia is training physicians and nurses, giving them actualised information and creating partnership relations. In service training directed at community leaders, we qualify them to act as multipliers. And last but not least: we are using an adequate language permitting user-women to take her own decision around contraception or climacteric method.

CELSAM Colombia is working in support tools: there is an Information Call Centre, Focus, where everybody can get reproductive health information. We create and produce printed educational material, booklets, table games, counselling support material and sexual and reproductive rights poster. There is also material developed from alliances with other NGOs, governmental, private and public institutions.

In 2002 there are US $900.000 for wages, support material, and travel expenses.
What does CELSAM Colombia want to be and what does CELSAM Colombia do?
- Research promoting sexual and reproductive health
- Became an information source referring sexual and reproductive health
- Increase contraception and climacteric coverage based on sustainability criteria
- Participate in the public policymaking concerning sexual and reproductive health
- Create measurement system concerning compliance
- Work on local alliances for CELSAM with other related organisations
- Create information focused on local issues and data on reproductive health, contraceptives, myths of oral contraceptives, abortion, Family Planning

Conclusion:
Our work surpasses the national Health System prescription index. It increases social capital in different work places. CELSAM's work is a service product that adds value to women's health in our countries.

Rolf Korte und Annette Gabriel
Head of Department of Health, Education Nutrition, Emergency;
Co-ordinator Nationwide Sector-Project Reproductive Health;
GTZ, Germany

Sexual and Reproductive Health – Success is possible

Introduction

Population matters affect all areas of sustainable development. Consequently, all development efforts have to take them into consideration. Population grows fastest where

- the mortality rate of children is especially high,
- there is widespread poverty,
- women have little education and a low social position,
- social services are inadequate.

Very often these are countries that are especially affected by environmental problems like the erosion of soil, floods and droughts, the lack of cultivable land, malnutrition and hunger. The excessive use of natural resources inherent to population growth is increased by the process of impoverishment.
The Action Programme of the Conference on World Population from 1994 is the first population policy document to explicitly stress the importance of reproductive rights and health and the corresponding health and counselling services for population development and the development process in general. For the first time, it also stresses the responsibility of men for reproductive and sexual actions, and it discusses the respective needs and rights of young people.

Problems of reproductive health, like sexually transmitted diseases, in particular HIV/AIDS, maternal mortality, expensive treatment of high-risk pregnancies, following unsafe abortions and cases of violence bring about high costs for the individual and for society. They contribute to the impoverishment of the affected individuals or families and also to the development of society as a whole. The WHO "Report on Macroeconomics and Health" estimates that 72 million disability adjusted life years (DALYs) – i.e. productive life years – were lost in 1999 alone due to AIDS. This corresponds to approximately 11 per cent of Sub-Saharan Africa's GDP. Statistically speaking, each person who died of AIDS in this region equals the loss of 34.6 DALYs.

It is clear that programmes to promote employment and the economy cannot bring about sustainable development without exerting positive parallel influence on a country's demographic and health situation. On the other hand, improving sexual and reproductive health services with a relatively small financial effort can considerably improve the health situation and development opportunities in our partner countries. To achieve this, it is necessary to supplement disease control programmes with reproductive health services like sexual education, mother-child services, family planning, prevention and treatment of sexually transmitted infections, and education programmes. This is the only way in which reduced fertility rates can back up the transition to reduced mortality rates.

Germany's contribution to development cooperation (DC) in RH

Promoting important aspects of Reproductive Health (RH), like a safe pregnancy and delivery and family planning, has long been an essential component of a functioning health system. The Federal Ministry for Economic Cooperation and Development (BMZ), in its sector concept on population development, established far-reaching principles for development cooperation projects in this area as early as 1991. They were reconfirmed by the International Conference on Population and Development in Cairo (ICPD) in 1994. This especially includes comprehensive education and the principle that all measures related to family planning and reproductive health be voluntary.

Germany's development cooperation in the area of reproductive health pursues the following objectives: It wants to improve the health of the population, reduce maternal mortality, sexually transmitted diseases and abortions, improve the living conditions of women and implement human rights in sexuality at the individual level. At the national level, it wants to contribute to a population structure and size and to the protection of natural resources, which enables the partner countries to enjoy positive economic and social development and helps to maintain the scope of action for future generations.

In accordance with the Cairo Action Programme approaches that contribute to the integration of RH services into health care and to thus make them available to a broad range of society on a long-term basis will receive special support. To achieve this, GTZ staff counsel our partners in developing countries at the

national and de-centralised levels. The integration of RH issues also covers training and the production of information and education material. In this respect it is essential to link HIV/AIDS prevention measures with other RH programmes. After 1994, a whole range of new projects have been developed in this field that are supported by the GTZ.

Technical Cooperation in the field of Sexual and Reproductive Health
Of altogether 117 health projects

63 projects have a SRH component.
Of those,

- 34 projects are in Africa,
- 10 projects are in Asia,
- 14 projects are in Latin America & the Caribbean,
- 5 projects are are supra-regional.

Since spring of 2000 a technical guideline has been the orientation for health project staffs and experts. It follows agreements of international law and the relevant BMZ sector concepts and constitutes part of the GTZ's quality management.

The essential strategies of Technical Cooperation in the field of SRH:

- integrated services, e.g. integration of family planning (FP), health care during pregnancy and treatment of sexually transmitted infections
- improved quality of RH services (through quality management, parallel research, training)
- community-based services ("CBS")
- promotion of innovative approaches with special target groups, especially young people
- promotion of cross-sector approaches
- cooperation with non-governmental organisations (NGOs) and private industry (PPP)

Some approaches will be presented as examples:
Community-based services in Kenya Approach:
According to the CBS principle, chosen laymen are trained to provide information on matters of basic and reproductive health to the members of their community, to distribute pills and condoms and to refer their clients to health care facilities – if necessary. As the laymen have been chosen by the community, their services are accepted by their environment. They can thus also address taboo topics and reach out to people that otherwise cannot be reached by the public health care service. The voluntary workers are trained and assisted by their future counsellors – qualified personnel from the nearest health care facility. This procedure strengthens the identification with the state health services and creates a notion of togetherness among the participants.

Methodology:
The project was initiated in 1986, and it has employed the CBD approach since 1991 to achieve a better coverage of the rural population. By now, the project covers 16 districts in Western Kenya and 4 in the Eastern Province, an extent hardly ever achieved in Kenya. While the initial focus in the reduction of the fertility rate was on education and the distribution of modern means of contraception, the topics covered by the voluntary community helpers or CBDs (community-based distributors) were gradually expanded. Since 1998 their interventions include topics like unsafe pregnancy and delivery, female genital mutilation, youth health and HIV/AIDS. Since then their interventions have also stressed sustainability and quality assurance. It was possible to develop a manual containing questionnaires, data sheets, instructions and guidelines that set standards and facilitate monitoring tasks.

Results:
So far, the project has trained more than 2,000 supervisors and approximately 13,000 CBDs. About 8,500 of the latter are still employed. The provided services are used by about 400,00 families (10-12 per cent of the population); but they reach roughly 8 million Kenyans or almost one third of the population. The compliance rate for contraceptives has grown from an average 10 per cent in 1984 to 36 per cent today. During the same period the fertility rate of women has declined from 8 to 4.4 children. In the past 10 years both the number of new and returning clients and the amount of distributed contraceptives has continuously increased:

1996	1999
number of clients	
815,000	
985,000 (2001)	

distributed condoms
8 million
12 million
distributed pill cycles
800,000
1.35 million

Currently, the number of clients is slightly decreasing. But this corresponds to a national trend in decreasing FP user rates and increased access to private providers. A pilot project was carried out and evaluated to make the CBD approach sustainable and to increase the motivation of the CBD agents. In this project government-issued condoms were repacked with more appealing packaging containing a product name and then distributed and sold by CBDs. Design, pricing, distribution channels and choice of name were determined by operational research studies.

By linking the two approaches of Social Marketing and community-supported RH services
- condoms can be provided for more clients – this is true for the large amount of young clients also in case young CBDs are employed;
- clients can be referred to health care services when problems or insecurities occur;
- there is a better possibility to counteract rumours and misunderstandings than with a pure SM approach;
- the fee-for-service idea is spread among many people. This also implies a motivation for the CBDs and thus a guarantee that their services are maintained for the community, including the questions that they answer without being paid for.

The distribution of condoms through CBDs has proven worthwhile and becomes sustainable in the long run given that there is appropriate training and supervision.

Cross-sector approach using the example of peer education in elementary schools in the Mbeya region, Tanzania

Background and approach:
Since late 1989, the German government has supported Tanzania's Ministry of Health to carry out an AIDS control programme in the Mbeya region close to the border with Zambia and Malawi. The special relevance of including young people as a target group in the intervention is given because of their demographic weight and the fact that they are especially prone to problems of sexual and reproductive health, but also because of their flexibility and openness which might assist in developing positive behaviour patterns. So young people become potential "change agents". Studies conducted in the project region showed that young people lacked essential knowledge of reproductive health, HIV/AIDS and sexually transmitted diseases, but that they were already sexually active. Consequently, it was necessary to communicate this information to the young people. "Peer education" was the method chosen to communicate the information because young people stated in the surveys that they preferred personal communication with people their age. A regional programme for elementary school classes 5 to 7 was developed in cooperation with the Ministry of Education. Based on the existing national curriculum for AIDS education, the results of the study and the ideas of the young people, the Ministries (Health and Education) and the GTZ staff developed a training of trainers and a training of "peer educators". The concluding summary of this training also serves as a manual for the trainees. Ministry staff regularly supports the young mediators. At the same time they also act as liaison officers for pupils who have problems or proposal for changes, etc. The programme has been equally accepted by pupils, teachers and parents alike, because all of the participants have been involved both in the development and in the implementation.

Results:
The programme has so far been implemented by 500 schools in 4 districts. The parents and pupils finance the training of "peer educators" themselves although it is the Ministries of Health and Education that continue to run it. A study has shown that pupils from schools that employ this programme become sexually active about 1-2 years later and possess greater knowledge and a better understanding of the topic than pupils from schools that do not offer these classes. Both teachers and parents report that the children show changes in their behavioural roles.

Cooperation with industry – cooperation with DaimlerChrysler in South Africa
Background and approach:
Before the backdrop of the dramatic AIDS epidemic in Southern Africa DaimlerChrysler South Africa (DCSA) developed a comprehensive anti-HIV/AIDS programme that covers 23,000 workers and their families. DCSA is one of the first companies in the country that take up the fight against HIV/AIDS. The company implemented its first measures as early as 1996. DaimlerChrysler completely reviewed its strategy in

cooperation with the German Agency for Technical Cooperation (GTZ) as a Public Private Partnership project: a programme was developed in close cooperation with the trade unions and supported by experts that aimed at facing the country's HIV/AIDS problem and reducing the threat of infection for the company's workers.

Methodology:
The programme includes
- education provided by trained "peer educators"
- comprehensive health care services including the distribution of condoms
- voluntary HIV/AIDS counselling and testing (VCT) based on anonymity
- a 2-year KAP study (knowledge, attitude, practice)
- social services for the workers including anti-retroviral therapy (ART), the treatment of STIs (sexually transmitted infections), opportunistic and secondary infections like tuberculosis and ART to prevent mother-child infections.

Education campaigns will be started in cooperation with the resident communities of the workers and the quality of health services will be increased. Priorities are efficient hospital care, the integration of traditional healers, and the further training of doctors and nursing personnel.

First results:
Since its introduction in November of 2001, 132 workers at all company levels have been trained to become trainers and liaison agents in HIV prevention. In a parallel effort the health campaigns in the plants and at community level will be increased. The required costs amount to six million Rand (1,000 Rand = 99 Euro). DaimlerChrysler has provided an additional 15 million Rand for the distribution and the monitoring of anti-retroviral drugs and the expansion of the respective supply infrastructure. From the beginning on, DCSA and GTZ have integrated an M&E system into the programme to monitor the programme's success in the target groups, the participation of the workers, changes in knowledge, attitudes, understanding and behaviour, the HIV prevalence rate, a cost-benefit analysis and the usage of the medical services.

Forecast & Theses
- SRH requires the integration of population matters

We cannot lag behind the decisions and claims of Cairo, where the interdependence between population dynamics and sustainable development was particularly stressed besides the focus on a comprehensive concept of reproductive health. Let us remember this without falling back into the old demographic objectives!
- Integrating SRH and HIV/AIDS prevention

Education, diagnosis and treatment of sexually transmitted diseases, including HIV/AIDS, are part of the core of comprehensive reproductive health services. But in practice, great problems prevail concerning the integration of the respective counselling and diagnosis services into family planning and pregnancy care services. On the other hand, information on contraceptives has not yet become an integral part of AIDS education services. Innovative strategies are required to better match the health services with the needs of their users.
- Expanding strategic options in the international discussion with European experience

Reproductive rights are indivisible. So we should not hesitate to confidently include our European values in international processes. We cannot fall behind the standards that we ourselves have fought for in democratic processes – and this also includes emergency contraception and safe abortions.
- Overcoming the "contraceptive gap" and "donor fatigue"

The need for contraceptives has continuously grown due to successful programmes. At the same time, there is a decline in supply due to changed donor priorities. This jeopardises the goals of the Cairo Action Programme.
- Creatively expanding partnerships with industry and winning sponsors

Faced with this multitude of challenges, the classic concepts of international development cooperation alone do not do the trick any longer. We need to redouble our efforts to increasingly use new players and new types of cooperation for the promotion of reproductive health. Topics like Social Marketing or Social Franchising prove that concepts stemming from private industry can be applied in a social and development policy context.

Dr. Hans Fleisch
Executive Manager, German Foundation World Population (DSW), Germany
Overcoming the supply crisis!
Campaign presentation

The desire to use family planning is growing throughout the world, but ever less people have the opportunity of using contraceptives. Or to put it differently: The need for family planning in developing countries on the one hand and its financing on the other hand are drifting more and more apart. Thus, supplying contraceptives for the world population is one of the big challenges for the future.
Although the health situation of women in general has significantly improved in the past decades, the situation – especially in the poorest countries – continues to be abysmal:

- Every minute, 380 women become pregnant worldwide – nearly half of these pregnancies are unwanted and unplanned.
- Every minute, 40 incompetent abortions are carried out worldwide.
- Every minute, one woman dies of complications during pregnancy or delivery worldwide.
- Every minute, 10 people become infected with the HI virus.

A lot of abortions and unwanted pregnancies could be prevented if each person had free access to contraceptives and competent medical counselling. This objective, defined at the World Summit on Population in Cairo, recedes into the distant future when we look at the current supply crisis of contraceptives.

According to information from the United Nations Population Fund (UNFPA), 350 million couples do not have access to methods of modern family planning. And this situation will continue to deteriorate: based on the latest estimates, up to US $210 million per year will be lacking to cover the existing demand for contraceptives. Until the mid 1990s the international community's share amounted to 40 per cent of the total costs, by 1999 this figure had dropped to only 25 per cent.

There are two reasons to expect a dramatic development of this crisis if the international community does not act:

- More and more people want to use contraceptives: Within the next 15 years the number of those who want to use contraceptives will presumably increase by 40 per cent – more than 210 million people. In those developing countries where the availability of contraceptives depends on the support of donor countries, the demand will presumably increase by almost 90 per cent.
- The number of people of reproductive age will continue to increase: Based on forecasts, the number of women in this age group will increase by over a third until 2015.
- The lack of contraceptives is intensified by the fact that donor countries, multilateral, state and private organisations do not sufficiently coordinate their activities. Logistical problems and donor fatigue should also be mentioned as additional problems.

A lot of governments in developing countries are lacking determination and concepts to efficiently tackle the shortage of contraceptives. For the future we need long-term solutions that include all target groups. The individual responsibility of the respective countries has to increase. Financial resources have to be mobilised. But we also need new framework conditions that favourably support a cooperation of the stakeholders and the coordination of their activities.

Due to the work of some committed organisations and foundations the problem has been recognised and they took up action. In the year 2000

- John Snow Inc. (JSI),
- Population Action International (PAI),
- Program for Appropriate Technology in Health (PATH) and
- Wallace Global Fund (WGF)

joined forces to found the Interim Working Group on Reproductive Health Security (IWG). It was the group's objective to raise awareness for the supply crisis and to speak out for a global supply of contraceptives. Supported by a number of additional organisations, including the Deutsche Stiftung Weltbevölkerung, the IWG organised an international conference on the topic of "Supply Crisis of Contraceptives" in Istanbul in 2001. The conference was able to put the topic on the international agenda and led to the IWG becoming a long-term institution.
But the main result of the conference was the passing of an action plan, the Istanbul Action Plan. Implementing the action plan, which also provides for an improved coordination of donors and an improvement of the logistics of worldwide procurement and supply of contraceptives, shall provide a long-term and sustainable solution for the supply crisis.

In order to drive forward the IWG's work after the Istanbul conference, the International Initiative on RH Supplies emerged from the IWG in January of 2002. Today, its name is simply Supply!. Its members are

- Deutsche Stiftung Weltbevölkerung (DSW),
- International Council on Management of Population Programmes (ICOMP),
- IPPF Africa Region (IPPFAR),
- John Snow Inc. (JSI),
- Partners in Population and Development,
- PRO FAMILIA,
- Population Action International (PAI),
- Programme for Appropriate Technology in Health (PATH) and
- The Wallace Global Fund (WGF).

It is the task of Supply! to drive forward the implementation of the Istanbul Action Plan and to be the voice and the liaison office for the stake holders who deal with this topic.
Supply! intends to mobilise the affected governments and international institutions and its partners from industry as well as NGOs to guarantee the maximum use of all available financial, technical and human resources in the fight against the supply crisis.

By doing this, Supply! has assumed the responsibility for an important yet not simple task. But without the success of this project the objective of providing access to reproductive health information and services to all people by 2015 – which is essential for the eradication of poverty – and which was decided upon in Cairo in 1994 and thereafter repeatedly confirmed, will recede into the distant future.
The Deutsche Stiftung Weltbevölkerung is a member of the initiative and has developed a special web site on the Internet. It provides the basis for the communication of the individual members and offers valuable information for the users.

Further information can be found at http://www.nostockouts.org

Wolfgang Bichmann
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Social marketing of contraceptives
Successfull financial cooperation with developing countries in Africa and Asia

The Federal Republic of Germany's financial cooperation (FC) with developing countries is guided by the overall priority of poverty alleviation. In 2001, 32 per cent of the funding was directed at social infrastructure (water, health, education); in a long-term average over 50 per cent of the projects were directly aimed at poverty alleviation! Since the late 80s of the past century, reproductive health has become an increasingly important topic for German financial cooperation and thus also for the Reconstruction Loan Corporation (KfW) – although it was still conducted under the heading of family planning. The annual commitments for population – i.e. reproductive health and HIV/AIDS – are recorded separately.
The commitments of the past years amounted to € 40 million per year and have by now surpassed the commitments for other health projects: in the long-term average approx. 3 per cent of FC was directed at the health sector and an additional 2 per cent at population; this relation has been reversed since 2000!
After co-financing measures were initiated to cover the need for hormonal contraceptives in Bangladesh, FC has increasingly turned to social marketing approaches to achieve universal provision of contraceptives in developing countries prior to the International Conference on Population Development (ICPD) in Cairo in 1994.

The reasons for focussing on social marketing programmes were:

- a growing recognition of the need for a broad supply range of contraceptives (which made it possible to link population policy goals with individual needs of sexual and reproductive health),
- the possibility of complementing the ineffective structures of national health services for education, counselling and supply of contraceptives with private sector service providers and supply structures,
- the awareness that traditional and person-oriented counselling approaches need to be linked with mass communication and advertising methods in order to achieve a change of behaviour in broad ranges of society,
- the fact that social marketing is especially suitable for a funding instrument like FC.

The threat posed by the HIV/AIDS endemic, which became apparent as early as the mid-90s, led to an increased focus on the social marketing of condoms as a causal instrument of prevention. Various countries have successfully linked education on possibilities for individual contraception and family planning with education on the prevention of HIV/AIDS infections and have also used professional advertising to do this. Since the early 90s, KfW has funded social marketing programmes in 21 countries around the globe with a gross commitment of almost € 200 million. According to the United Nations Population Fund (UNFPA), Germany has become one of the most important donors in the contraceptive sector through its financial cooperation. Some of these programmes, e.g. in Burkina Faso, Côte d'Ivoire or India, are exclusively financed with means from German FC. Others, e.g. in Guinea, Nepal, the Philippines or Viet Nam, are co-financed by other important donors like the United States Agency for International Development (USAID), the Department for International Development (DfID) and the World Bank.

This paper presents the typical FC approach to social marketing – as it were, KfW's "standard product" in the reproductive health sector:

FC programmes implement the development policy principles and sectoral guidelines and concepts of the Federal Ministry for Economic Cooperation and Development in the reproductive health sector. Thus, FC prioritises prevention and anti-poverty programmes. We finance improved access to services by improving the supply of contraceptives and by fighting sexually transmitted diseases (STDs). At the same time, we always guarantee a person's freedom to decide.

Education on contraception and sexual behaviour and STDs have to go hand in hand with improved access to a supply of high-quality and affordable contraceptives that are available in the target group's local environment.

Traditional concepts of health education in the sensitive fields of contraception and sexual education are worthwhile but not appropriate for a general approach. As far as HIV/AIDS prevention is concerned, prevention signifies influencing people's attitude towards sexuality and how they talk about it in order to de-mystify the topic and advocate "safer-sex" practices.

The supply side uses all possible kinds of outlets. Contraceptives that are handed out for free are generally not as appreciated by the users as those that need to be actively purchased. Consequently, contraceptive compliance for free-of-charge contraceptives is generally lower. On the other hand, commercially supplied contraceptives – pills, injection products and condoms – are often not affordable for poorer income groups. Providing access also means providing the availability in a cultural environment: even for free-of-charge distribution, local health centres or delivery facilities are hardly the appropriate supply channel for the majority of users.

In this context social marketing means using private industry structures and marketing techniques that are applied in the commercial sectors to achieve the social goals!
FC provides funding for a package of measures that tries to simplify access to contraceptives for poorer population groups. This package includes:

- procurement and supply of contraceptives by using the existing distribution channels of the private industry. In social marketing the sales price is established on the basis of the low-income target group's ability to pay; the price has to be set at a level that still guarantees that the user attributes a certain value to the product! Regular market research surveys are carried out for this reason,
- information and communication campaigns (IEC) with heavy use of mass media and education and training measures for users and providers,
- "generic" education measures and product advertising as well as market research.

Efficiency is an indispensable prerequisite for the implementation of a programme! The costs of the programmes vary considerably depending on the context and package of measures of a programme (between 5 € and 25 € per CYP).

Transparent accounting and close monitoring of measures and supply are of utmost importance. With an increasing standardization of the appropriate programme parts (e.g. procurement, market research), increased benchmarking methods are to be applied.

For reasons of efficiency, a social marketing programme – wherever possible – should be implemented by an autonomous social marketing agency (SMA) that does not fall under a Ministry's direct sphere of influence. This role is often played by national and international non-governmental organisations (NGOs). Being a financial institution, we put special emphasis on binding contractual regulations between the private implementing organisation and the state's auditing and regulation agencies.

Frequently in these cases, bilateral development cooperation has to accept compromise solutions: there are examples where an SMA's administration was required to become integrated into a health authority in order to get policy makers to give their consent to the implementation concept. In cases like these, there should be an agreement on a maximum of autonomy as far as management independence is concerned (pricing, advertising, responsibility for personnel).

The availability of financial means is an important determinant to achieve access and market penetration. It is often necessary to mobilize additional means from donors to supplement the amount contributed by Germany. KfW's experience as an internationally renowned financing institution of development cooperation enabled us to become active in other sectors as well on behalf of other bilateral donors, the EU and the Global Environmental Facility (mandates).

In the priority sectors water, waste water and energy supply, KfW has acquired internationally recognized experience with private sector participation and commercialisation of state-owned utility companies.
As there continues to be an undiminished increase in the projected need to fund

- contraceptives and medication in reproductive health provision and
- condoms in the context of HIV/AIDS prevention,

we see a fast-growing need of un-bureaucratic donor cooperation with simultaneous consistent transparency over how the funds are being used: further development of funding instruments, priorities for the use of funds, increased structural efficiency of the programmes, reinvigorated partnerships and cooperation.
We think that this model of cooperation between an experienced financing institution and organisations or NGOs that implement the programmes based on private industry mechanisms and that are increasingly paid for successful outputs and achieved outcomes instead of simply being reimbursed is the model for the future.

Approaches of social marketing and social franchising of services are especially well-equipped to achieve this. This approach would also make way for new types of partnerships with the pharmaceutical and clinical service industry that desperately require new concepts.

I do not want to come to a close in this presentation without using the opportunity, now that we are in the preparatory phase of the World Summit for Sustainable Development in Johannesburg, to point out two recent developments of importance:

- Contrary to many fears, the demographic changes in developing countries seem to indicate that the world's population development will not reach a maximum of over 12 billion but of "only" approximately 9 billion by the year 2050.
- It has been proven that the decreasing life expectancy of infants due to the AIDS epidemic can increase again as a successful consequence of rigorous AIDS prevention policies – e.g. in Uganda.

But all this is only possible if the Cairo agreements on reproductive health policies are also rigorously implemented. This includes

- gender equality with adequate education opportunities for women,
- a rigorous reduction of poverty, economic hardships and losses of income,
- the prevention of unnecessary illness, unwanted pregnancies and improved opportunities of survival for infants and children.

Social marketing and the participation of the private sector can help to achieve this aim – even if governments seem to increasingly join in "foot-dragging coalitions" again at the international level!

Siddhartha Bajracharya
Anapurna Conservation Area Project (ACAP), Nepal

Protection of forest, does it mean less birth? The integrated conservation and development project in Nepal

Introduction

Nepal, a land-locked country covering an area of 147,181 sq. km, is located between India and China at 80°04' to 88°12'E and 26°22' to 30°27'N. Nepal has an average north-south width of 193 km and east-west length of 885 km. The altitude varies from 90 metres above sea level (masl) in the south to 8,848 metres in the north. There are three ecological regions: the mountains, the Hills and the Terais (plains).
Nepal is centrally located in the Himalayas. Out of the 24 high peaks above eight thousand meters in the Himalayas, 17 are located in Nepal. For administrative purposes, the country is divided into 75 districts, 3,912 village development committees and 58 municipalities. According to the census of 2001, the total population of Nepal was 23,151,423. The population was increasing at an annual growth rate of 2.24 per cent in 2001. The Terai region contains 48.43 per cent of the population whereas the Hills only contain 44.28 per cent and the mountain region 7.29 per cent.

In terms of area, the Hills occupy 50 per cent of the total land, whereas Mountains and Terai regions cover 27 per cent and 23 per cent respectively. Due to the wide range of physiographic conditions, Nepal is also an excellent habitat for a diverse flora and fauna. Over 7,000 species of plants, 175 species of mammals, 861 species of birds, 143 species of reptiles and amphibians have been recorded in Nepal Biodiversity Conservation Data Project. About 1000 species of Nepali plants are known to possess medicinal properties and 246 flowering plants are endemic. Rich faunal wealth of Nepal includes one-horned rhinoceros, the tiger, the red panda, the snow leopard and the musk deer.

Although Nepal is bestowed with rich biodiversity, it is equally threatened by severe ecological problems. Out of the population of 23 million with a growth rate of 2.24 per cent per annum, 90 per cent are subsistence farmers. These people depend on the depleted forest for fuel, fodder, timber and medicine. Traditional energy sources such as firewood and agriculture residues respectively supply about 75 per cent and 20 per cent of total energy demand in Nepal, which has resulted in rapid deforestation and local environment degradation. The domestic sector accounts for 95 per cent of the total energy use. This sector consumes almost all of the firewood and part of the commercial energy. Illegal and free grazing of livestock is another chronic problem in Nepal. Tourism has also played a role in depleting the natural resources. More than 375,000 tourists visit Nepal every year and most of the impacts are associated with the loss of natural vegetation, destruction of flora and fauna, deformation of natural landscapes, and loss of pastoral land.

Human Development in Nepal

Nepal, ranked 144th in Human Development Index, is also ranked in (1) low-income category with GNP per capita of $ 760 or less in 1998, (2) least development countries category and (3) low human development category. A recent nationwide survey estimates that 42 per cent of Nepal's population – about nine million people – still live in poverty, particularly in the rural areas. Poverty alleviation efforts have failed to reach these hinterlands. Moreover, large areas of the country lack even the most elementary infrastructure. Similarly, throughout the entire country, development efforts have failed to make significant changes in the lives of most people from disadvantaged groups. Poor governance pervades development efforts in Nepal. Nepal's case clearly shows that without people's participation in development and people's ownership of the development process, poverty will perpetuate.

Poverty coupled with population growth is argued to be the most pressing factor contributing to environmental degradation in less developed countries such as Nepal. However, poverty and population growth are not only the casual factors of un-sustainability. Poverty as such cannot be said to cause environmental degradation, however, often the two are associated with each other. It is the failure of policies to adapt to new circumstances that is a common cause of these twin scourges. Since poverty and threats to environment are inextricably linked, it follows that strategies, which do not address both issues effectively are likely to fail.

If the poor find no alternative, they will use the land and water endowments of their communities in ways that will impair the future productivity of those same resources. The not so poor behave in similar ways unless policies are enforced which effectively discourage them from doing so. Environmental degradation can be the result of inadequate social organisation, flawed legislation, and improper policies that impose constraints, limit opportunities, alter incentive structures, or misdirect capital and labour flows among sector and regions.

There are many good integrated practices of conservation and development in the world, which have successfully dealt with poverty, population growth, and environmental issues. Nevertheless, the experience gained during planning, designing and implementation of good practices are not often shared amongst similar interest groups and regions. Learning from other experiences and replicating the experiences with modification as needed could make similar new initiatives more successful and efficient.

An attempt has been made here to present an integrated approach to Conservation and Development based on the experiences from Annapurna Conservation Area Project in Nepal. The integrated approach is explained here as a procedure for systematic amalgamation of conservation and development projects in different regions or cultural communities with certain modifications. Furthermore, the approach offers the alternative for rural economic and social development that should not deplete the very resources on which human population depends for survival. Successful, integrated models may offer a means of balancing the needs of local people and the environment for future generations.

Annapurna Conservation Area Project

The Annapurna Conservation Area (ACA) is a microcosm of Nepal and is a designated protected area located in western Nepal. It covers around 7,629 sq. km, which is about five per cent of the total area of Nepal. This area is well known for its remarkable physical setting, ranging from an elevation of less than 1000 meters to 8091 meters - Annapurna I, the eighth highest peak in the world, within a distance of 120 km. The ACA's great diversity of habitats has produced a correspondingly outstanding diversity of plants and animals, including 1226 species of plant, 101 species of mammals, 474 species of birds, and many of Nepal's 700 medicinal plants. The ACA is inhabited by many rare and endangered species of mammals and birds such as the snow leopard, musk deer, and Tibetan argali. The King Mahendra Trust for Nature Conservation, a national environmental NGO, manages ACA through official mandate from His Majesty's Government of Nepal (HMG/N).

Integrated conservation and development

Conservation and development issues in rural areas are multifaceted and diverse. They are often interlinked. Therefore, targeted approach to a single issue might not be very effective. For example, deforestation in rural areas is a common phenomenon because the rural people very much depend on forest resources. But, the issue of deforestation cannot be tackled just by excluding the local people from the area. The deforestation might be caused by lack of alternative source of energy, population growth, lack of a system of management, overgrazing etc. Thus, an original plan of conservation and/or development initiatives must adopt a holistic and integrated approach to address all these issues carefully.

Programmes must be designed in a way that fulfils the local needs and at the same time motivates the local community to participate in these initiatives. The programme implementation must be flexible and open to revision according to local situations because effectiveness and participation of the villagers during implementation depends on interest of the villagers, management capability of local community and solidarity within the village. The intervening agency, which may be governmental, non-governmental, or a donor agency, must change their role from implementing to facilitating financial and technical support that helps to foster local ownership, institutional building, and long-term sustainability.

Annapurna Conservation Area Project (ACAP) is an innovative scheme directly linking conservation with quality-of-life issues and the basic human needs of the people living in an environmentally sensitive mountain region of Nepal. Instead of deploying the military to enforce protection as in other parks, the ACA has involved local communities as a 'conservation partner' to achieve long-term biodiversity conservation goals. Local community's needs such as drinking water, health post, school building, and trail repair, and global biodiversity conservation needs are carefully adjusted in the integrated conservation and development projects. The Annapurna Conservation Area, at present, is one of the most frequently cited examples of integrated conservation in the World. Successful integration of local needs with global biodiversity conservation obligation made it a model Community-based Conservation Project.

The ACA project is based on a grass-roots philosophy. It believes that biodiversity conservation is possible only when local people are brought into the mainstream of conservation and their basic needs are fulfilled. ACAP bases its activities on three main principles of people's participation, catalytic role and sustainability. The local people are involved in all stages of conservation and development activities - from the inception to the designing, planning, implementation and future management. One of the main approaches used to accomplish this is by the formation, strengthening and empowering the local/traditional institutions such as Conservation Area Management Committee, Mother's group, Tourism Management Committee, Village Electricity Management Committee etc.

The local institutions cover all sectors of people from the community. All these institutions are made

responsible for executing and linking their specific activities with the conservation and development of the ACA. The aim of involving people is to empower communities to undertake increasingly self-reliant conservation and development initiatives. The participation of local people provides a unique assurance of the sustainability of the initiatives.

The conventional administered development process creates dependency on the intervening institution, which makes the intervention unsustainable. To reduce the dependency on the intervening agency, the ACAP played the role of a facilitator or catalyst to link community needs with external funding and technical expertise. This enabled local people to plan, make decision, implement and manage conservation and development initiatives. This helped to make the initiatives effective and sustainable. All the ACAP activities are based on sustainability and only those programmes and activities that can be managed by the local people are implemented.

The local people are encouraged to participate and share cost of a project in cash or kind. This aspect has greatly assisted ACAP in developing a feeling of ownership among the local people. Depending on the village resources, ACAP usually provides approximately fifty per cent subsidies on a project, with the remaining amounts to be contributed by the villagers themselves. Today this has enabled the local committees to raise own funds for community development activities. For example, the Mother's Group raises funds by performing cultural programmes in the village. The funds are used in various conservation and social development projects such as trail repair, community plantation, micro hydro project etc.

The other approach adopted by the ACAP to sustain its programmes is through awareness raising and capacity building of the local people by empowering them with appropriate skills, training, knowledge and technical and financial assistance. Along with this, local people are provided with various training and orientation to motivate and develop self-realisation on importance of the activities that they have started. For example, the micro hydro project in Ghandruk is fully managed and run by the local people. They have realised that the micro hydro project is extremely important for electrifying their village. As a result, today the project is running smoothly with no support from the ACAP.

The project activities are concentrated in four main programme areas, namely, Resource Conservation, Conservation Education and Extension, Sustainable Rural Development; and Sustainable Tourism Development and Management. Implementation of conservation and development projects by the ACAP is based on the cooperation of local people. Therefore, the conservation education and extension programme is always the first step in the project implementation. The ultimate aim of the conservation education is to ensure that effective actions are taken by the local people themselves to conserve and develop the village. A set of activities are designed to successfully implement the conservation education programme which are public campaigns, mobile awareness camps, non-formal education, grassroots level orientation workshops, educational tours, exchange visits, home visits, celebration of special events, and publication.

Sustainable Rural Development Programme focuses on enhancing the basic living standard of the local people mainly through agriculture development, infrastructure improvement, health and sanitation improvement, and women's empowerment. This programme is very popular among the local people as it directly addresses their basic needs and deals with issues that occur in their day-to-day lives. In many instances, this programme has acted as an entry point to ACAP's conservation initiatives. For example, the drinking water project in Sidhing village played a key role in controlling the poaching of wild animals and medicinal herbs. An avid hunter gave up hunting for a drinking water scheme in their village and started physically monitoring the forest to stop illegal hunting and medicinal herb collection. It was the outcome of a trade-off established by the ACAP between controlling hunting and drinking water.

The Resources Conservation Programme addresses the sustainable use and management of natural resources, particularly the forests. Hunting of wildlife is restricted throughout a year. The lodges and teashops are encouraged to use other sources of energy such as kerosene, LPG and electricity to minimise pressure on the forest. The villagers are supported for planting fodder and firewood tree seedlings in community and marginal farmland. The local conservation area management committees are authorised to manage forest and reforestation in the denuded hills and slopes, promotion of sound wildlife conservation, soil and water conservation. Millions of trees of different species useful for the community have been planted in the area.

There are currently 545 lodges and 223 tea houses with around 67,000 trekking tourists per annum. Sustainable Tourism Management has been initiated with the aim of improving tourist facilities, minimising pollution, reducing negative impact on resources, increasing local economic benefit, etc. It includes formation of tourism management committee, capacity building of tourism entrepreneurs, alternative energy schemes; providing information to tourists through publication and information centres, and conservation of

local culture and important heritage sites.

Need for integration of reproductive health

One of the fundamental driving forces shaping the environmental resource base in Nepal is its population. The rapid growth in population has put tremendous pressure, directly and indirectly, on available natural resources. These people depend on the depleted forest for fuel, fodder, timber and medicine. But, it was realised that the reproductive health services are severely limited in rural areas of Nepal. Assistance at delivery from a doctor or nurse/ANM is relatively low in the country. A doctor or nurse/ANM attends just over one in ten births. Nearly one in four births are attended by a traditional birth attendant (TBA) and relatives or friends attend more than one in two births. Nine per cent of births are not attended by anyone at all. According to the Nepal Demographic and Health Survey 2001, under-five mortality for the most recent period is 91 deaths per 1000 live births. This means that one in 11 children born in Nepal dies before the fifth birthday. More than 70 per cent of deaths among children under five occur during the first year of life; infant mortality is 64 deaths per 1,000. The situation in mountain areas can be expected to be even worse than the general national statistics mainly because of the lack of development infrastructures.

A study on the local health status conducted in a few villages of ACA in 1996 gave an alarming picture of the health situation. The average family size was 6 persons per household. It was reported that 42 per cent of the households were devoid of health care facilities. Generally, knowledge of family planning is very high in Nepal, with nearly all ever-married women and men (more than 99 per cent) in the reproductive age groups having heard of a method. However, the study in the ACA showed that the awareness and demand on family planning was almost non-existent.

Due to ignorance, superstitions and myths, the local people were not interested in family planning and young couples did not have much idea and interest in using contraceptives although they were available. Many of them believed that more children meant more security as they hoped that their children would look after them in their old age. Direct taboos and indirect restrictions deter women from discussing their health needs and risks, while women who cannot read or readily associate with others have difficulty finding health information. These restrictions mean that women are dependent on the decisions of others about medical attention; whether to delay or prevent pregnancy; have antenatal exams during pregnancy; arrange for a skilled delivery attendant; or obtain transport in an obstetric emergency.

Early marriage was more common among female than male. About 7.4 per cent of the girls got married when they were less than 15 years old whereas this figure for boys is only 1.2 per cent. Almost half of the female population got married when they were 15-20 years old. The majority of women in the surveyed villages get married and get pregnant when they are at the age of 15 to 20. Almost half of the women get married at that age and 44.33 per cent become pregnant. These figures were particularly high for those belonging to the occupational groups who were also the poorest. Moreover, the highest percentage (42.5 per cent) of women of 15 to 20 years age group gave birth to not one but two children. It is not only the first pregnancy that occurs at early age, but also subsequent pregnancies. More than 70 per cent of 2nd to 5th pregnancies occurred at the age of under 25 years.

Illiteracy was more common among women than men. About half of the females aged 5 years or above were illiterate in the study area. The figure for women above 60 years is 69.7 per cent. Therefore, awareness on family health was extremely low. More than half of the respondents were not aware of the existence of a village health centre. Regarding family planning, it was noted that 80.47 per cent of the respondents did not use any family planning methods at all. The study report mentioned that 47.39 per cent of the respondents were totally ignorant of family planning. Nevertheless, more than half of the population was aware of family planning. Most of them gathered the knowledge from extension media such as radio. Very limited respondents were aware of availability of traditional birth attendant (TBA), female community health volunteer (FCHV) and maternal and child health (MCH) facilities. Only 18 per cent of respondents were aware about TBA facility whereas 33 per cent and 18 per cent respondents have knowledge about FCHV and MCH services respectively.

The study strongly justified the immediate need for integration of reproductive health with conservation and development project. Therefore, the ACAP designed an Integrated Conservation and Reproductive Health Project with the aims to improve the reproductive health situation of the women; to help create economic opportunities for the women and effectively conserve natural resources in the project area. This new integration carefully amalgamated the concerns of the United Nations Conference on Environment and Development (UNCED) the Rio+10 such as social and economic dimensions of sustainable development, conservation and management of resources, strengthening the role of major groups in sustainable development, and implementation. The project also addresses the International Conference on Population and Development (ICPD) Programme of Action, negotiated in Cairo in September 1994. The project included

reproductive health as one of the key components of overall integrated conservation programme. The integrated project was initiated as a pilot project from Bhujung area of the ACA.

The project followed specific reproductive health related sub-objectives:
- Overall improvement of the reproductive health of women in the target area.
- Generate awareness of the need for and practice of family planning.
- Improve the existing family planning and health delivery services.
- Ensure safe delivery practices, mother and childcare facilities and improve the nutritional status of women and children.
- Generate awareness on HIV/AIDS and STDs and their prevention.
- Gender advocacy to remove discrimination against women.

The key strategies followed to implement this pilot project were:
- The activities directly focussed on women, men and children of the target area.
- The main thrust of the programme was on generating awareness amongst local villagers focusing particularly on women.
- Close coordination and cooperation with the government and non-governmental line agencies were maintained for the capacity building of the beneficiaries and for supporting the government family planning and health care delivery mechanisms.
- Emphasis was given to linking the activities with the overall programme and activities of the ACAP so that they support each other.

Young men and women face different social pressures and expectations, which may work against responsible sexual behaviour. Training young people as peer educators encourages discussion and responsible behaviour. Many girls and boys, however, are forced into early and unsafe intercourse by child marriage or poverty. Adults also prevent young people from acting responsibly by limiting their access to information and health services. Therefore, education and awareness have a great deal of influence on changing social attitudes. A set of reproductive health activities such as family planning - counselling and service delivery; safe motherhood - Counselling and service delivery; Mobile clinic with counselling and service delivery; education and information (EC) material distribution with extension/counselling; Training/workshop for married women of reproductive age (MWRA) , traditional birth attendant (TBA), female community health volunteer (FCHV), local youth, staffs; reproductive health (RH) class in conservation education (CE) school with CE-materials distribution; support for infrastructure in Health Posts; RH awareness camp (group extension); adult education for women; RH Mobile Extension (mass extension); and Youth Exchange visit and extension through peers group etc. with significant focus on education and awareness have been put into action. Nevertheless, immediate acceptance of reproductive health issues is difficult because RH is a sensitive programme dealing primarily with the reproductive organs, their functions, sex, marriage and reproduction, which are considered a taboo in our socio-cultural context. Besides, reproductive issues are considered very private issues, which are not generally discussed with other people. In many instances, even the husband and senior family members might not know and share the issue. Therefore, extra carefulness and politeness are needed during social dealing. The mode of counselling and service delivery, thus, was considered with much care. For example, discussion of sex and reproductive issues was not acceptable to a woman in front of her father or mother in law. The Bhujung experience suggests that women felt more comfortable discussing with a female reproductive health worker rather than with a male. Similarly, males were more open during discussion with a male reproductive health worker.

This implies that rapport building and trust gain with target community was equally crucial for successful implementation of a RH programme. Considerable focus on youth from the early stage of programme was very important. Youth target groups effectively get reached through peer's group extension than other means since youth is a quite vulnerable and introvert age group who feel comfortable with own age group members. Integration of RH education in the school curriculum was also found very effective to reach the adolescence group in a village. These awareness and attitudinal changes of local people were determined and reflected by the sense of RH rights (marriage age, understanding between couple, right to choose the type of family planning (FP) methods, FP methods, number of children, birth spacing etc.

One of the significant changes observed after three years of the reproductive health intervention in 1999 in the Bhujung is increase in knowledge of family planning service and methods. More than 62 per cent of the villagers knew about service of the TBA and similarly 82 per cent knew about the female FCHV service in the village. Most of the TBAs and FCHVs are providing regular counselling services to their clients. It is interesting to note that 25 per cent of the married fertile couples are using either a reversible or temporary family planning method. A good number of community members such as youth group (83 per cent), mother's group (92 per cent), and secondary school students (70 per cent) now could name at least two main transmission routes of sexually transmitted diseases (STD) and HIV/AIDS. Enrolment of girl students in a school in Bhujung is increasing annually. A recent evaluative study has shown that there is 34 per cent increase in enrolment in comparison to 1998. This is a positive indication for lowering early marriage and

pregnancies.

Education is directly linked with knowledge, perception and attitudinal changes. However, illiteracy is prevalent among females in the area. Therefore, adult literacy classes have been initiated to increase the literacy skill of especially women by informal approach. Various populations, family planning and family health issues are dealt with in the literacy classes. Women are also encouraged to get involved in different conservation and development activities through women groups. They are supported to be self-reliant and establish women groups as equal partners in social activities. They are also exposed to various conservation and social issues by involving them in training, workshop and exposure trips to areas with and without good practices. This has gradually made women able to make decisions regarding conservation and development in the village. The gradual change in women's role and capacity in the village helped to expedite the reproductive health activities.

Micro-enterprise and finance schemes have been initiated with the aim to encourage and increase household income through creation of income generating opportunities within villages. These schemes help to empower women in their families and communities by making low-cost loans to small, women-run business. The impact of micro-credit programmes clearly demonstrates the positive effects of providing women access to resources and control over their life choices. These lending programmes have proven financially viable with higher repayment rates than more commercial lending and with viable and competitive interest rates. Micro credit programmes have shown to contribute to reproductive health when provided with proper technical support. Increased income and autonomy for women can result in the adoption of new health and family planning practices.

Some of the income generating activities initiated by ACAP in Bhujung area are goat farming, support in tailoring, vegetable farming, village grocery shop, poultry farming, bakery etc. Saving and credit groups have been formed in order to promote and develop micro enterprise. Formation of a saving and credit group encourages and motivates to create funds for creating and developing micro enterprises. Most of these activities are very promising but still too early to evaluate. Saving and credit groups besides facilitating to establish a micro enterprise also helped women to come in a team.

Conclusion

Successful management of poverty, population growth, and environmental issues have become very obvious needs in a rural development project. The degree of success in managing these issues would depend upon how far one succeeds in integrating diverse and varied issues of conservation and development. Successful integration of poverty, population growth and environmental issues could complement each other leading to sustainability of the overall project. ACAP's experience on integrated approach to conservation and development has shown that protection of forests also means a lower number of births. Integration of local needs such as village infrastructure, agriculture, adult literacy, tree plantation, protection of forests together with reproductive health have become incentives to reduce childbirth. ACAP is also empowering women by working to improve their access to health services, education, exposure and economic opportunities. Women of reproductive age group, nowadays, have started talking about birth spacing even when they are working in agriculture farms or during tree plantation in a community land. Education and awareness on conservation and reproductive health to all age groups have been found instrumental in the effective integration. Gradual increase in level of awareness has increased in use of contraception among the married couples. Nevertheless, the contraceptive prevalence rate for any method in rural areas is only 37 per cent compared with 62 per cent in urban areas in Nepal. This could be a major hindrance in this novel approach.

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The promotion and practice of family planning in a catholic country
The case of Mexico

The concept of the “Catholic Church”, which in modern terms would mean the “Global church”, belongs to that period of history when Europeans considered the world as the territories neighbouring the Mediterranean Sea. If we mark on a world map the countries of the world where Catholicism is the predominant religion, we will soon realize that the so called “Catholic Church” is a minority religion nominally practiced by little more than one sixth of the world population.

Additionally, the bulk of Catholics are concentrated in two very well identified parts of the world: Latin America and Southern Europe. More than half of the Catholic population lives in Latin America and two countries of the subcontinent, Brazil and Mexico, concentrate about one quarter of Catholics in the world. This fact explains very well the big interest that the dying Pope has in repeatedly visiting these two countries.

Having in mind the above-mentioned facts, it is not difficult to understand why the Catholic Church struggles so harshly against family planning, because this relatively new practice is substantially undercutting the number of Catholic faithful. In the last 30 years alone, the practice of family planning has meant the loss of more than 120 million potential Catholics, just in Latin America.

The decrease in the prevalence of the Catholic faith is not only due to family planning, but also to the advancement of other religions. In the case of Mexico, for instance, a country where traditionally close to 100 per cent of the population was at least nominally Catholic, the last census shows that just 88 per cent of the population still professes this religion.

The critical situation of a Church that considers itself “universal” or “global” which has been reduced to a minority religion and is decreasing in relative terms, has led the church to desperate attacks against family planning and all related concepts. In a recent statement, the Bishop of Oaxaca in Mexico amazingly compared the recently publicized crimes of the clergy: paedophilia and sexual molestation, with contraception, abortion, homosexuality, lesbianism and the use of condoms (!).

In similar excess, some Catholic priests force brides and grooms during religious wedding ceremonies to swear that they will never use “artificial methods of family planning not accepted by the Church”.
All those efforts notwithstanding, family planning has been fully successful in Mexico. While before the widespread practice of contraception, population was doubling every 20 years between the years 1940 and 1970, the growth curve has already subsided: the estimated population growth between the years 2000 and 2020 will be only 20 per cent and the estimates of the National (Mexican) Population Council point out that the Mexican population will stop growing around the year 2050.

While the average number of children per woman, what demographers call global fertility rate, was 7 in the year 1970, it will be 2.1 in the year 2005. Correspondingly, the prevalence in the use of contraceptives, or the proportion of cohabiting women using contraceptives, was just 30 per cent in the year 1976, while it has reached the standard of 70 per cent in the year 2000.

Mexico, a typical Catholic country, has a level of contraception similar to countries like the Netherlands, the USA and Norway.
How was the battle won against the fierce attacks of the Catholic Church?
Four main factors can be cited as the base for the victory of family planning in Mexico:

- A strong civil society movement,
- an amendment of the Constitutional Law in 1973,
- a decided action by the government health institutions,
- a strong support by the media.

The strong civil society movement started in the sixties and several non-profit organizations were founded, the most important and still existing is MEXFAM, the Mexican Association for Family Planning, which established the first 100 family planning clinics in the main cities of Mexico. Mexfam also started the community distribution of contraceptives in rural areas and is still championing sex education for youth and emergency contraception.

The action of civil society organizations was very successfully supported by international agencies, mainly by United Nations Population Fund (UNFPA) and International Planned Parenthood Federation (IPPF).

Currently the civil society organizations continue to be the spearhead of reproductive health, mainly in the areas of safe abortion (still not fully admitted by the Mexican Law), sex education and emergency contraception, the two latter still being fiercely attacked by fundamentalist and conservative sectors of the Mexican Society.

In the early seventies civil society representatives successfully lobbied the Mexican Government so that the recommendation of the UN Conference in Bucharest was fully adopted in Mexico. One of the most important actions taken by the Government was a legislative change in the Constitution. Its article 4 was changed in order to guarantee the right of every individual to choose, freely and in an informed way, the number and spacing of their children.

This change influenced legislation all across the board and opened the door for a decided action by all public health institutions in Mexico. In this regard it is important to note that the Mexican Public Health System is one of the most developed in the world. The Social Security Institute covers around 40 per cent of the population and other important institutions, among them the Ministry of Health, provide services to another 40 per cent of the population. In the 15,000 or so clinics run by such institutions, family planning is totally free of charge and provides 72 per cent of all family planning services in the country.
Media have also provided full support to family planning. Soap operas broadcasted on the main TV channels were a very important means to disseminate and legitimise the concept of family planning. Even recently, in the year 2001, the main TV channels sided with Mexfam in a controversy with conservatives on the use of video materials for sex education of youth. As a result, the demand for such materials produced by Mexfam substantially increased.

One important fact to mention is that the two confronted armies in the family planning battle are very unequal. Doctors promoting family planning overwhelmingly outnumber priests, by more than 175,000 to 13,000. Nevertheless, not everything is solved in terms of sexual and reproductive health in Mexico. There are several pending tasks, the main one being the large number of pregnancies among youth. Seventy percent of all pregnancies occur in Mexico to women between the ages of 15 and 24, an age when girls of developed countries are still in college or not yet thinking of becoming mothers. In the year 2001, more than 360,000 deliveries were registered among girls under 19 years of age. This fact has grave consequences on the vicious circle of poverty. Poor girls get pregnant very early, miss the opportunity of a better background to get a job and end up absorbed by family chores and in very low wage employment, if any.
All this is happening while Mexico is passing through a boom in the youth population that exceeds 30 million, which will continue at this level until the year 2020 when it starts to decrease and finally stabilizes around 20 million.

This means that the battle with conservatives is still going on. The very concept of reproductive health was a Vatican victory in the Cairo Conference, because it supports the false concept that sexuality equals reproduction, the Catholic doctrine. The appropriate concept, the one to disseminate among the youth of the XXI century is Sexual Health, which means a new vision of sexuality as an important component of a human being, whose enjoyment is not necessarily linked to reproduction, as the Catholic doctrine holds.
Sexual health is based on the values of Love, Respect and Responsibility and encompasses:

- Pleasure as a universal right,
- youth sexuality, not linked to reproduction,
- women’s right to safe abortion.

Even inside the Catholic Church there are numerous movements that contest the positions still held by the hierarchy about celibacy, sexual rights, exclusion of women of clergy status and life tenure of the Pope.

The fight goes on for
The right to decide about reproduction
A new vision of sexuality among the youth
The universal right to sexual health

Dr. Hans-Peter Schipulle
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Population at the Johannesburg world summit
Where are we on our way towards Johannesburg?

The findings of the "Commission on Macroeconomics and Health", headed by the renowned Harvard economist Jeffrey D. Sachs, were published last December and have vigorously reintroduced the central role of human capital investments – and I deliberately use economist terminology as the economic arguments constitute the basic pillars of the analysis – into the centre of the international debate on development. Its main statement was that health is more than a mere value, that it is of strategic importance to the economic development of poor countries. By no means is this new. But stemming from great authorities in the realm of economic sciences and Nobel Prize laureates it might finally convince a number of sceptics. And the figures on the "return of investment" speak for themselves: if the annual expenditure in the health sector were to globally increase by 66 billion US$ over the next 15 years – i.e. increase fivefold – an additional 360 million US$ – five times as much – could be gained per year. According to the authors around Jeff Sachs, the international community should focus on programmes that can be quickly implemented in order to achieve these yields – mainly AIDS, tuberculosis, malaria and the fight against maternal mortality and children's illnesses.

But as necessary as it might be to shake up the international public – the health problems of poor countries cannot be solved by command and control kind of activities to fight HIV/AIDS, TB and malaria that are the reason for approx. 10 per cent of the premature deaths in the developing countries. Almost one third of the unnecessarily lost years of living of the poorest of the poor are due to malnutrition and unsafe water. At least since Alma Ata have we known that these diseases can only be fought with prevention and self-help, by building self-sustaining basic health systems with services integrated in anti-poverty strategies that tackle the sources of the diseases: access to safe water, improvement of the sanitary situation, food safety and massive pre-emptive measures in the areas of education and training.

Campaigns that fight individual diseases are certainly able to rattle the public and mobilize new funds. But what happens if it is not possible to collect the undoubtedly needed billions that were asked for? In this case we should remember the experience that we have gathered with primary health care for over a decade now and integrate it into the broad anti-poverty strategies. This message is also contained in the Health Chapter of the Action Plan for the implementation of Agenda 21 which was prepared for the Sustainability Summit in Johannesburg and the agreements achieved in numerous programmatic UN decisions and also at the Millennium Summit in 2000. The corresponding passages of the draft that was last negotiated in Bali two weeks ago pertain to those parts of the document that have mostly been agreed upon and passed. It reconfirms the Millennium goals to reduce under-5 mortality by two thirds until 2015 and maternal mortality by 75 per cent in relation to 2000. The decisions on HIV/AIDS, made by the special general assembly last year, are also taken up.

On the other hand, nobody will be surprised at me saying: the Johannesburg final document will not contain anything that is really new – as far as health is concerned. A lot has been expressed in earlier conferences in a more detailed, clear and definite way – including matters of reproductive health. Actions in this area are demanded as follows: "Address effectively, for all individuals of appropriate age, the promotion of their healthy lives, including their reproductive and sexual health, consistent with the commitments and outcomes of recent UN conferences and summits". Following this, the above-mentioned conferences are listed: Rio, Cairo, Beijing, New York etc.

Is this a reason for us to be disappointed? I don't think so. Because this summit, 10 years after Rio, is not supposed to make new programmatic statements, announcements and promises. It is about taking up the many loose ends from the earlier world conferences of the 90s and tie them together into substantial actions, strengthened – if not inspired – by the agreements made in Doha and Monterrey. But: until this will happen, a lot of scepticism, mistrust and lethargy have to be overcome. How does Germany participate in the implementation of the agreements in the health sector? Health has long been one of the pillars of Germany's development cooperation (DC). Bilateral DC in the health area has increased significantly in the past years: from 17 million Euro in 1999 to 70 million Euro in 2002 – excluding contributions to international organizations like World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA), International Planned Parenthood Federation (IPPF) and Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Germany's DC is currently settling on at this level.

This also includes measures of reproductive health. Since the International Conference on Population and Development in Cairo, a new strategy to reduce population growth has gained acceptance and is supported by the work of the Federal Ministry for Economic Cooperation and Development. This integrated concept of reproductive health and reproductive rights is based on the principle of the voluntary nature of population policy measures. This is the only way to guarantee human dignity. Our measures are not limited to just the health sector, they cover social and cultural aspects as well, especially in the education sector. We have provided 0.5 billion Euro for this end since 1994, and German funds supported approximately 100 projects in 60 countries.

Promoting health systems, improving access to essential medication and supporting family planning, especially for young people and girls, is an important line of action of Germany's anti-poverty action programme 2015 which was passed by government in April of the past year and has provided an orientation for our development cooperation ever since.

In this context, it is especially important to note that a considerably broader scope of action for the establishment of basic social services in developing countries has been created within the framework of the debt relief initiative for the heavily indebted poor countries (HIPC). This initiative has paved the way for more personal responsibility of the developing countries that have now moved to the "driver's seat" also in matters of reproductive health. One of the results of the decisions made at the Cologne World Economic Summit in 1999 was the current debt relief in 26 countries with a volume of almost 41 billion US dollars. This is a considerable relief of interests and repayments for the budgets of the affected countries. According to a World Bank/IMF cross-section assessment, public spending in these countries will increase from 5.3 billion US dollars in 1999 to 7.6 billion US dollars in 2002 or from 6 per cent to 9 per cent as a direct result.
In many cases this is a support for bilateral programmes. In Nepal, where our development cooperation mainly focuses on matters of health, this helped to create a programme for sectorial reforms of health and family planning.

State of the negotiations during the preparations to the Johannesburg Sustainability Summit, especially focussing on reproductive health:

At this year's World Summit for Children, the U.S.A. were already hesitant to agree to certain wordings that would make them indirectly approve certain programmes that also provide for the possibility of abortions (In this context the American delegation was stated as saying: "The previous administration has committed errors which we will have to correct.").

During the following preparatory meeting for the World Summit on Sustainable Development (WSSD) in Bali the negotiations on matters of reproductive health were the most difficult ones – especially with the Americans. Immediately after the change of government, President Bush cut the American contributions to the IPPF. According to the so-called Global Gag Rule, American support to all non-American institutions is not possible if the mere possibility of granting an abortion is even mentioned during counselling of pregnant women. The regular US contributions to UNFPA are about to be cut as well, as conservative circles erroneously claim that UNFPA is involved in China's practice of abortions. Together with its European partners, Germany supports UNFPA both political and financially – in 2001 and 2002 with 14.3 million Euro each year. This is a significant increase to the year 2000. The same applies to the IPPF, which received 2.5 million Euro each year from 2000 to 2002.

What can we do, what can you do to make the summit a success?
It is the objective of the Johannesburg Conference to "solve global problems through joint action". Monterrey, in March of this year, focussed on the funding of development, this time it is about concrete partnerships between all social players.

When I look at the ecological consequences of an increasing population growth I do not see the juxtaposition of opportunity and risk as it might exist for population policy in the social and economic sectors. More people almost inevitably equals increased waste of resources. This is even truer when consumption increases at the same time. The environmental problems and social conflicts that go hand in hand with a population that grows too quickly have been documented again and again. I do not need to repeat them one by one. The example of freshwater shows it very clearly. Just looking at the forecast that one third of mankind will be acutely threatened by water shortages in the next 25 years, will make it clear to everyone that investments into partnerships for development are investments into a safe future for ourselves.

We need a new covenant. We are all affected by the matters on the agenda – and they go beyond agreements that can be made between governments of developing countries and the developed countries. Demonstrably, politicians, industry and society show great interest in matters of population policy, family

planning and the survival of mothers and children. I am glad that representatives of industry have made possible this conference with this intriguing and challenging topic. And I am glad that so many representatives of industry have followed the invitation to participate. This means that there is a huge potential for alliances for action and innovative ways of cooperation. I would be glad if you also used the Sustainability Summit, Rio+10, to create partnerships. The satisfactory experience of many industry representatives who have long been active in developing countries show that win-win options can be found again and again so that economic interests can be combined with development policy objectives of improving the situation of the people in the partner countries for the mutual benefit. The Federal government supports corresponding initiatives e.g. through well-directed public private partnership agreements.

Johannesburg provides us with the opportunity of turning Rio's vision of a global partnership in the creation of a model for sustainable development into concrete initiatives. Today, I plead to you to participate.