Conference Proceedings

International Dialogue
Population and Sustainable Development

Ways out of the Crisis – Reproductive Health in Need of New Ideas

October 14, 2003

GTZ-house,
Reichpietschufer 20, 10785 Berlin

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kfw Entwicklungsbank

in cooperation with

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Schering AG would like to thank all the organizations and numerous participants who made this Second International Dialogue a success. We would also like to express our special thanks to the Federal Ministry for Economic Cooperation and Development (BMZ) for their support in drawing up this brochure.

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Editorial

Schering AG

"Sexual self-determination – particularly for women and girls, access to family planning methods, healthy pregnancy, safe birth and motherhood" – at the UN Conference on Population and Development in Cairo, 179 nations agreed that these rights should be guaranteed for all women, men and young people. That was ten years ago. Today, as we prepare to mark the tenth anniversary of the Cairo Conference – "Cairo plus 10" –, the question we must ask is: what has been achieved?

The United Nations has incorporated reproductive health goals in its Millennium Declaration on Poverty Reduction. The action programme of the German government aims to reduce extreme poverty by 50 percent globally by the year 2015 and emphazises gender equality as the key factor in the fight against poverty. Despite considerable progress in some sectors of family planning the situation seems to have worsened. Family planning and reproductive health receive increasingly less Official Development Assistance funding. Rich countries have prioritized other topics; the fight against HIV/AIDS – beyond doubt an equally important task for the international community – has gained in importance.

Besides religious and social constraints, insufficient information and money are the most common causes that prevent women from practising active family planning. Social Marketing Programmes enable women from the social middle class to purchase Schering products at affordable prices; the objective behind this is to increase the acceptance of contraceptives in this population group. Experience has proven that the compliance rate and consequently contraceptive safety increase if the women assume a part of the costs within the realm of their possibilities. This global commitment for family planning programmes is only possible if Schering can make sufficient profit on the retail market – i.e. through the sale of prescribed contraceptives in the industrialized nations of the world.

Schering, as a manufacturer of contraceptives, has entered into an alliance with those international experts who advocate a fair distribution and unhindered access to information and health services. For this reason we were happy to see that the Second International Dialogue on Family Planning and

Sustainable Development: "Ways out of the Crisis – Reproductive Health in Need of New Ideas" has met with such a great response. Numerous experts in the field of family planning and reproductive health have come from Asia, Africa, Latin America, from the neighbouring European countries and Germany. Besides analyzing the status quo, the conference also tried to find "ways out of the crisis". It was the manifest objective to communicate the resulting recommendations to the decision makers in politics, in international organizations and the respective media as a preparation for Cairo plus 10. All of the experts agreed that Public Private Partnerships had gained in importance.

Schering would again like to thank the German Foundation for World Population (DSW), the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), the International Planned Parenthood Federation (IPPF) and the Kreditanstalt für Wiederaufbau (KfW) for their support and the successful alliance this year. We hope we will be able to expand and enhance the relations we have established at the national and international level in the coming year, and that we will continue to look for pragmatic possibilities of implementing the Cairo Action Programme.

Dr Ulrich Köstlin

Member of the Executive Board,
Schering AG

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Introduction

Safiye Cagar
Director, United Nations Population Fund (UNFPA), Geneva

The right to family planning, safe motherhood, and protection against sexually-transmitted infections such as HIV/AIDS, should be available to all women, men and adolescents worldwide. This is what the world's governments agreed ten years ago in Cairo at the International Conference on Population and Development, ICPD.

But while nearly all people applaud reproduction and welcome health care, when you put the two together as reproductive health services, you do not get the same overwhelmingly positive response.

Governments do not spontaneously include these vital health services in their spending plans, even though there is a wealth of evidence to support the many benefits of doing so. In addition, there is increasing opposition to reproductive health and rights, UNFPA and the Cairo agenda.

The real question is: how do we safeguard the ICPD agreement and make greater progress in its implementation?

I believe the real answer lies in increased partnerships.

The British social reformer and poet, Edwin Markham, once wrote:

"He drew a circle that shut me out –
Heretic, rebel, a thing to flout.
But love and I had the wit to win:
We drew a circle that took him in."

While it may not always be possible to bring opponents over to our side, it is possible to widen the circle of partners and to reach out to non-traditional partners. And this should be made a priority. It is only through strengthened and expanded partnerships, that we can make greater progress in implementing the ICPD Programme of Action. I believe special efforts should be

focused on lawyers and legal associations, religious leaders and organizations, the private sector, and officials involved in the financial and economic sector.

The second action area is increased advocacy. All partners must increase their advocacy efforts on several fronts. We must show the cost benefits of investments in reproductive health and family planning and gender equality. Together we must also make the links between ICPD and Millennium Development Goals more clear to policy makers and others. As UN Secretary-General Kofi Annan has rightly stated: "The Millennium Development Goals, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed." And that means greater investment in education and health, including reproductive health and family planning.

We must address HIV/AIDS as a reproductive health issue. We must make a strong case that AIDS is a reproductive health issue and a gender issue. And we should reach out to women's groups on this issue.

And we must make greater noise about the consequences of the shortfall of ICPD funding and reproductive health commodities. Donor governments are currently at the 40 percent level of the 2000 year ICPD commitment. This is a major shortfall. And while developing countries have contributed a larger share of their target, they too have not met the 100 percent mark. When it comes to condoms, contraceptives and other reproductive health supplies, we have reached a crisis point. Funding is at 16 percent of the level that is required, and demand for family planning alone is expected to increase by 40 percent by the year 2015. So these issues are critical.

I understand that the results of the discussions of this conference will be combined into a recommendation for the preparations at the political level for Cairo plus 10. Equity, rights, participation, inclusion, and a concern with coming generations and the world they would inherit – these were the hallmarks of sustainable development, not least as it was envisioned in Cairo and the ICPD Programme of Action. We should make sure that we don't fall behind in these goals.

Summary of Discussions

Welcome

Conference presenter **Gabriele Heuser, Radio Berlin Brandenburg,** welcomed the participants and introduced the topic "Ways Out of the Crisis: Reproductive Health in Need of New Ideas" with some introductory remarks on the situation of family planning and reproductive health (RH) which has drastically worsened since last year due to a shift of focus towards other topics like international terrorism, the war in Iraq and other pressing problems.

Opening Address

Dr Assia Brandrup-Lukanow, Gabriele Heuser

Dr Assia Brandrup-Lukanow, Director of the Division for Health, Education and Social Protection, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), proposed to analyze why, ten years after the Cairo Conference, we have only reached a limited number of goals, and asked how the Millennium Development Goals (MDGs) could be used to carry forward the commitments of Cairo. She outlined successes in the work of the RH community, e. g. in the fields of obstetrics and natal care, but stressed the fact that a lot still remains to be done, especially regarding young people (early motherhood, sexually transmitted diseases). Dr Assia Brandrup-Lukanow underlined the challenges we had to face, e.g. rising infection rates of HIV/AIDS in Asia and Eastern Europe, and drew the conclusion that we had to target user groups more efficiently by providing counselling in the areas of Sexually Transmitted Diseases (STD) and RH. In this context, she said we needed to clarify and analyze the role of cross-cutting issues such as drug abuse, sexual or gender-based violence, topics that had been neglected both at the Cairo Conference and ever since. She therefore stressed the importance of empowering service providers to tackle sexual abuse more actively. In conclusion, Dr Assia Brandrup-Lukanow stated that the creation of partnerships must be promoted between the reproductive health community and the HIV/AIDS community to collaborate in the effort of reaching the MDGs to carry forward the Cairo commitments.

Topic I Family Planning and Reproductive Health: Where is the international community headed?

Dr Steven Sinding, Director-General of the International Planned Parenthood Federation (IPPF), stated that the achievements of the past 40 years would not have been possible without the cooperation between the private sector, which provided the technology needed to control fertility, the public sector, which created the public health infrastructure, and Non-Governmental Organizations (NGOs), which took on the burden of legitimizing contraceptives and changing the public attitude towards using them. However, despite all the progress a lot remains to be done to provide access to reproductive health programmes for people in rural areas, the marginalized and socially excluded and above all young people. He felt his cause weakened by the emergence of other international development priorities such as the MDGs, the HIV/AIDS pandemic or the fight against terrorism. Dr Sinding formulated the key question: What needs to be done to ensure that the central goals of Cairo will be achieved so that the reproductive revolution that began nearly 50 years ago can be successfully completed?

Dr Sinding went on to outline the ensuing change of paradigms in international thinking and policy making in the fields of RH and development in the past years, which led to growing resistance from conservative political and religious forces. As a result we face a double challenge today: first, to persuade governments to stick to the commitments they made in Cairo, and second, to counteract the conservative resistance that is being led by the U.S. government – which in the past was one of the strongest champions and architects of the Cairo consensus.

Largely due to a change in global perception (mainly in Europe and Japan) that the population crisis is over, and due to the lack of cooperation and the resulting splitting of funds between the RH and HIV/AIDS communities, the funding, including stagnating Official Development Assistance (ODA), has dropped dramatically during the past ten years, making it necessary to focus the limited available resources on a small number of high priority issues. These issues are:

- universal access to reproductive health services;
- young people, especially adolescents;
- maternal mortality resulting from pregnancy;
- under-five mortality;
- HIV/AIDS.

Dr Sinding concluded that the international development community needed to return to putting RH on the agenda in order to fulfil the MDGs. He came up with three suggestions: First, to ensure access to reproductive health services for the poor and for young people; second, to identify the direct causes of child and maternal mortality and third, to create hope.

Discussion

In the ensuing debate, **Dr Hans Fleisch, former Executive Director, German Foundation for World Population (DSW),** stated his opinion that the RH community's efficiency was unbeatable in poverty reduction and therefore urged it to be more aggressive in pursuing new funds and counteracting the attacks of the conservative political and religious forces.

Dr Sinding responded that it was difficult to take the offensive since the decision makers were not convinced that RH was efficient in poverty reduction given that there was no empirical proof. The religious hardliners were hard to fight because they were backed by the most powerful government; exposing their disinformation which contained obvious lies ("Condoms do not prevent AIDS.") was probably a proactive strategy, he concluded.

Dr Berthold Kuhn, Consultant, InnovateCo, asked if intensified cooperation with the private sector could be a new way to raise more funds? **Ingar Brueggemann, former Director of IPPF,** stated that the opponents were successful in spreading misinformation ("RH is abortion"); therefore, spreading information should be a strategic counteraction. Dr Steven Sinding answered that private sector funding helped to prevent the situation from getting worse; however, it could only partly fill the void left by deficient public funding. Dr Sinding agreed with Ms. Brueggemann and said that it was important to respond seriously to the lies instead of laughing them off.

Mechai Viravaidya, former Senator and Chairman of the Population and Community Development Association (PDA), Thailand, said that the rich countries needed to be reminded to stick to their promises. Governments should help NGOs in the respective countries and train them to become financially independent. **Dr Steven Sinding** answered that Third

World countries had done much better in fulfilling the commitments than the Western countries. His opinion on the topic of financial independence that it was impossible to generate enough income in the RH field to help the poor and disadvantaged even in the most successful countries from a development standpoint. Assistance and development cooperation will still be needed.

Topic II Birth Spacing: Presenting the "Catalyst Consortium" programme

Victoria Baird, Director of Meridian Group International, introduced the Birth Spacing Initiative by giving information on some important new research on maternal and child health benefits associated with longer birth intervals (optimum three years). She also described the activities the Initiative has been involved in and shared her organization's ideas on how to increase the clients' awareness of the benefits of birth spacing.

Recent research findings show that birth spacing saves the lives of children and mothers and leads to improved child nutrition. Baird told the audience that most women wanted longer birth intervals but the data showed that family planning use was not very high, thus the possibility for an unintended or mistimed pregnancy was quite high.

Victoria Baird described the Catalyst Consortium, which serves as the secretariat for the Optimal Birth Spacing Initiative, as a family planning/ reproductive health project funded by USAID and consisting of five organizations (Pathfinder International, Meridian Group International, the Academy for Educational Development AED, the Centre for Development and Population Activities CEDPA and PROFAMILIA/Colombia). The project's ultimate goal is to reduce unintended and mistimed pregnancies by helping women to achieve the birth intervals they want and to improve contraception continuation rates.

Birth Spacing initial activities are:

– a signed Declaration by the Ministers of Health and Education from the Central American region that stated their political commitment to "promote guidance, norms and actions to integrate these scientific findings in the regional strategy for the reduction of maternal, infant, and child morbidity and mortality, taking into account the social and economic conditions of each country";
– the research was presented to government representatives in Angola, South Africa, Nigeria, Congo and Haiti. They commented that the term

"birth spacing" was culturally more acceptable than the term "family planning" for the clients in these countries;

– a systematic review of the literature on birth spacing by the summer of 2004.

The challenges for the future will be questions like: "How can information be used?" or "What is going to make a difference?". It is important to keep in mind that birth spacing cannot replace reproductive health and family planning.

Topic III CELSAM – Family planning for young people in Latin America

José Luis Corral Ruiz, Executive Director, Centro Latinoamericano Salud y Mujer (CELSAM), presented a brief overview of CELSAM's organizational structure. Emphasizing young people in Latin America and the Caribbean, he gave facts about the demographic profile, education trends, sexual and reproductive trends, and social and environmental influences. He then went on to describe the organization's work in the field of training and counselling, showing press clippings, giving facts about total hits and audience figures for 2000-2002.

Workshops I – III

Working Group I

Working Group I looked at the topic: "Programmatic orientation and funding". **Dr Wolfgang Bichmann, Vice President, Sector and Policy Division Health, Sub-Saharan Africa, Kreditanstalt für Wiederaufbau (KfW), Frankfurt am Main,** took on the role of a moderator and provided initial impetus. The questions raised were:

Dr Wolfgang Bichmann

- Where is the international community headed – does the U.S.A. set the course?
- Have new approaches been developed? What are the approaches from Asia and Africa?
- How should family planning be funded in the future?

- What are the consequences of the newly reinvigorated religiousness?
- Are family planning programmes increasingly neglected in favour of HIV/AIDS prevention projects?

Initial situation

The participants agreed that additional activities under the banner "Let's be proactive" were needed. They suggested unusual partnerships (BMW, DaimlerChrysler, Rotary Club, Egypt). They discussed the domestic agenda vis-a-vis the international agenda and highlighted both that the European Union should assume the "leading role" in regional meetings and the importance of expressing the term "Reproductive Health (RH)" in a different way.

New approaches

The participants determined that the comprehensive view of both RH and HIV/AIDS would require a stronger focus. The family planning organizations should put greater emphasize on the fact that the WHO should reconsider HIV/AIDS as an RH issue (infectious disease). The HIV/AIDS Conference in Bangkok could offer a good opportunity to establish positive contacts for the future. Another important new approach is the principle of positioning prevention versus treatment in the future. Work place policies could exert great influence on the mitigation of socio-economic impact in this respect.

Funding

According to the participants, funding possibilities arise by linking RH and family planning with sustainable development. New types of funding could be made accessible by providing convincing arguments to mobilize funds. A connection between the Millennium Development Goals and poverty reduction should be established; another possibility would be an approach via youth programmes or population dynamics (subject to reservation, no consensus). Additional activities in the realm of projects with a public private partnership component should be used for RH supplies. The topics health, reproductive health and family planning should be included in the Global Public Goods discussion. If necessary, funding could also be achieved through efficiency gains.

An example given for the public private partnership approach was the development of a middle-tier model (pricing studies, studies on the willingness to pay, transferring funding to those in need). Creating a demand in the private sector by means of social franchising, the "third generation of social marketing" – would be another possibility.

The working group particularly stressed that links to the HIV/AIDS community were of utmost importance. This was an area were RH could learn a lot from HIV/AIDS.

Working Group II

Working Group II looked at the topic: "Birth Spacing – save motherhood". Responsible for input and moderation was **Dr Assia Brandrup-Lukanow, Director of the Division of Health, Education and Social Protection, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), Eschborn.** The questions raised were:

Dr Assia Brandrup-Lukanow, Victoria Baird

- Is the catalyst model applicable to all countries?
- Which strategy is pursued?
- Are we dealing with a new puritanism?
- What role does safe motherhood play?

Transferability of models

The participants noted that the birth spacing model held many advantages, if the statistics are proven to be correct, i.e. by FIGO (Federation of Gynaecology and Obstetrics), and that it could be included in other approaches. They stressed that the data needed to be put in perspective and be made part of an integrated approach that took family dynamics into account. There should also be more evidence and a clearer formulation of goals, in particular for countries with high adolescent pregnancy rates.

Missing steps

The participants were of the opinion that the birth spacing model was still missing various aspects. Awareness for the model should be raised in public through information, education, communication (IEC). They stated that the professionals and the work done in schools had not been efficient enough.

The recommendations in Workshop II stressed:

- that more innovative approaches in, as well as better research and evaluation of IEC is necessary, that it is important to get away from leaflets and posters,

from the sole support of governments, and that we must instead collaborate with the media!

- that paediatricians should be part of birth spacing programmes, that the term "child-spacing" should be used instead of "family planning", that traditional leaders should be involved, i.e. Traditional Birth Attendants (TBAs) and town criers, that incentive schemes should be used, e.g. links to micro credit schemes.
- that training for professionals should be stepped up, that there need to be incentives for professionals and reimbursement where health insurance exists, and that certification/re-certification is needed.

Other areas of intervention should be antenatal care, obstetric care, postpartum care, male involvement, breastfeeding, reproductive/sexual rights/violence prevention and special targeting of groups in need.

The participants of the workshop singled out the gross neglect of the private sector, the under-use of services, too much training abroad, not enough attention to people who really provide the services and the lack of evaluation as the most important mistakes in cooperation.

Recommendations to the German Federal Ministry for Economic Cooperation and Development (BMZ)

The participants developed their own recommendations for the BMZ.

They highlighted their opinion that RH should not be taken off the agenda but rather be re-introduced as a prominent topic. Investment in education as a way to reduce poverty should be stepped up. It was also proposed to strengthen personnel and financing through sector funds for reproductive health. New mechanisms of cooperation with NGOs and the private sector need to be established. New ideas should be balanced against the priority of older issues. Partnerships could be used more strategically in view of the limited funds that are available. The BMZ's advocacy role for the social sector in negotiating with partner countries should be further supported. It was also suggested that more software and less hardware was needed. Also, there is a need for analyzing why the United Kingdom and the U.S.A. have increased health funding so significantly. Finally, priority countries for RH should be defined.

Working Group III

Working Group III looked at the topic "Family planning campaigns for young people". Responsible for input and moderation was **Dr Jörg F. Maas, Executive Director, German Foundation for World Population** (DSW). The questions asked were:

- What does a modern youth campaign look like?
- How can we reach young people on the streets?
- Do new partnerships exist, e.g. with the media?
- Do the programmes reflect the new morale of some donors?
- How does the lack of contraceptives affect the work?

By way of introduction Dr Jörg F. Maas presented the figures of the most recent World Population Report:

– Three billion people are under the age of 25.

– Some 87 percent of young people live in developing countries.

– Every 14 seconds one person becomes infected with HIV.

– As a consequence, approximately 30 million children and young people have lost their father or mother, or live as orphans.

– In 35 years, the population of Kenya will have doubled.

These facts suggest that the sexual education of young people needs to be the central point of development cooperation in the sexual and reproductive rights sector. As a consequence, the availability of contraceptives that are appropriate for young people needs to be guaranteed. To get the discussion started Dr Jörg F. Maas introduced the following three theses:

- Young people should themselves become active, and not only be recipients of help.
- The availability of contraceptives that are appropriate for young people is not high enough, many countries do not even have sufficient contraceptives.
- We must enter into new and extensive partnerships.

Sexual education in a difficult political context

Tewodros Melesse, IPPF Regional Director, Africa Region, pointed out that in the countries he operated in, normal government structures very often were limited in their actions due to civil wars or armed conflicts. Greater efforts were needed to provide sexual education and access to contracep-

tives particularly for the rural areas in these countries. Another impediment to providing sexual education and access to contraceptives is a lack of democracy, the rule of law and the respect for human rights.

Appropriate methods of education

But how can you really transfer values to young people without providing them orientation and changing their awareness?

José Luis Corral stated that the focus should particularly be on the peer approach. Often the parents are not available, not interested or simply not skilled to provide sexual education. Many countries could use so-called "soap operas" on TV or the radio for sexual education. These can address sex in a way that will allow young people purposes to still see it as something joyful and not as a disease which forces them to go to the pharmacy, the doctor or a hospital. When reaching out to young people you have to offer them prospects that are beyond the imagination of adults: The specific prospect of being attractive and successful is more appealing to them than highbrow discussions about having children and how to plan their lives; the prospect of being a successful athlete is more appealing to them than leading a healthy life that is detached from the world. This motivation could be used if celebrities from the respective sectors, e.g. beauty queens and sports stars, become champions of family planning and contraception.

Sustainability of youth clubs

Based on experiences from Haiti, doubts were raised whether it was at all possible to operate youth clubs in a sustainable and efficient way. The group agreed that youth clubs needed to be linked to the traditional institutions of a community in order to be managed in a sustainable manner. Dr Jörg F. Maas reported from the work of DSW that mechanisms had been developed that helped to achieve far-reaching sustainability: one mechanism was to have young people participate in youth clubs from the beginning and to transfer responsibility to them. If anything were to be called into question, it would be the participation of adults and not that of young people.

Opposition to sexual education and contraception

The influence of groups that do not follow the integrated "ABC approach" were extensively discussed. "ABC" stands for "abstinence", "be faithful" and "if you are not, use condoms". These mostly religiously motivated groups preached that only abstinence could prevent the spread of HIV/AIDS and was the only morally acceptable option. While in the past it was mostly the Catholic Church that advocated this approach, the coming into power of the George W. Bush administration in the U.S.A. increased the influence of the mostly protestant and free church communities that advocate this

attitude. It was agreed that only the integrated approach could work. As a consequence, the rejection of "C" requires firm protest. The misinformation propagated by that side should be pointed out to the young people.

Recommendations

The following recommendations were collected for family planning campaigns aimed at young people :

Continued use of customary places/environment and tools of sexual education: sports, schools, celebrities, churches, soap operas, the mass media, cultural activities (theatre and music) and telephone counselling services.

Education should deal with the topics of sexuality and family planning in a comprehensive way: by offering health and beauty as a prospect, explicating the human rights dimension, empowering women, adapting the medium and the message to the respective age group and communicating values and skills for life.

Donors must become committed on a long-term basis in youth projects to guarantee a lasting effect.

A language that is appropriate for different age groups should be developed – most preferably by the respective age group itself.

The responsible players should conclude innovative partnerships: with young people, the existing social and community structures, and the private sector.

Appropriate contraceptives should be available for everyone at any given time. The distribution networks (and marketing methods) of the large brands should be employed.

Fundamental research on the health services that are appropriate for young people should be supported in the sexual and reproductive health sector.

Presentation of the results

After the workshops were concluded, the three chairs presented the respective outcomes and recommendations. Questions arose regarding Workshops II and III.

Dr Jörg F. Maas

After the presentation of the results of Workshop II by Dr Assia Brandrup-Lukanow, **Julia Kazan** of the GTZ asked if the shift shementioned should be

from IEC toward behavioural change communication. Dr Brandrup-Lukanow replied that while not actually having used the term "behavioural change communication", that was exactly what the group had been trying to point out in their recommendations.

Vicki Clays of IPPF European Network wanted to know if one of the recommendations to the German government was to select priority countries and added that in her opinion it would be wise to consult the donors about their priority countries as otherwise some countries might be entirely left out. **Dr Wolfgang Janisch** answered that the Hewlett Packard Foundation, when they became involved in the population programme about five or six years ago, had identified seven countries where population growth really had an effect on the overall world population. There should be a focus on RH/family planning in Pakistan, India, Myanmar, the Philippines, Nigeria, the Sudan and Ethiopia. To this, Dr Brandrup-Lukanow added that in fact there are countries, especially in Eastern Europe, with a great need for intervention which might not be so costly.

After the presentation of the results of Workshop III, **Wolfgang Theiss** of the KfW wanted to know what exactly the group had meant when they said that the indicators for success had to be redefined. To this, **Tewodros Melesse,** Director IPPF Africa, answered that in an RH programme, success could not be measured by numbers only, e.g. how many people were reached, how many commodities were distributed. So many factors must be considered because target groups are so different.

Bernd Hamann, gynaecologist, Berlin, added that based on his experience many parents are convinced that their children learn about RH in school, while teachers feel this is up to the parents, the result being that gynaecologists have to deal with abortions or pregnancies of very young girls. He explained that the most successful approach was to go to schools and talk about RH. Contrary to his and the teachers' expectations, young people are very eager and absolutely not shy when it comes to asking questions. Hamann said it is very important to use the adolescents' curiosity and to instruct teachers and representatives of organizations accordingly.

Plenary Discussion

The discussion on the topic "Visions – Ways out of the crisis – challenges prior to Cairo plus 10" was moderated by **Mechai Viravaidya,** former Senator and Chairman of the Population and Community Development Association (PDA), Thailand. The panellists were **Safiye Cagar,** Director of the United Nations Population Fund (UNFPA) Office in Geneva, **Karin Kortmann,** Member of the German Bundestag, Berlin, **Dr Gunta Lazdane,** World

Safiye Cagar, Dr Gunta Lazdane, Mechai Viravaidya, Karin Kortmann, Dr Steven Sinding (l. to r.)

Health Organization (WHO), Copenhagen and **Dr Steven Sinding,** Director-General of the International Planned Parenthood Federation (IPPF), London.

Mechai Viravaidya gave a quick overview of his organization's history, explaining that when they started in 1974, they received funding and commodities from the IPPF for the first five years, and commodities only for the next five years. After this, they were on their own. They developed the concept of "capitalism condoms", based on the idea that contraceptives have to be as easily available as vegetables. To make that happen, the organization used the most efficient multipliers to spread information and commodities, and these turned out to be shop-keepers, taxi-drivers, policemen, teachers, and gas station tenants who began distributing and selling contraceptives. Thanks to accompanying continuous educational programmes beginning at pre-school level, the level of sexual education and open-mindedness is such that even vasectomy campaigns are very successful. All these activities were carried out under the slogan "Use entertainment, make it fun". Further, the organization initiated several incentive and subsidy programmes in the fields of birth spacing and HIV/AIDS. Mechai described himself as a successful example for becoming financially independent through entrepreneurial skills: the Population and Community Development Association (PDA) owns three resorts, seven restaurants, several shops and factories.

Dr Gunta Lazdane argued that Europe has the lowest fertility rate in the world. Here, the question arises whether we should speak about RH or whether we can sacrifice RH for the MDGs. She said that there was quite a

Dr Gunta Lazdane

struggle going on about RH in Europe. Even at the WHO regional office in Europe she was facing the problem whether the topic of RH will survive in Europe. One of the most important things characterizing Europe today was the attitude of neglecting RH despite having the highest abortion rate globally, despite having the highest increase in HIV cases worldwide (due to Eastern Europe). Europe's interest in its own problems was by far not as important as maternal and child health in Central Asia, and even if one looked at today's speakers and discussion partners, Europe had almost not been mentioned, she stated.

Dr Lazdane considered two aspects to be decisive in order to tackle Europe's problem with the RH issue. One was partnership, but partnership should, first and foremost, start with internal partnership because the WHO was huge and had headquarters, member states, and regional offices in many countries, she said. Besides that, the WHO also had vertical programmes: reproductive health, child and adolescence health, and HIV/AIDS. Dr Lazdane was of the firm belief that in order to succeed in its work the WHO had to make the organizational structure compatible with the programme structure. She hoped the new director general would help to achieve that. Especially for Europe she hoped that there would be some progress. The second important point she mentioned was ownership of understanding in the country itself to stop the demanding attitude especially in Eastern Europe and Central Asia (e.g. "You should give us that much, if not we will ask somebody else"). The question should not be about "asking" but about what we could do in the country itself to reach the goal. And that was one of the things WHO Europe was starting to follow in a strategic approach: Even with the amount of money the country has, it must to prioritize its needs.

Karin Kortmann pointed out that the population problem in Europe, especially in Germany, differed from the kind of problem the rest of the world was facing. Due to depopulation, the social security systems were under-funded, and therefore funds for prevention and care in the health sector were insufficient. The real problems resulting from this situation will be felt by the younger generation in 15 to 20 years. She pointed out that

problems in the education sector already existed and that overall funding could not be guaranteed. Ms Kortmann stressed the fact that RH problems needed to be discussed without focussing solely on developing countries as the industrialized countries also had problems in this area (e.g. teenager pregnancies in the UK).

As a second point, Ms Kortmann explained that it was very important for the parliamentarians to have founded the "Parlamentarischer Beirat für die DSW im Bundestag" (Parliamentary Advisory Council for the DSW in the German Bundestag) as they were aware of the fact that new funds would be needed to tackle those problems. Given that RH was not commonly discussed in Germany the Advisory Council decided that it was a priority to offer information to parliamentarians and to come up with an applicable and holistic policy. She continued that the MDGs reflected the diversity of the problems and underlined the necessity to find action modules that click together to be able to contribute to poverty reduction. According to Ms. Kortmann, the German Government initiated an Action Programme 2015, headed by the Federal Ministry for Economic Cooperation and Development (BMZ), with the collaboration of all the Ministries. The parliamentarians insist on receiving an impact report every six months.

Given the great cultural diversity in the target countries, Ms. Kortmann stressed the fact that albeit there were enough action models to choose from, the funds simply did not suffice. It was her conclusion that we needed an inter-parliamentarian network to keep pressuring governments to fulfil their promises as the Cairo tragedy would otherwise repeat itself – a gradual send-off followed by a new programme like the MDGs. However, she said that we needed a sustainable programme that was permanently adapted to changing demands.

Dr Steven Sinding said that Thailand's approach should serve as a model for increasing awareness of a method that is about saving lives given that the message of demystifying condoms was immensely important in the area of HIV/AIDS. He wanted to return to the "brave and angry" roots of IPPF and wondered what kind of approach could be used to promote the use of condoms in cultures that had strong sexual taboos, e.g. Sub-Saharan Africa or the Islamic world. Referring to Mechai's attitude and enthusiasm, he pointed out that it was necessary to find people in other countries who were able to mobilize their compatriots and find an appropriate way to demystify the use of condoms and overcome the reluctance of men in many cultures to use them.

Dr Steven Sinding asked what IPPF could do to respond to different cultural ways of perception. He said that the opposition of a well-organized, well-financed and determined alliance between the Vatican and the US

government had created a global confrontation in sexual and reproductive health that had made the contemporary political environment different from anything the RH community had faced in the past. He deduced that parliamentarians should be made aware of the extent of opposition; until now, they had been secondary in effect to civil servants in the movement, but as the political dimension was becoming more important, the support of parliamentarians in sustaining the Cairo Agenda would prove to be critical over the next several years.

Given this situation, Dr Steven Sinding claimed that finding ways to effectively support parliamentary groups, conferences, and involvement in order to pursue the work that UNFPA had very effectively performed in the past three or four years, as well as sustaining a parliamentary movement on RH and rights really were other important priorities. He concluded by saying that the growing problem of depopulation in the industrialized countries would make it more important than ever to understand that talking about RH meant talking about human rights, women's rights and a fundamental commitment to gender equality.

Safiye Cagar was concerned about the reaction of different cultures to talking about using or distributing condoms. She suggested adapting Mechai's ideas to the culture of each individual country.

Ms Cagar talked about the time of the Cairo process when Germany had held the presidency of the EU and had negotiated very convincingly on behalf of the EU and had very strongly supported the Cairo ICPD Programme of Action. She expressed her hope that Germany would keep up this support given the opposition of the US. In that regard, Ms. Cagar wanted to see Germany play a greater role in supporting UNFPA with the European Commission as Germany was one of the most important donor countries in the EU and therefore had a lot of influence.

She stated that UNFPA's main goal was to help women. The opposition, she said, was fighting against contraceptives and women's rights. In her opinion, it was most important to empower women, to educate them, to enable them to decide for their own about family planning, about child spacing and thus to be more active economically and thus to contribute to their nations' economy.

Regarding funding, she said that the needs for RH postulated in Cairo were not being fulfilled; the donor countries had paid only 40 percent. Instead of 17 billion dollars for the year 2000, UNFPA had received only 2.5 billion. The developing countries themselves contributed about 7.1 billion. Germany had been one of UNFPA's largest donors at the time of the Cairo Conference,

and shortly after Cairo it had been the fourth largest donor. Today, it had dropped to number eight. She acknowledged the difficult economic situation in Germany and said that hope remained within UNFPA that Germany would again become one of the top donors. For UNFPA, Germany was an important dialogue partner not only with respect to funding but also with respect to ideas and carrying out UNFPA's role in the RH sector. Unlike the very creative Mechai, she said, UNFPA depended on the donor community and the private sector, so in her mind, they had to keep encouraging their donors to increase their contribution. The shortage was such that in Sub-Saharan countries alone, only 16 percent of the needed number of condoms could be provided, which posed a great problem in the area of HIV/AIDS.

Ms Cagar was aggravated by the aggressive opposition of the US government. She told a story about how during the ASEAN meeting in Bangkok the US had tried to pressure 31 Asian governments into changing the wording of the Cairo Programme of Action which would have set a precedent for other areas. Fortunately, the Asian governments had resisted.

She informed the audience that UNFPA would not be holding a special meeting to celebrate the ICEP plus 10, but that the regional commissions of the UN would have technical meetings (one in Bangkok and others in Latin America and the Caribbean, Africa, the Middle East, and one in January 2004 in Geneva for the European Commission). She gave the prognosis that the US would try to exert its influence in Latin America and the Caribbean since those countries are very religious and conservative. In Bangkok, the US had tried to threaten the countries by saying it was going to cut aid to them unless they agreed to change the wording in the Programme of Action. Ms Cagar voiced her fear that the countries in Latin America may not withstand a similar threat. According to her, in the last 20 years alone, the opposition of the US had cost UNFPA about 500 million dollars: UNFPA had not received US funding for 11 of the past 18 years. She complained that the opposing groups had become experts in misinformation and that UNFPA had to spend time and energy contradicting their lies.

Karin Kortmann took issue with Germany's commitment, the EU alliance, opponents and the funding gap. She explained that the Parliamentary Advisory Council was against reducing efforts, i.e. that the already small financial contribution of Germany in the area of development aid needed to be at least maintained, if not increased. With regard to the European level, she declared that they were observing shifts of priorities due to the new member countries from Eastern Europe that were going to become part of the Union. Ms Kortmann stated that it was one of their priorities to raise awareness with regard to RH questions and mentioned that a cross-partite delegation of parliamentarians was going to visit the Vatican to demonstrate unity in the

face of clerical opposition. Given her professional experience with conservative clerics, she expressed her hope that parliamentarians in other countries would imitate this project to exercise political pressure. Ms Kortmann also voiced her concerns about the situation in South America, where the Catholic Church had lost influence due to sects and other religious movements. Given the fact that these organizations were unknown quantities and could not be controlled, they posed an even greater challenge than the Catholic Church. She concluded that the financial gap needed to be addressed, but that Europe could not cover the deficient financial contribution of the US.

Eva Quistorp, UNIFEM Commission Germany, proposed that Mechai should conduct workshops for which he would travel to another country and offer one-week training seminars since his intelligence, imagination, humour and knowledge should be included in the campaigns and benefit the training of campaigners in other countries. She further argued that there should be much more knowledge about the reasons for the pope's opposition and about which interest groups behind the US administration were working against RH and UN standards. Certain organizations should provide very precise information on the identity of these groups, where they were located, how they were organized, etc., in order to be prepared for further attacks and to begin our own work of education. One should learn from Thailand and Mechai's examples and not limit oneself to cooperation with companies like Schering but also look into cooperation possibilities with football teams and MTV and certain global film makers. They should see cooperation as a form of social obligation because they use a global market and should therefore have some social responsibility.

Dr Steven Sinding responded to a number of questions, including those about the organization of the opposition and the motives of US opposition groups. He said that there were two really excellent publications, one which had recently been produced by Planned Parenthood in the US, the other by Catholics for Free Choice which explained the opposition in great detail, i.e. who they were and how they functioned. He hoped that DSW and other groups in Germany could make these publications available as they contained information that should be widely available for all of the events that are coming up in order for the RH community to be prepared.

As to the question of the motives of the Americans, he stated that as angry as he was with President Bush and as embarrassed as he was about the behaviour of the UK, he could not go so far as to accept the thesis that it was the purpose of the American opposition to keep the rest of the world weak and dependent. In fact what this was about was the extension of the abortion debate in the US to an international level and the reason it had

become an international debate was that protection under American law was so strong that the opposition to abortion had been unable to make any progress. And so they focused on weak, vulnerable groups that did not enjoy political representation in the US. Like the Reagan administration before it, the Bush administration was making its payoff to the religious right.

Dr Robert Zinser, Rotarian Initiative for Population and Development (RIFPD), argued that during his 10 years of work he had never encountered a problem with the Catholic Church, neither in Africa nor in Germany. He mentioned that the German bishops even promulgated in 1973 that the use of chemical and mechanical contraception methods should be permitted since calendars or clinical thermometers were not available on the African continent. He therefore wanted to encourage the RH community. But he also told the experts among the participants that this information should be repeated over and over again, and that those who banned abortion put abortion on their shoulder and had to settle this with their own conscience irrespective of their country of origin or what sect they belonged to. He stressed that this fact deserved to be continuously repeated. If German parliamentarians used the media to state that sustainable development was not possible without family planning, more aid would flow, perhaps even from Brussels. Furthermore, it would help if parliamentarians declared more often that RH is very effective and that funds allocated to it are used in a sustainable way.

Family Planning and Reproductive Health: Where is the international community headed?

Dr Steven Sinding
Director-General, International Planned Parenthood Federation (IPPF), London

I'd like to congratulate the organizers on convening this meeting at this crucial moment in the history of the population and reproductive health movements. It was just 50 years ago that the first international conference on population was held in Rome at a time when modern contraceptives were still at the early development stage. What tremendous progress has been achieved since then!

We are also meeting on the eve of the 10th anniversary of the International Conference on Population and Development in Cairo – a watershed in humanity's progress towards reproductive health for all by 2015. The results of the past four decades would not have been possible without the partnership between the private sector, which provided the technology needed to master fertility, the public sector, which created the public health infrastructure, and NGOs, which took the early risks and in many countries have carried the burden of making contraceptive use legitimate and accepted.

However, despite the progress achieved so far by reproductive health programmes, many sectors of society, mainly people in rural areas, the marginalized and socially-excluded and above all young people, are still lacking access to reproductive health programmes due to a variety of political, economic, social or cultural barriers.

In addition, the emergence of new international development priorities such as the Millennium Development Goals, the HIV/AIDS pandemic, and the fight against terrorism, appear to have weakened commitment to the Cairo Programme of Action in general and to reproductive health programmes in particular. And this despite the fact that few of the MDG goals can be realized if the core goals of the ICPD are not achieved.

The key question today is: What must we do to ensure that the central goals of Cairo are achieved so that the reproductive revolution that began nearly 50 years ago can be successfully completed?

RH: a successful social revolution.
But there is still much unfinished business

The middle of the 20th century was characterized by major developments relating to population growth. The apocalyptic predictions of growing human numbers put population growth and fertility regulation firmly on the political agenda, first in the US and later in the other industrialized countries. In addition the major advances in contraceptive technology – particularly the Pill and the IUD – made it possible for Non-Governmental Organizations to advocate the benefits of family planning and for them and governments to provide family planning services.

In most countries, including developing countries, the emphasis was on reducing human numbers and on meeting often ambitious demographic targets, mainly through policies and programmes designed to increase contraceptive use. Driven by the desire of governments to curb population growth, by the efficacy of modern contraceptives as opposed to the doubtful outcome of traditional methods of fertility regulation, and by the eagerness of the middle classes to enjoy a better quality of life by limiting births, family planning services grew rapidly among married couples, mostly in urban areas. The success of this social revolution is reflected in today's relatively high levels of contraceptive use, lower levels of fertility, and reduced rates of population growth.

A recent report[1] using the results of 120 demographic and health surveys concludes that over 620 million married women around the world – nearly 500 million in developing countries – are currently using contraception. This represents some 57 percent of married women of reproductive age. While the average in developing countries is 55 percent, the range is from as low as 15 percent in Sub-Saharan Africa to as high as 68 percent in Latin America and the Caribbean. Almost 90 percent of contraceptors today are using a modern method, which testifies to the success of family planning programmes in introducing highly sophisticated products to wide sectors of society which otherwise lack access to many features of modern life.

As a result, fertility declined by an average of one percent per year in the 38 countries surveyed more than once since 1990. Fertility fell by 0.5 child per woman in India between surveys conducted in 1992-93 and 1998-99, while it fell by nearly two percent per year in Latin America and the Caribbean. In Africa, fertility fell by more than one percent per year in 9 of 16 countries surveyed since 1990. Overall, the total fertility rate (TFR) declined from nearly 6 children in the period 1965-70 to just over three in 1995-2000.

[1] *John Hopkins Bloomberg School of Public Health. Population Reports. Volume XXXI, Number 2, Spring 2003, pp 2-15*

In terms of global population growth, the increase declined from a high of some 89 million additional people per year in the late 1980s to 77 million in early 2002 – well below the forecasts made by the UN as recently as the early 1990s.

Despite these results, the success of family planning programmes might have been even greater had the people who expressed a desire to reduce their fertility had access to family planning services. The surveys just mentioned found that 105 million married women (about 21 percent of all married women of reproductive age globally and 24 percent in Africa) have an unmet need for contraception – a need that is not being met by existing service delivery systems.[2] One of the results of the lack of access to contraception and other reproductive health services is that the world's population is set to increase by another 2 billion people over the next 25 years.[3]

The Cairo Conference of 1994 is seen by many as marking a watershed in international thinking and policy making in the fields of reproductive health and development. After years of population policies aimed at reducing fertility through family planning, at Cairo the community of nations adopted a new approach – sometimes called a "paradigm shift." This approach called for the dropping of demographic targets, considered by many as producing insensitive, even coercive programmes, and the substitution instead of services that respond to the full range of reproductive health needs, especially of women.[4]

The ICPD Programme of Action (PoA) also called for a broad range of social and economic reforms that would empower women, expand their rights, and greatly strengthen their roles vis-a-vis men. Alongside the consensus document produced by the Beijing Women's Conference less than a year later, Cairo represented a call for a fundamental transformation of women's roles and status in society. The final negotiated documents of both conferences were approved by UN-style consensus and widely hailed as major breakthroughs. But they have produced strong reactions among conservative forces in many parts of the world.

Some of the reactions complain that Cairo and Beijing undermine basic family structures and the traditional division of roles between men and women; others maintain that Cairo went too far in recognizing reproductive

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[2] *ibid, p.24*

[3] *www.unfpa.org/population/demogra.html*

[4] *see SW Sinding, Getting to replacement: bridging the gap between individual rights and demographic goals, in P. Senanayake and R.L. Kleinman, eds., Family Planning: Meeting Challenges: Promoting Choices, 1994, Carnforth, United Kingdom and New York: Parthenon Publishing Group.*

and sexual rights – that the concept of reproductive rights is a code name for abortion – and that the agenda for action encourages under-age sex and promiscuity. Family planning has always engendered such fears among social and religious conservatives, but the Cairo and Beijing conferences re-awakened these groups after years during which voluntary family planning programmes had moved steadily forward.

As I will argue further in a few moments, today, nearly ten years post-Cairo, we face a double challenge:

- Persuading governments that there is still an urgency regarding the Cairo PoA which requires them to meet their commitments – especially the financial commitments – they made at Cairo; and
- Overcoming the strong and growing conservative backlash that is being led by the U.S. Government – one of the strongest erstwhile champions and architects of the Cairo consensus.

Many successes, but the job is not finished

It seems quite clear that we will not achieve the funding goals of the Cairo PoA – $17.0 billion per year in 2000, gradually rising to some $23 billion by 2015. Today global funding stands at about $9.5 billion, or just about half of what was committed at Cairo. Inasmuch as Official Development Assistance (ODA) has not risen at all over the same period of time, and given that other priorities have emerged that threaten further the funding for sexual and reproductive health and rights programmes, I think it is time to conclude that we must focus and concentrate the very limited resources we have – and are likely to have in the future – on a small number of the highest priority undertakings. What are these?

1. Universal access to reproductive health services

While the ICPD PoA aims to achieve global access by all to reproductive health services by 2015, many individuals and couples still lack access. In terms of contraceptive use, only 57 percent of women of reproductive age are using contraception and, as mentioned above, 105 million women who expressed a desire to limit or space their fertility have no means to do so.

In this regard, it is important to note that it is the women in rural areas who are hardest hit. One of the reasons for lack of access to services are the issues of service availability and proximity. It has been established from several surveys that contraceptive use is invariably higher where services are easily accessible, in terms of both distance and travel time. In Thailand, where the median distance to a service delivery point is three kilometres and the median travel time is 15 minutes, contraceptive prevalence is 68

percent. On the other hand, in Uganda, where the median distance is 19 kilometres and the median travel time is 60 minutes, contraceptive prevalence is only 5 percent.[5] (Of course, time and distance are not the only variables involved and I don't mean to imply that if services were as accessible physically in Uganda as in Thailand, prevalence would be equal – only that it would be considerably higher.)

Consequently, the contraceptive revolution will not be achieved and the goal of ICPD/PoA of ensuring access to reproductive health by 2015 will not be accomplished if the relevant institutions do not focus on bringing services to rural areas.

But beyond physical access, there is also the issue of cost. In today's world there are basically two ways of getting contraceptives: at commercial prices (usually in the major urban centres); and through free or highly subsidized publicly supported programmes. For increasing numbers of couples, neither of these is ideal: commercial prices put contraceptives beyond their reach; and they either lack access to or prefer not to use public facilities.[6] Furthermore, many couples that have an ability and a willingness to pay something, but less than the full commercial price, are receiving free or highly subsidized products at the expense of the truly destitute, many of whom cannot be reached for lack of resources. The funding shortfalls of Cairo are especially acute with respect to contraceptives and other reproductive health commodities. Indeed, UNFPA estimates that, while global funding for all RH needs is at around 45 percent of needs, the funding of commodity requirements is meeting only 16 percent of the need![7]

It is imperative that we find ways to service this "middle tier" of clients and consumers. I believe that creative Public Private Partnerships are the way to do this and I urge participants at this conference to engage in a serious conversation about how such partnerships can be constructed.

2. Young people, especially adolescents

The world today has the largest cohort of young people in history – around 1.2 billion. Never before have there been so many people in the age group 15-25, and never again will there be so many. This "youth bulge" represents a huge challenge in terms of the investments needed in education, health, shelter and employment, but also an opportunity for development

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[5] *www.infoforhealth.org/pr/j40/j40chap3_2*

[6] *There are many reasons for this disinclination to use public facilities: e.g., shame; lack of privacy, poor service.*

[7] *Cited by UNFPA Executive Director Thoraya Obaid at the October 2003 Conference of European NGOs (Eurongos) in Sexual and Reproductive Health, Population and Development, Hämeenlinna, Finland, 3 October 2003.*

as young people are increasingly aware of the implications of globalization. But most significantly, how well or how poorly we respond to the sexual and reproductive health needs of this largest generation ever has profound implications for future economic, social, political, and, of course, demographic conditions worldwide. Young people are having their sexual debuts earlier, and marrying later, than ever before. They are, thus, exposed to a longer period of risk of unprotected sex in larger numbers than ever before. No wonder, then, that young people are twice as likely to experience unwanted pregnancies or sexually transmitted diseases and infections – including HIV – than older, married people. While there has been some recognition of the enormous extent to which young people's sexual and reproductive health needs are not being met, most governments continue to have their heads buried in the sand.

Traditional elements in society, both in developing and developed countries, are in denial, hoping that moralistic talk and advocacy for abstinence will keep young people out of trouble. But the reality is different. The various demographic and health surveys demonstrate that among adolescent women, aged 15 to 19, reported levels of premarital intercourse are not negligible: 29 percent in Sub-Saharan Africa and 24 percent in Latin America and the Caribbean. In the unmarried age group 20 to 24, the percentage reaches almost 50 percent.[8]

Of course, one consequence of premarital sex among the age group 15-19 is childbearing. It is estimated that each year 15 million births occur in this age group;[9] and 7 percent of adolescents worldwide, and 19 percent of adolescents in Latin America (LAC) and 26 percent in Sub-Saharan Africa, have begun childbearing.

3. Maternal mortality resulting from pregnancy

The World Health Organization and UNICEF estimate that 585,000 women worldwide die each year of conditions related to pregnancy and child birth; this is equivalent to one death every minute. There are several causes of maternal death which have been clearly identified, among them: neonatal tetanus, delivery outside a medical facility, and unsafe abortion.

- Neonatal tetanus killed an estimated 150,000 to 300,000 women during the 1990s and accounted for some five percent of maternal deaths every year. In addition, it accounts for 14 percent of neonatal deaths.[10] Two

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[8] *Population reports, op cited. p. 27*

[9] *Alan Guttmacher Institute, Risks and realities of child bearing worldwide. Issues in Brief. AGI. 1997*

[10] *Fauveau, V. et al: Maternal Tetanus: Magnitude, epidemiology, and potential control measures. International Journal of Gynaecology and Obstetrics (40) pp. 3-12,1993*

doses of tetanus vaccine injected two or three times during pregnancy can prevent infections and save the lives of mothers and infants.

- Only an average of 25 percent of women in Asia delivered in a medical facility (less that 10 percent in Bangladesh, Cambodia and Nepal) as opposed to 70 percent in LAC and 50 percent in the 30 African countries which were surveyed during the 1990s.
- Unsafe abortion: It is estimated that around 60,000 women die every year as a result of unsafe abortion. Where abortion is illegal, women often feel compelled to take life-threatening measures to terminate an unwanted pregnancy. It is estimated that 20 to 50 percent of maternal deaths in South Asia result from unsafe abortion. Even when abortion is legal, there is no guarantee that services will be accessible, safe and of good quality. In India, where abortion has been legal since 1971, only around 600,000 legal procedures – a small percentage of the estimated total number of abortions – are reported each year.[11] Access to modern contraceptives has been shown to reduce abortion rates. In the Czech Republic over a three-year period abortion fell 36 percent after contraceptive use in creased by 30 percent. In Russia, abortion rates dropped from 108 per 1,000 pregnancies to 68 in the late 1990s.

These three interventions – tetanus inoculations for pregnant women, safe delivery, and eliminating unsafe abortions – could greatly reduce maternal mortality in developing countries.

4. Under-five mortality

During the 1950s an average of 20 million children under the age of five died each year in developing countries. Thanks in large part to Unicef's Child Survival initiative, this average went down to 11 million during the 1990s. However, despite this decrease worldwide, the average in Sub-Saharan Africa doubled in the same period, rising from an estimated 2.3 million to 4.5 million. In 2000, 43 percent of the world's child deaths occurred in Sub-Saharan Africa.[12] In most cases, the cause of death has been documented: diarrhoea, malaria, pneumonia and measles. Malnutrition contributes to more than 55 percent of these deaths.[13] In addition to these four causes, another deadly cause has emerged: AIDS. It is estimated that between 1995 and 2015, AIDS will kill some 3.7 million children before the age of five. The

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[11] *Alan Guttmacher Institute, Sharing responsibility: women, society &abortion worldwide, 1999*

[12] *UNICEF. World Summit for Children, 2001*

[13] *Caulfield LE, Black RE, Malnutrition and the global burden of disease: underweight and cause-specific mortality. Quoted in Gillespie, D., Child survival: the unfinished revolution. Unpublished, 2003*

proportion of children under five killed by AIDS is estimated to be 13 percent in Tanzania and 61 percent in Zimbabwe.[14]

5. HIV/AIDS

UNAIDS stated at the Barcelona meeting in 2002 that "the scale of the AIDS crisis now outstrips even the worst-case scenario of a decade ago. Dozens of countries are already in the grip of serious HIV/AIDS epidemics and many more are on the brink."[15]

The results of the epidemic: 25 million dead, 40 million people living with HIV, 50 percent of those infected worldwide in 2001 are women, an increase from 41 percent in 1997. The proportion in Sub-Saharan Africa is 52 percent, compared to 48 percent in 1997.[16]

International Support: not enough to cover the needs, and declining

Since the end of the Second World War and especially since the widespread achievement of independence after the 1950s, Official Development Assistance (ODA) became a major feature of international relations and international cooperation. As 95 percent of ODA is given by Organization for Economic Cooperation and Development (OECD) members, the history of ODA can be seen through OECD and its Development Assistance Committee (DAC).

We will review here the historical developments relating to the ODA of the major 14 donors who in the course of the last 40 years have given at some point or another more than US$1 million. The table below shows the ODA trends in selected years (1954, the baseline; 1974, Bucharest Conference; 1984, Mexico City Conference; 1994, Cairo Conference; 1999, Cairo plus 5 / The Hague Forum; and 2000/ and 2001, the last two years for which comparative data are available (in constant 1999 US$ million).

[14] *Population Reports. Op cited , p. 34*

[15] *The report on the Global HIV/AIDS Epidemic; The Barcelona Report, UNAIDS, 2002*

[16] *Achieving the Millennium Development Goals: Population and Reproductive Health as Critical Determinants. UNFPA. Population and Development Strategies series. No.10. 2003*

The ODA trends

COUNTRY	1954	1974	1984	1994	1999	2000	2001
Australia	100	483	777	1,091	982	987	873
Canada	78	716	1,625	2,250	1,706	1,744	1,533
Denmark	10	168	449	1,446	1,733	1,664	1,634
France	828	1,176	3,026	8,466	5,639	4,105	4,198
Germany	459	1,433	2,782	6,818	5,515	5,030	4,990
Italy	48	216	1,133	2,705	1,806	1,376	1,627
Japan	116	1,148	4,319	13,239	15,323	13,508	9,847
Nether-lands	49	463	1,268	2,517	3,234	3,135	3,172
Norway	10	131	540	1,137	1,370	1,264	1,346
Spain	-	-	135	1,305	1,363	1,195	1,737
Sweden	33	402	741	1,819	1,630	1,799	1,666
Switzer-land	9	68	286	982	984	890	908
UK	493	787	1,430	3,197	3,426	4,501	4,579
US	3,602	3,674	8,711	9,927	9,145	9,955	11,429
TOTAL DAC	5,924	11,180	28,130	59,152	56,424	53,734	52,336

Source: OECD/DAC, ODA 1950-2001. Updated on 18/12/2002

This table permits the following observations:

- The following countries increased their ODA after ICPD: Denmark, Japan, the Netherlands, Norway, Spain, UK and US.
- Countries which decreased their ODA since ICPD are: Australia, Canada, France, Germany, Italy, Sweden and Switzerland.
- Overall OECD/DAC ODA has decreased since the ICPD.
- After reaching an all-time high of US$ 15.323 billion in 1999, Japan's ODA has seen a major decrease, particularly from 2000 to 2001.

Percentage of ODA in comparison with Gross National Income

COUNTRY	1985-86 average	1990-91 average	2000	2001
Australia	0.47	0.36	0.27	0.25
Canada	0.49	0.45	0.25	0.22
Denmark	0.84	0.95	1.06	1.03
France	0.59	0.61	0.32	0.32
Germany	0.45	0.40	0.27	0.27
Italy	0.33	0.30	0.13	0.15
Japan	0.29	0.31	0.28	0.23
Netherlands	0.96	0.90	0.84	0.82
Norway	1.09	1.15	0.80	0.83
Spain	0.10	0.22	0.22	0.30
Sweden	0.85	0.90	0.80	0.81
Switzerland	0.30	0.34	0.34	0.34
UK	0.32	0.30	0.32	0.32
US	0.23	0.20	0.10	0.11
TOTAL DAC	0.33	0.32	0.22	0.22
of which EU members	0.45	0.44	0.32	0.33

Source: OECD/DAC - Net ODA. Updated on 11/12/2002

This table indicates the following:

- A general decrease of ODA has occurred, from 0.44 percent of Gross National Product (GNP) prior to ICPD to 0.33 in 2001.
- The following countries have honoured the commitment to devote at least 0.7 percent of GNP to ODA more than 40 percent between the time of the Mexico Conference and 2001: Denmark, the Netherlands, Norway, and Sweden.

Calls for renewed commitment to ICPD

During The Hague Forum held in February 1999 to prepare for the events commemorating Cairo plus 5, it was clear that the international community needed a reminder to renew commitment to ICPD and to increase ODA in general, and the share relating to population and reproductive health in particular. As noted earlier, five years after Cairo the target of US$17 bil-

lion needed in 2000 to implement the Cairo Programme of Action was unmet.[17]

At their 2003 meeting in Paris, the OECD governments reviewed the state of development assistance in light of the results of some major international meetings held in 2002-03: the Doha meeting of the World Trade Organization, the Financing for Development Conference held in Monterrey, Mexico and the Johannesburg Summit. The Paris meeting confirmed that ODA increased from US$ 52.3 billion in 2001 to $57 billion in 2002 and that it is estimated that by 2006 there would be an increase of 30 percent in comparison with 2001. Despite the increase in 2002, the total ODA in that year is equivalent to the amount of ODA in 1991 and is below the all-time high level of $60.8 billion given in 1992, as well as below the amount of ODA given one year after Cairo ($59.1 billion).

ODA to population and health

While only US$ 500 million was allocated by DAC countries to health and population in 1973, this amount grew by an average of 3.3 percent per year to reach $3.5 billion in 1998 (in constant 1997 prices).[18] Here we can see the performances of individual countries.

ODA to health 1990-2001 (in US$ million)

COUNTRY	1990-92	1993-95	1996-98	1999-2001	percent of total ODA to health 1999-2001
Australia	14	43	83	124	3
Canada	31	57	36	69	2
Denmark	69	71	90	56	2
France	71	65	100	59	2
Germany	37	114	163	125	3
Italy	94	31	26	38	1
Japan	107	198	242	152	4
Netherlands	61	97	140	145	4
Norway	32	38	42	92	3

[17] *Population Action International, Fact Sheet: Why Donors Must Renew Their Commitment to Population Assistance. Washington, D.C., 1999*

[18] *Recent Trends in ODA to Health. OECD, Paris, September 2000*

Spain	26	59	117	93	3
Sweden	154	92	73	73	2
Switzerland	31	19	30	34	1
UK	134	98	233	500	14
US	383	800	733	1,108	30
TOTAL DAC	1,286	1,841	2,201	2,817	-

Source: OECD: Aid to Health. Paris, September 2000 (for 1990-1995) and December 2002 (for 1996-2001).

A few observations on this table:

- Countries that increased ODA for health following ICPD are: Australia, Canada, Germany, Italy, the Netherlands, Norway, Spain, Switzerland, UK and US.
- The following countries decreased their ODA for health: Denmark, France, Japan and Sweden.
- The UK increased its ODA for health five-fold (from US$ 98 million in 93-95 to $ 500 million in 2001).
- The US, which ranks first in total ODA but last in ODA as a percentage of GNP, has a commanding leadership position in terms of ODA for health.
- The percentage of ODA for health is very important in the case of the US (30 percent) and UK (14 percent); Japan and the Netherlands follow with 4 percent, Italy and Switzerland devote a much lower percentage to health (1 percent of their total ODA).

Share of ODA for health devoted to family planning and HIV/AIDS

An analyzis of the breakdown of spending within the health sector confirms that family planning is losing ground to HIV/AIDS when it comes to funding. The following table indicates the percentage of the various components of the health sector during the period 1990-98.

Population/Health	
Basic health care	10 %
Basic Health infrastructure	15 %
Infectious Disease	7 %
Medical services, training and research	12 %
Health policy and administration	20 %

Breakdown of share of the various components of the population/health sector

Family Planning	15 %
Reproductive Health Care	10 %
STD/HIV/AIDS	7 %
Populations policy and management	4 %

While family planning enjoyed a dominant position between 1990 and 1998, funding began to shift rapidly toward HIV/AIDS starting from 2000, as can be seen in the following table (in $US million).

	1994	1999	2000	2001
Population policy and administration	14	98	131	135
Reproductive health care	92	177	194	142
Family planning	563	397	409	356
STD control including HIV/AIDS	193	282	521	587
TOTAL	863	953	1,255	1,220

Source: OECD response to an IPPF query in September 2003

The change in funding to the four components between 1994 and 2001:

Population policy	+ 964.3 percent
Reproductive health care	+ 154.3 percent
Family planning	- 36.8 percent
HIV/AIDS	+ 300.1 percent
TOTAL	+ 141.4 percent

Impact of the decrease of the share of family planning in ODA for health on contraceptive security

The decrease of ODA in general is compounded by the decrease of the share of health resources committed to family planning. The problem is particularly acute considering the fact that 105 million women have an unmet need for contraception and that an increasing number of young people, often unmarried, become sexually active without adequate contraceptive supply. As mentioned earlier, all this leads to a growing contraceptive security problem. In order to maintain the current worldwide contraceptive prevalence, the number of users of modern contraceptives needs to increase from 310 million users in 2000 to some 460 million in 2025, an additional 150 million users.[19]

The current donor expenditure has to increase annually by 5.3 percent to cover the commodity needs by 2015. As a matter of fact, the gap in contraceptive funding was estimated at US$ 24 million in 2000 and is projected to increase to some $210 million by 2015.[20]

The Bush Global Gag Rule

As if the ODA decrease and the decrease of family planning funding were not bad enough, the arrival of President Bush in the White House seriously compounded the problems for the field of reproductive health.

The first action taken by Bush on his first day in office was to reinstate the so-called Mexico City Policy which was enacted by President Reagan in 1984, according to which non-US NGOs were banned from receiving USAID funding if they in any way promote, provide, or refer patients for abortion.

IPPF refused to agree to the restrictive practices of this policy because of its belief that it curtails the right of women to reproductive choice. As a result of what has since become known as the Global Gag Rule (GGR), IPPF lost in early 2001 US$ 12 million which at that time represented 20 percent of the IPPF operating budget.[21]

Human rights, reproductive health and women's organizations considered Reagan's GGR I and Bush's GGR II as an attack against women in developing

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[19] *Duff Gillespie, International Support to Family Planning is Declining. Unpublished paper, March 2003*

[20] *Duff Gillespie, Reproductive Health: agenda for the future. Unpublished paper, September 2003*

[21] *In 1984, when the original Mexico City Policy was imposed, IPPF lost US$17 million, which at that time represented 25 percent of its budget. The Mexico City Policy was rescinded by President Clinton and IPPF funding was restored in 1995, only to be lost again in early 2001, following the election of Bush. In addition, USAID-IPPF negotiations for a possible $75 million grant resulting from a positive USAID assessment of IPPF in the summer of 2000 came to an end.*

countries since it took from them rights which the US Supreme Court had granted to American women in 1973. Many thought that IPPF was a unique case and that the US neo-conservatives would not seek additional victims. However, no sooner had the dust settled from the IPPF de-funding than the Bush Administration turned its attention to UNFPA and succeeded in withdrawing the $34 million it was set to receive because of alleged (and largely refuted) charges that UNFPA participated in coerced abortions in China.

The reach of the US right wing did not stop at IPPF and UNFPA. Next on the agenda was "reproductive rights" and "reproductive health services." During the Summit for Children held in New York in May 2002, the US delegation insisted on using "access to family planning and contraception" instead of "reproductive health." They lobbied also to replace "reproductive health services" with "basic health care".

The march of the anti-reproductive health choice movement continued. During the 5th Asia and Pacific Population Conference held in Bangkok in December 2002, the US delegation again attempted, unsuccessfully, to change the language of the Cairo Programme of Action. A recent example of the White House antagonism toward reproductive and sexual health programmes was the decision of the Bush Administration in mid-September 2003 to abruptly cancel an $8 million grant to a group of Brazilian HIV/AIDS NGOs because they did not limit their programmes to abstinence-only interventions and actively promoted the use of condoms.[22]

All these examples show that beyond IPPF, UNFPA and other reproductive rights and reproductive health organizations, it is the basic right to reproductive choice that is the target, first in developing countries and ultimately in the US.

Millennium Development Goals

During the Millennium Summit held in New York in September 2000, the world community adopted the Millennium Development Goals (MDGs) as a way to sharpen the focus of governments and NGOs in developed and developing countries on specific development objectives to be achieved by 2015.

While the MDGs represent a step forward in alleviating poverty and other health and social ills, unfortunately they remain silent on a number of objectives of the ICPD PoA, such as achieving universal access to reproductive health services by 2015. Some of the MDGs are directly linked to reproductive health and rights – for example, improving maternal health, combating

[22] *DKT International/ US Newswire, 15 September 2003*

HIV/AIDS, promoting gender equality and empowering women, and reducing child mortality.

As successful family planning programmes play a strategic role in reducing maternal and child mortality, reducing the incidence of unsafe abortion, preventing HIV infection, reducing poverty and empowering women, one may legitimately ask: "Can these MDGs be achieved while financial support to family planning is being reduced?"

It is important for the reproductive health community to go beyond merely recognizing the linkage between RH and the MDGs. What is needed is evidence-based analyzis of the direct impact of family planning and reproductive health on the MDGs. There is much evidence to show that birth spacing and limitation dramatically reduce infant mortality and contribute to improved maternal morbidity and mortality rates. More recent evidence has shown that family planning liberates women to pursue a range of economic and social activities that continuous pregnancy and childbearing make impossible. Finally, there is now strong evidence that families that limit their fertility are significantly more likely to escape poverty than families that do not or can not.[23] The message from all this research is clear: No ICPD = no MDGs.

Where do we go from here?

The analyzis of ODA trends earlier in this presentation does not give much grounds for optimism about the commitment of the development community either to the Millennium Development Goals or to the Cairo Programme of Action. While effectively combating HIV/AIDS now occupies centre stage in the development field and transferring resources to countries recently devastated by the so-called War against Terrorism has captured significant new resources, funding to realize the objectives of ICPD and to achieve the MDGs is basically declining.

This is why we need to have a second look at the ICPD objectives and the MDGs with a view to adopting a new approach to implementation – an approach that would concentrate on those most strategic interventions that actually enhance the synergy among several of the related objectives. These include:

1. Ensuring access of the poor, rural populations and young people to RH services. This would necessitate a partnership at the country level between

[23] *Much of this evidence is presented in Nancy Birdsall, Allan C. Kelley and Steven W. Sinding, eds., Population Matters: Demographic Change, Economic Growth, and Poverty in the Developing World. 2001. Oxford, UK: Oxford University Press.*

public authorities, NGOs and the private sector. Achieving contraceptive security and filling the condom gap cannot be achieved without such a dynamic partnership.

2. Identify the most direct causes of maternal and child mortality, including birth spacing and limitation, and act upon them in cooperation with the support of private foundations.

3. Create innovative forms of partnership between the private sector (especially the music, entertainment and pharmaceutical sectors) and NGOs in order to reach young people with the right messages and with credible substance. Here the issue is not “keep the hope alive“ but rather “create hope“ before it is too late on all fronts.

Birth Spacing: Presenting the "Catalyst Consortium" programme

Victoria Baird
Director, Meridian Group International,
Washington, D.C.

Catalyst consortium

The international health community has known for years that birth spacing is important for maternal and child health. So for many people involved in family planning and reproductive health, the first comment or question is – so, what's new?

First, there has been recently published research that shows the association between longer birth intervals and improved maternal and child health. The research confirms the long held "notion" that birth spacing is important for maternal and child health, but it also shows, particularly in the case of child health and nutrition, that birth spacing intervals of three years or longer have even more health benefits than the previously recommended two year birth spacing interval.

Some of the highlights of the new research document that longer birth intervals can contribute to a lower risk for fetal, neonatal, infant and underage five mortality, as well as preterm birth and low birth weight. In addition, research from Latin America shows that longer birth intervals can contribute to a lower risk for maternal death, third trimester bleeding, anemia and premature rupture of membranes.

Birth spacing: major data sources

While there have been hundreds of different studies/papers produced over the past twenty years on birth spacing, many have not been methodologically rigorous. The primary sources that constitute the new research on birth spacing have controlled for important socio-economic and biological variables. They are as follows:

The data on the impact of birth spacing on maternal health comes from the work of Dr. Agustin Conde-Agudelo and Dr. Jose Belizian who studied the effect of the interpregnancy interval using data from the Perinatal Information System in Montevideo, Uruguay developed by the Latin American Centre for Perinatology and Human Development (CLAP). From 1985-2000 the database recorded over two million pregnancies in Uruguay, Argentina, Peru, Colombia, Honduras, Paraguay, El Salvador, Chile, Bolivia, Costa Rica, Panama, the Dominican Republic, Nicaragua, Brazil, Ecuador, Mexico, the Bahamas and Venezuela.

To test whether the birth spacing interval is a risk factor for adverse pregnancy outcomes, the following sociodemographic and biological variables were controlled for using multiple logistical regression: maternal age, number of previous deliveries, history of spontaneous or induced abortion, history of stillbirth or neonatal death, previous Cesarean delivery, marital status, education, cigarette smoking, body mass index (BMI) before pregnancy, trimester during which prenatal care began, number of prenatal care visits, geographic area, hospital type, and year of delivery. In a separate analysis Dr. Conde-Agudelo studied the effects of birth spacing on perinatal health and on the health of adolescent mothers.

The data on the impact of birth spacing on child health and nutrition comes from the work of Dr. Shea Rutstein of Macro International who analyzed Demographic and Health Survey (DHS) data from 15 developing countries in Asia, Latin America, and Africa. Using logistical regression design he analyzed the pregnancy outcomes of over 430,000 pregnancies. The analysis of the effects of birth intervals on child mortality is from the following 17 countries: Bangladesh, Bolivia, Egypt, Ghana, Guatemala, Ivory Coast, Kenya, Morocco, Nepal, Nigeria, Peru, the Philippines, Tanzania, Uganda and Zambia. The analyzis of the effects of birth intervals on child survival controlled for the following: mother's age at pregnancy, mother's parity at pregnancy, results of previous pregnancy (if known), mother's education, urban-rural residence, survey phase, and country.

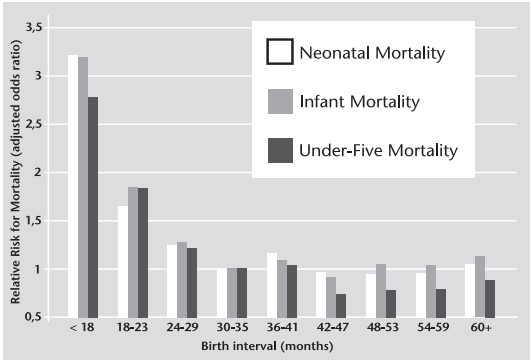
Research from the United States supports the findings from developing countries by Dr. Rutstein and Dr. Conde-Agudelo, confirming the health benefits of birth spacing, and indicating that the effect of birth spacing is strong even in more developed settings where women may have better nutritional status and access to health services. A study done by the Centers for Disease Control and Prevention examined the impact of interpregancy intervals on perinatal health in two U.S. States. Using stratified and logistic regression techniques, Dr. Zhu analyzed the pregnancies of over 500,000 women. Dr. Zhu's results in the U.S. mirror those of Dr. Conde-Agudelo's in Latin America.

DHS Data from 27 countries between 1993 and 1996 suggest that many women experience an unmet need for contraception in the year following a birth. Moreover, while such women often state a desire to practice family planning, substantially fewer actually do so. Given the sizable proportions of postpartum women who come into contact with health care providers during prenatal visits, at delivery and when seeking infant care and other services this research shows that concerted efforts to make contraceptive information and services available at these times might substantially reduce unintended pregnancy.

Given our time constraints today, I'm only going to present a brief overview of some of the key research findings. We begin with the impact birth spacing can have on child survival.

Birth spacing saves children's lives[1]

Data from developing countries show that the risk for death among neonates, infants and children under five decreases the longer births are spaced.



For example, compared to a 36-47 month birth interval, a child born after an 18 month birth interval may face over 3 fold risk for death.

The most important finding in the research is the downward trend of risk. This research indicates that the longer births are spaced, the less risk a child has of death at all developmental stages up to age five years.

Birth spacing saves mother's lives[2]

Data from the CLAP/PAHO database shows that when mothers space their births, not only are their children healthier and more likely to survive, but mothers themselves are at lower risk of pregnancy-related morbidities.

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[1] *Source: S. Rutstein, "Effects of Birth Interval on Mortality and Health: Multivariate Cross Country Analyses. Presentation to the USAID-sponsored Conference on Optimal Birth Spacing for Central America, held in Antigua, Guatemala, June 2003.*

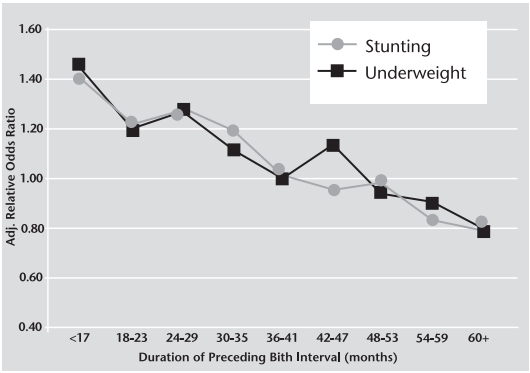
[2] *Source: Conde-Agudelo, A. and J. Belizan. 2000. Maternal Mortality and Morbidity Associated with Interpregnancy Interval: A Cross Sectional Study. British Medical Journal (321): 1255-1259. 2000.*

Findings from Latin America show that:

- The highest risks for maternal complications occur at the shortest birth intervals.
- The risks decrease the longer births are spaced.
- The statistically lowest risk for complications was found to be 27-32 month birth interval- or about three years.

Birth spacing leads to improved child nutrition[3]

- The highest risk births are those that occur at the shortest birth intervals.
- The risks for stunting and underweight for children decrease the longer births are spaced.



Most women want longer birth intervals[4]

The data show that birth intervals of at least 2-3 years can save the lives of mothers and infants. So, we must ask: "Who needs this information? Who is having short birth intervals? Who should we be targeting with birth spacing messages?"

Certainly all women and men of reproductive age have the right to know about the health benefits of birth spacing and the right to access to quality contraceptive methods and services.

Programme planners need to work to identify potential missed opportunities for birth spacing services. For example, in Latin America, as this slide

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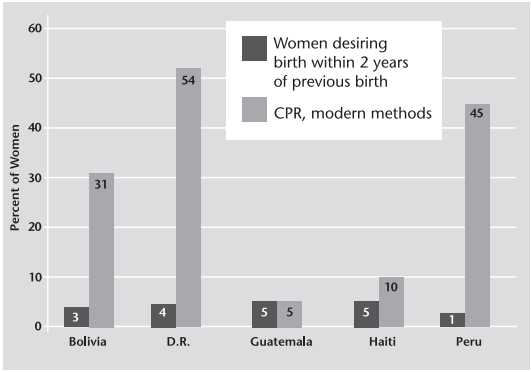
[3] *Source: S. Rutstein, "Effects of Birth Interval on Mortality and Health: Multivariate Cross Country Analyses. Presentation to the USAID-sponsored Conference on Optimal Birth Spacing for Central America, held in Antigua, Guatemala, June 2003.*

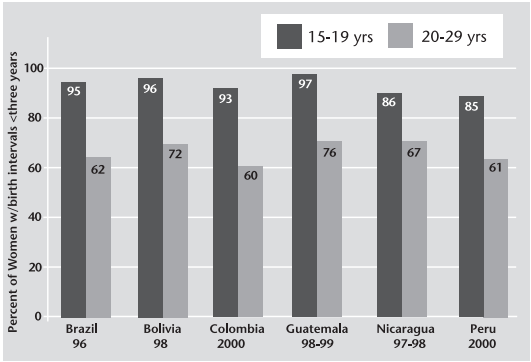
[4] *Source: Ross, John A. and William Winfrey. "Contraceptive Use, Intention to Use and Unmet Need During the Extended Post-Partum Period." International Family Planning Perspectives, Vol. 27 Number 1, March 2001*

shows, only about three percent of post-partum women want another birth within two years. Given this, we would expect family planning use among post-partum women to be quite high, but in fact, as we can see, it averages only about 40 percent. Thus the possibility for an unintended or mistimed pregnancy is quite high.



Birth spacing needs for young women (ages 15-19)[5]

Young women aged 15-19 years are having babies less than three years apart. In fact, in Guatemala, Brazil and Bolivia almost 100 percent of adolescents are having repeat high-risk pregnancy.



Young women are at the highest risk[6]

- Adolescents are at increased risk of adverse health outcomes including maternal mortality, as compared to adult women.
- The youngest mothers (aged <15 years) had the highest rates of adverse maternal outcomes whereas mothers aged 16-17 and aged 18-19 years had smaller but still significant increases.

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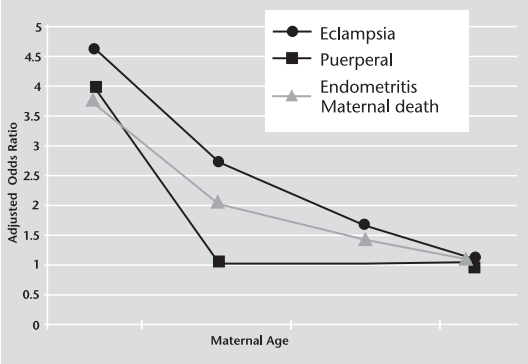
[5] *Source: V. Setty-Venugopal and U.D. Upadhyay "Birth Spacing, Three to Five Saves Lives". Series L, No. 13. John Hopkins Bloomberg School of Public Health, Population Information Program, Series L, No. 13, Summer 2002.*

[6] *Source: A. Conde-Agudelo "Maternal and Perinatal Morbidity and Mortality Associated with Adolescent Pregnancy in Latin America". (May 2002). Presented at the OBSI Champions Meeting, Washington, D.C.*

- There is a clear trend toward increasing rates of maternal morbidities and mortality as maternal age decreased.



Inter-Pregnancy Interval (IPI) and Birth Interval (BI)

The International Health community tends to understand birth spacing in terms of "birth intervals" and that is how the research data is presented today. The birth interval is defined as one child's birth date to the next child's birth date. This method is preferred by demographers that look retrospectively at population data. Many clinical researchers and physicians prefer to collect data on birth spacing using the "interpregnancy interval." The interpregnancy interval is defined as the time elapsed between the woman's last delivery and the date of next pregnancy (birth-conception). In order to compare data that uses different measures, simply add nine months to the interpregnancy interval to get the birth interval.

Not only do many physicians use the IPI, but also qualitative research that we have conducted shows that women and men understand birth spacing in terms of "interpregnancy interval". In other words, family planning users understand "when I will get pregnant next" better than they can calculate "when my next child will be born".

Therefore messages for birth spacing for providers and clients need to be crafted with this in mind.

Also, some evidences from our colleagues working in Africa, the Middle East and parts of Asia show that "birth spacing" is often a more culturally acceptable term and more understandable than "family planning".

Focus of the optimal birth spacing initiative

I'd like to turn now from the research data to present our current thinking on what to do with these research findings. We feel that the Optimal Birth

Spacing Initiative activities must be carried out among policy makers, providers, communities/families and for individual clients.

Policy and provider level

On the policy level, our research found that while the concept of birth spacing is generally accepted, very few family planning programmes are educating women and men about the positive benefits of longer birth intervals or on the risks for death associated with shorter intervals. As we looked further at this issue we found that few governments or institutions have protocols on birth spacing. There are few training manuals or counseling guides that include information on birth spacing and no operations research to give guidance on this topic.

Literature reviews and qualitative research conducted by Catalyst have revealed that:

1) most Ministries of Health and governments do not have specific norms on birth spacing;
2) providers differ in the advice they give to their clients about birth spacing;
3) and data on unmet need show that women express a desire to have longer birth spacing intervals than they are achieving.

Therefore at the policy level we need to work towards influencing government norms, practice guidelines and institutional protocols. In addition to working with health ministries and institutions, non-health ministries such as education and programmes that work with youth can be instrumental toward reaching women and men with birth spacing information and services.

Finally, it is critical to work collaboratively with private sector providers and institutions. For example, Schering Berlin is conveying the birth spacing research findings to private sector providers through their retailers and their promotional department.

Community level

Years of work in family planning have shown that it is not enough to merely give clients information. From Cairo we learned that programmes need to address an individual's physical, mental and social needs throughout their reproductive lifespan. We also learned that any information or services should be provided within the context of human rights and within the context of informed choice.

Community involvement is crucial for this to take place. In order to do this programmes need to work closely with community-based organizations, such as social clubs for women, men, and youth, programmes for newlyweds, or literacy programmes to create innovative strategies to help families achieve the birth spacing intervals that are best for their health and well-being.

Family and individual levels

Individuals have the right to know the mortality risks for infants and mothers when births are spaced to closely together. Family planning users should have accurate information on contraceptive methods and be able to obtain quality affordable products.

Women need to be able to negotiate timing and spacing of births with their partners.

Introduction to the Catalyst Consortium partners

The Catalyst Consortium is a family planning/reproductive health project funded by USAID. The Consortium is a partnership of five organizations: Pathfinder International, Meridian Group International, Inc., the Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), and PROFAMILIA/Colombia.

Each partner brings a unique expertise to the project: Pathfinder International has over 30 years of experience in family planning service delivery. In particular, Pathfinder addresses the reproductive health needs of adolescents and promotes male involvement in family planning. Meridian Group International, contributes expertise working with the commercial sector; creating innovative public-private sector partnerships; social marketing; and corporate social responsibility. The Academy for Educational Development is a large research institution specializing in behavior change communication, non-clinical service delivery and rural outreach.

CEDPA, the Center for Development and Population Activities contributes expertise in women's empowerment, gender-sensitive service delivery and advocacy; links to non-health CBD programmes, quality improvement, and sustainability. Finally, PROFAMILIA, our partner from Colombia, engages in advocacy and reproductive rights work. Profamilia/Colombia also specializes in South-to-South technical assistance; clinical programmes; male involvement; working with adolescents and, sustainability.

The Catalyst project goal is to "increase use of sustainable, quality family planning/reproductive health products/ services and healthy practices

through clinical and non-clinical programs." Our ultimate goal is to reduce unintended and mistimed pregnancies.

One important way of meeting this goal is to help women achieve the birth intervals they want and to improve contraception continuation rates.

Catalyst is serving as the secretariat for The Optimal Birth Spacing Initiative and has been working in collaboration with many international health agencies and institutions in these efforts.

Institutions currently involved in The Optimal Birth Spacing Initiative

Although Catalyst is the secretariat for The Optimal Birth Spacing Initiative, many organizations are actively working to revitalize this fundamental part of family planning and reproductive health. For example at the global level, USAID has provided both funding and technical support. UNICEF, USAID and Catalyst are co-publishing a fact sheet on birth spacing that will be distributed to all UNICEF country offices. The World Health Organization, UNICEF and USAID are collaborative partners with Catalyst in a systematic review of the literature on birth spacing.

In an effort to get the birth spacing data out to the field, Catalyst has made presentations to several national governments, including Belize, Bolivia, Costa Rica, El Salvador, Honduras, Nicaragua and Panama. The USAID-funded project Advance Africa has presented the new birth spacing research to government representatives in Haiti, South Africa, Congo, Angola and Nigeria.

Several research institutions have published the birth spacing research on their websites or contributed to our meetings, including the Centers for Disease Control and Prevention (CDC), the Latin America Centre for Perinatology and Human Development (CLAP), Georgetown University, Johns Hopkins University, Macro International, and University of North Carolina at Chapel Hill.

Currently we are working in collaboration with over twenty international health institutions and agencies on birth spacing, including: Advance Africa; Africare; Academy for Educational Development (AED); Center for Development and Population Activities (CEDPA); Christian Children's Fund; Cooperative for Assistance and Relief Everywhere (CARE); EngenderHealth; Family Health International (FHI); Management Science for Health (MSH); Meridian Group International, Inc.; Pan American Health Organization (PAHO); Pathfinder International; Population Action International (PAI); Population Services International (PSI); PRIME II/Intrah; Project Concern International; PVO Networks; Save the Children; The Population Council; White Ribbon Alliance; and World Vision International.

Birth spacing initial activities

Catalyst and our collaborative partners have initiated several activities to reach clients.

In June, 2003 Ministers of Health and Education from the Central American region attended a two-day conference on birth spacing. At the closing, the Ministers signed a declaration stating, their political commitment to "promote guidance, norms and actions to integrate these scientific findings in the regional strategy for reduction of maternal infant and child morbidity and mortality, taking into account the social and economic conditions of each country".

As mentioned above, the USAID-funded project Advance Africa has presented the new research on birth spacing to government representatives in Angola, South Africa, Nigeria, Congo and Haiti. The noted comment was that many governments felt that "birth spacing" was more culturally acceptable than "family planning" for the clients in these countries.

A systematic review of the literature on birth spacing is being conducted in collaboration with WHO, USAID, UNICEF and Catalyst. It will be completed Summer 2004 and the results will be disseminated at an international donor meeting.

CELSAM: Family planning for young people in Latin America

José Luis Corral
Executive Director, Centro Latinoamericano Salud y Mujer, (CELSAM), Mexico City

- In Latin America and the Caribbean, young people between the ages of 10 and 24 make up 30 percent of the population, with adolescents aged 10-19 representing 20 percent of the population. This distribution is evenly split between males and females.
- The number of young people in the Region stands at 155 million and is expected to reach 163 million by the year 2025.
- It is estimated that 80 percent of the Region's youth live in urban areas and that 65 percent live in poverty.
- The growth of the youth population varies within the Region. In the Caribbean, for example, the youth population is expected to remain at 11 million, while in Central America and South America this population group is expected to increase with the exception of Uruguay, Guyana and Panama.

Education trends

- Education levels of youth in Latin America and the Caribbean have improved dramatically over the last few decades.
- The illiteracy rate for those aged 15 and older has dropped from 26 percent in 1970 to 12 percent in 2000; the female illiteracy rate decreased from 30 percent in 1970 to under 13 percent in 2000, based on 1999 estimations.
- The improved literacy rates demonstrate that the region has made strides towards providing universal access to education at the primary level.
- However, as the youth population fulfills its primary education goals, the demand for education at the secondary and tertiary level rises. This is evi-

denced by the demand for tertiary education in countries such as Argentina, Brazil and Mexico, which enroll between one and two million students.

Sexual and reproductive trends

- The reproductive health situation in the region indicates some improvements.
- Adolescent fertility rates are above 50 per 1,000 in most countries.
- Overall fertility rates for adolescent females aged 15-19 years have decreased in the region, which is attributed to the increases in education levels.
- But fertility rates remain higher than 100 per 1,000 in Central America (except Costa Rica), the Dominican Republic, Jamaica and Belize.
- Awareness of contraception is high, as is awareness of HIV/AIDS in most countries.

Important facts on youth sexuality

Youth are sexually active and at early age:

- Approximately 50 percent of adolescents under the age of 17 are sexually active in the region.
- Between 53 percent and 71 percent of women in the region had sexual relations before the age of 20.
- The average age of first sexual intercourse is approximately 15-16 for girls in many Latin America and Caribbean countries.
- For boys the average age is approximately 14-15.

Adverse reproductive health outcomes

Young women are getting pregnant:

- Between 35 percent and 52 percent of adolescent pregnancies in the region were not planned.
- On average, 38 percent of women become pregnant before age 20.
- In most Latin America and Caribbean countries, between 15 and 25 percent of all babies are born to adolescents.

Young women are aborting and are victims of maternal mortality:

- Maternal mortality remains one of the leading causes of death for adolescents.
- In Chile and Argentina, where abortion is highly restricted, more than one-third of maternal deaths among adolescents are direct result of unsafe abortion.
- Between 21 and 30 percent of pregnancies in Mexico, Colombia, Brazil, the Dominican Republic, Chile and Peru end in abortion.

Socioeconomic influences on reproductive health:

- In Colombia, the Dominican Republic, Guatemala and Mexico, girls who received 10 or more years of education were four times less likely to have initiated sexual activity by age of 20 than those who had less education.
- In Ecuador, the percentage of young women between 15-24 that have been pregnant decreases with education, from 60 percent (no education) to 29 percent (university education).

2001 Latin American Survey on Contraceptives

In February 2000, 7500 women between 15 and 44 years from 14 Latin-American countries were surveyed.

Contraceptives top of mind		
1.	Pill	98 %
2.	Condom	97 %
3.	Intranterine Device (IUD)	88 %
4.	Ligation	87 %
5.	Injectables	86 %
6.	Rhythm	73 %
7.	Vaginal	67 %
8.	Vasectomy	65 %

Have you used contraceptives?	
Yes	72 %
No	28 %

Which contraceptive have you used?	
Pill	65 %
Condoms	35 %
IUD	26 %
Injectables	19 %
Rhythm	19 %
Ligation	19 %
Coitus Interruptus	7 %
Vaginal	5 %
Vasectomy	1 %
Others	2 %

How do you get information about contraceptives?	
Friends/Family	34 %
Doctor/Hospital	34 %
School/Work	18 %
Media	11 %
Other	3 %

Who decides?	
Couple	46 %
Woman	37 %
My partner	6 %
Physician	4 %
Other	8 %

Where do you find the contraceptives?	
Pharmacy	39 %
Public Hospital	21 %
Private Doctor	16 %
HMO Hospital	8 %
Other	8 %
Public Employees Hospital	5 %

Reviewing sexual education in Latin America

Social and environmental influences

Family:

- In the Latin American and Caribbean context, family, including extended family, is probably the most important factor contributing to adolescent health and development.
- Research has revealed that parents and their adolescent children commonly have difficulty talking each other about sexuality.
- Among Caribbean adolescents, 24 percent of youth feel that their mothers "understand little about their problem" and 32 percent of adolescents feel the same lack of understanding from their fathers.
- Adolescent boys from nine countries in the region indicate that sexual information received from parents is often provided too late and loaded with myths and taboos.

Peers:

- Peer acceptance plays an important role in adolescents defining their identity and their self-esteem.
- Studies indicate the power of peer group on boys, which may tend to spend more time on the street with their peer groups.
- Peer groups can serve several important functions, such as providing a sense of belonging as males seek independence.

Education and school:

- Education opportunities are linked to increased positive sexual and reproductive health outcomes, particularly for girls.
- Studies in Barbados, Chile, Guatemala and Mexico indicate that attaining a certain level of schooling and providing income to the family are two protective factors that help adolescent mothers stem an otherwise vicious cycle of poverty.

Media and communication:

- In Latin America and the Caribbean, the majority of information that adolescents receive on health and sexuality comes from the media and their peers.
- Media are a powerful tool that has demonstrated positive effects on adolescent sexual life and development:

– In Brazil, an AIDS prevention video entitled "Via de Rua" (Street Life) contributed to an 18 percent increase in condom use among youth targeted in the programme.

– Latin MTV broadcasted a show for young people called "Smart Sex". Some 78 percent of youth that saw the programme recomended it to their peers and 91 percent approved of the messages broadcasted.

Sexuality education programmes

- Most countries in the region agree that sexuality education is important.
- Many countries such as Argentina, Chile, Colombia, Brazil and Peru have implemented National Sexuality Education programmes.
- Discrepancies arise in how to implement sexuality education and there is considerable disagreement throughout the region on what age, where to implement and how to approach sexuality education for youth.
- Programmes that provide sexuality education that includes both abstinence and contraception are found to be more effective.
- Few of these programmes reduced sexual behavior, either by delaying the onset of intercourse or by reducing the frequency of intercourse.
- It was found that some of the programmes that focused on HIV education actually increased condom use among sexually active youth.

Multi-service youth centers

- In Latin America and the Caribbean, youth centers have been developed with multiple health and social services to address the broad needs and concerns of youth.
- Research shows mixed results for such programmes.
- Successful programmes included intensive outreach efforts, but when the intervention ceased, behavior changes were not sustained.
- Attendance at centers tends to be low for reproductive health services, yet youth come in for non-educational and recreational activities.

School-based and school-linked family planning services

- Studies of schools with health clinics and schools with condom availability programmes have consistently shown that the provision of condoms or other contraceptives through schools does not increase sexual activity.

- Given the relatively wide availability in most communities, most school-based clinics, especially those that did not focus on pregnancy or sexually transmitted diseases (STD) prevention, did not appear to markedly increase the school use of contraceptives.

Can sex and HIV/AIDS education programmes reduce adolescent sexual risk-taking?

Study criteria

- Programmes:
  - targeted youth 11-19 years old,
  - were implemented in groups in schools or community settings,
  - were implemented in the U.S., Canada, or developing countries.
- Studies:
  - employed experimental or quasi-experimental design,
  - had a sample size of 100 or larger,
  - measured impact upon behavior.

Studies with special importance

- Safer choices: Preventing HIV, other STD and pregnancy
  - reduced unprotected sex for 31 months or more
- Reducing the risk: Building skills to prevent pregnancy, STD and HIV
  - was independently evaluated three times in three different States in the U.S. and each time it delayed the initiation of sex;
  - in two of three States it increased condom or contraceptive use.

Characteristics of programmes that did not change behavior

- Focused mostly on increasing knowledge,
- taught only generic decision-making or communication skills (not skills specifically about sexual behavior),
- did not give a clear message about sexual behavior,
- were too short to include many activities.

Characteristics of effective programmes

- Focus on reducing sexual risk-taking behavior;
- are based on psychosocial theories that identified psychosocial sexual risk and protective factors;
- give a clear message about avoiding unprotected sex (i.e., avoiding sexual intercourse or always using condoms or contraception);
- provide basic accurate information about risks of unprotected intercourse and methods of avoiding intercourse or using condoms or contraception;
- address social pressures on sexual behavior.

Characteristics of effective programmes continued

- Provide modeling of and practice in communication and refusal skills;
- use teaching methods to involve participants and help them personalize information;
- incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience and culture of the students;
- last a sufficient number of sessions to complete important activities;
- select teachers or peers who believe in the programme and then provide training for those individuals.

Reproductive Health in Need of New Ideas?

Mechai Viravaidya
Chairman of Population and Community
Development Association (PDA), Thailand

Looking at the audience I notice that I am probably the only one here from a developing country. I am the only one who comes from a country that once had a population problem. Most of the participants, I imagine, are from donor countries. What I want to say first is: don't be misled by the name of this conference: "New ideas for reproductive health and family planning activities". There are no new ideas. All ideas are old, all wheels have already been invented. We don't need to have new ideas, we just have to have new visions, new energy; we need to be brave and to believe in what we are doing.

I think we've done reasonably well, but unfortunately, the family planning movement has in recent years been very apologetic, we've been put on the back burner. Many gatherings of people working in family planning are like the gatherings at a funeral parlor, of undertakers: dull, no new ideas.

But we do have new ideas, and I hope that Europe will be the leader in visionary assistance in family planning, for those countries and the areas that need it. To be successful, allow them to bring in some of their ideas with your ideas. Let me very quickly just run through some of the problems we had to face in Thailand: family planning must deal with the fact that the people we want to reach are typically poor. They need more than just family planning; they need many, many things. However, the only money we received was from the IPPF for family planning. So family planning became a start. Thinking about solution strategies, we thought in the beginning of a Western solution, of doctors giving out the pill. But as it turned out, that wasn't the solution for our country. There was only one doctor per 100,000 people, nine doctors for each million people. It couldn't work. So we developed our own ideas: train the nurses. The results showed that they did a much better job, because it was a woman-to-woman approach. This was the

soulution for the urban areas. For the rural areas we involved the midwives and thereby covered 20 percent of the villages. "If the Vietcong can fight a war without having to go to West Point, we can do the same" – this was our approach. So besides training the nurses and the midwives, we also trained ordinary people in villages. Most of them were shop-keepers, well-trusted, selected by the villagers. We set up centers and developed a brand for the product: a yellow-colored label that says: Village family planning center, get your pills and condoms here, or consult for IUDs, sterilization, at the government health center. Over time the yellow colour became as well recognized as the colour red, which stands for CocaCola – so that wherever you are, people recognized the yellow label as a place to get contraceptives. That is what we call the family planning floating market - wherever there are people, contraceptives must be there. Take for example, the name Cabbages & Condoms: if family planning is to succeed, contraceptives have to be as easily found as vegetables in the villages. So obviously the supply is very, very important. Commodities are important. But who gives them out? You can't have a commodity sitting in town, the people may not go into town – they'd rather get pregnant. The commodities have to be where the people are.

Dressmakers are very good distributers of contraceptives. "Get your pills from me and I'll give you a ten percent discount when I make a dress for you." In another part of the country, in the north, the hairdressers were very good advocates for family planning. Women chat and talk and by the way, she gives you ten percent discount on your hair-do if you purchase the pill from her. There were also religious leaders involved. We did a study into the Buddhist scriptures and discovered that Buddhism did not oppose family planning. In fact, Buddha said: Many births cause suffering; to prevent births means to prevent suffering as well. So, we distributed all of the information on the Buddhist scriptures to society. But the villagers said: Please, could you ask the Buddhist monk to help? When we have a new house, a new motorcycle, a new room, we get it blessed with holy water. Can you get the contraceptives blessed with holy water? This was 30 years ago! So, I asked the monk. It was agreed and I held a bowl of holy water and he blessed all the contraceptives with that holy water. We sent this picture into the villages, and the monks in the villages started doing the same thing. Then the women said: No wonder we have no side effects, it's been blessed. We didn't say that, but the villagers did and this was very important: The target audience must be the major actors. They must also be the teachers.

We trained half a million rural school teachers in the first five years. They are the people who teach the students. We organized the "teachers condom blowing championship" and the "students condom blowing championship", throughout the country, everywhere! The message was: The condom

is a wonderful product; the condom is clean if your mind is not dirty. So we passed them out and all children had them. The teachers did many more things in addition to this. They taught a family planning song; and in the song every contraceptive method was mentioned. The melody was based on the National Anthem. We also came out with a new alphabet: B for birth, C for condom, I for IUD, V for vasectomy; we can do the same thing in any country! And we had a new game, Snakes and Ladders, a dice game. It has every family planning method on it, for example: mother takes the pill every night, good mother, move ahead five; sister, 18, gets pregnant: too early to get pregnant, move back five; uncle buys condom, move ahead three; uncle get's drunk, doesn't use condom, move back ten. For all these activities, we didn't ask for permission from the Ministry of Education. We knew they would have said no. Our experince is that: it's easier to ask for forgiveness than to ask for permission.

One of our main issues is: make it simple! Make all the kids blow up condoms. Don't be shy with the condoms, it's a wonderful product. You can use it as a balloon; use the lubrication for after shave lotion. And nowadays, you can use it to put your mobile phone in during the rainy season.

During this conference, I'm staying in a very nice hotel. But I checked: No condoms in the mini-bar, but lots of alcohol! One of the things we ought to do is to get as many hotels as possible to put condoms in the mini-bar, this helps to push for family planning, for reproductive health, for HIV/AIDS prevention and therefore for saving lives.

Now, let me tell you something very interesting: we are currently doing research with lemons. Lemons have been used as a contraceptive for over 200 years, but there is no scientific research. In the lab it's clear that a sperm is immobilized within 30 seconds of contact with the lemon every time. Now we have already done a study on monkeys in collaboration with the University of Melbourne Medical School, and we are now going to do the human trial in Bangkok. We found out that lemon would be very important in the prevention of STDs of nearly every type. It also kills HIV within two minutes, though it is a bit more difficult. The microbicide effect in the lemon works due to the low PH. The lemon has a PH of between 2 and 2.4, and sperm cannot survive in it. It is a very interesting, simple method; no grand design, no Ph.D. needed, just a simple lemon. And it can be grown in Africa, in Asian countries, and even in Berlin! You just need some lemon juice on cotton wool, and the female inserts the cotton wool. People said: Before or after? I said: Before, of course. "Listen" they ask, "won't it sting?" No, unless you have a cut or you have an abrasion, then it becomes a very good diagnostic tool.

Now let's move on to AIDS. I will show you how family planning was a major contributing factor in of the HIV/AIDS prevention programme in Thailand. Everything we did in regard to family planning was copied as a response to AIDS, and it really helped. Our previous speaker, Steven Sinding was mentioning how family planning and the HIV/AIDS communities are separated; I, however, believe the people who are working in family planning are the very ones who can help immensely in terms of HIV/AIDS prevention programmes and activities.

When talking about HIV/AIDS prevention, we should also think about unusual ways of distributing prevention materials. In Thailand we have taxi drivers selling condoms and pills; the whole front of the car is full of pills and condoms, so when AIDS came along, the taxi driver now sells condoms as well as gives out AIDS safety tips. Why stick to just the medical profession? Everyone who can influence society must be involved in a programme, be it family planning, be it reproductive health or HIV/AIDS. This is very important: policemen helped us a lot. Policemen gave out condoms! We call it our Cops and Rubbers programme. All the information was printed by banks, insurance companies and Avon. Imagine all the Avonladies handing out information material. I persuaded them by saying: "Keep your customers alive, so they buy more Avon next year, and all the years after. Don't let them die of AIDS." We had done this as an NGO, and then I was asked to join the Cabinet, and the Prime Minister agreed, he became Chairman of the National AIDS Committee, every governor was trained, there must be an AIDS programme, an AIDS plan in every province, in every district, every village. As I mentioned before, we also trained policemen. They had helped us a lot with family planning before, so we asked them to help us with HIV/AIDS, as well. We also involved religious leaders: all religious institutions were asked to help to promote understanding and compassion, against discrimination. So everyone was involved, not just the Ministry of Health, and this was the coup. I was also in charge of the media, so every reporter, presenter, newsreader had to be trained and given a book with answers and questions. We also brought movie stars in meet with HIV-positive people, and we gave subsidies to all the movies and soap operas if they included something on HIV/AIDS, we gave them money for the film. Don't use government films to promote the message, because it puts people to sleep. Use regular, commercial movies. India should do this, because they have a very, very large commercial movie industry. AIDS training, education at every workplace, AIDS education from primary school upwards, as in family planning from grades four and five up to university. Let universities help secondary schools and let secondary schools help primary schools. These are all kids who have

knowledge about condoms already. We also have a special English language programme on AIDS; so they learn about AIDS and they learn English at the same time. Also, we worked in the commercial sex area, with our so-called condom nights. We also have a Miss Condom Asia-Pacific. We hope to compete with Miss Universe one day, Miss Universe sells perfume, these ladies save lives. We have competitions; the most knowledgeable woman wins the prize, not because she is the most beautiful. She has to have compassion and knowledge about safe sex and HIV/AIDS. They go and train people in other bars.

Gas stations are giving out condoms, policemen are giving out condoms. They stop traffic; they raise their hand and say: "Please, take a condom!" It gives them a nice change from their routine work. The Prime Minister is also involved. This of course is very important for fighting HIV/AIDS - he increased the budget. Every ministry was involved. Then, we introduced the programme to help the people. We have a programme of lending money to HIV positive people and we have a partnership programme for both, negative and positive people to work together. The HIVnegative people will help spread understanding and compassion while they are earning income. Again, it all followed from family planning, so now these HIVpositive people have an income, they couldn't have gotten a job before, they work in pairs, positive and negative together.

When the next AIDS conference takes place in Bangkok in July 2004, when you land and get your passport stamped, I hope the officer at the Immigration Office will put in a condom for you. And during the World AIDS Conference policemen will give out condoms with each parking ticket. You're saving lives! Everyone can be involved. Imagine the policemen of Berlin giving out condoms! They would be very happy! It changes their daily life, makes it much better! Have you tried asking them? Please, do that! They'd be very happy! Or send some Berlin policemen to Bangkok to join us during the World AIDS Conference!

But now back to family planning. One day the Thai government said: Men in our country seem to be cowards, they don't want sterilization. Can you find out why? We found out why: Because they don't want to go to hospital. So we had mobile vasectomy programmes, like picnics. In factories, we let the men have a look, because they thought vasectomy meant cutting from the belly all the way down. We said: No, no, no. Have a look, so you can see, you also can have the music of your choice while having a vasectomy. We also have vasectomy picnics. We don't have camps, we don't make it medical, we make it fun. We choose special occasions: our King's birthday - the King's Birthday Vasectomy Festival. We got the best 52 doctors in Thailand

to come and offer free vasectomies. Also, we have this so-called telephone vasectomy: I was the chairman of a telephone organization in the early days of the mobile telephone; they were big; and when you had a vasectomy, you could ring home and tell your wife: Honey, I'm on the table right now. Also on the 4th of July we provide the Independence vasectomy in honour of the USA.

We also do it on the Australian National Day and call it the Kangaroo Vasectomy. The Australian Embassy gives us wine and Foster's beer. Before the doctor does a vasectomy, the client has a bit of wine or beer; the doctor also takes a sip, but only a tiny one. We have the Chopstick vasectomy, the Vodka vasectomy, many occasions combined with fun. Don't make it dull; make it like going to a movie, not like going to church. We even have Father's Day vasectomy; they bring their fathers for the vasectomy. We encourage children to bring their fathers saying: "Look, if you don't want your inheritance to be divided by a larger number, bring father for a vasectomy." We make it fun; everyone is involved, so it is not some doctor or some government, it is the people's movement, that's why it works.

Let's remember the very beginning of family planning in Thailand. We realized that family planning was also an issue of poverty. So we invented programmes, considered both problems. I said to the poor people: "We have the Buffalo family planning ploughing service, we plough your field and you pay only half price if you practice family planning." We also introduced the non-pregnancy pig-raising programme, which said: Spacing is very good, when you space, you earn money. If you are not pregnant for one year, you get two pigs to raise on credit for that time; if you are not pregnant for two years, you get four pigs to raise; if you are not pregnant for three years, you get six pigs to raise for that time. And they began to realize: My gosh, if I am not pregnant, I earn a lot of money. If I am not pregnant for four years, I can form a pig cooperative. People became so good at this, they became major pig raisers. We even had a Microcredit programme: for every month a person is not pregnant, we put five dollars into the Village fund; if a woman used the pill, then we gave more; if she used sterilization, even more. But everyone could borrow money. This was the beginning of the microcredit fund. And so it went on, e.g., with water tanks, this was assisted by Deutsche Welthungerhilfe from Germany, but in development, not family planning. They paid for the tank, but 25 percent off if you practice family planning. The villages using the best family planning practice got extra help: We work with them on small dams and on water supply systems.

We are now working on employment programmes for elderly people, we give special loans to families that take care of their parents rather than getting

the government to take care of them. Now they have all sorts of income; all of which began with family planning. Growing vegetables and using public land by the railway line is sponsored by companies. All in all, poverty is being wiped out by asking the companies to work with us. We currently work with about 150 companies, banks, insurance companies, and architectural firms, to name a few. They help in the villages and in many, many of the areas. We now are working on what we call the Minifarm, 12 metres by 12 metres for elderly people, sick people and handicapped people, and they can earn about two-thirds of a factory wage with three hours of work, one and a half in the morning, one and a half in the afternoon. We go along with the tide, we raise crickets and frogs. The frogs make very, very good money; also the escargots, and – mushrooms! 500 percent return of investment!

Also the NGOs must learn to make money. Steven Sinding mentioned that Pro Familia, a very good organization, doesn't earn enough money – of course not, because they stick only to family planning. We have many activities: we have restaurants, we give out condoms after the meal, we show what we do in the villages in the restaurants, we have about 500 people each night, we've got condoms all over the place. The restaurant is very good, and we have a sign saying: Sorry, we have no mints, please take a condom instead. So after the meal, we give out condoms. We have shops, we have factories, we have resorts. Who says NGOs can't own and run a good hotel? I just wanted to let you realize that nothing is new. All these things we are doing, someone else has done it before. But bring it into our arena, we need to help ourselves. I don't want your money forever! IPPF gave us contraceptives for five years only, and they gave us contraceptives for onother five years only, we managed to earn the money. And these are the things that we should do. I think as donors, you've got to help the NGOs become financially independent. The only way to help them and train them is to provide some loan, some grant. That's how we got started.

Basically, I'd like all of us here to say what additional things we can do, it doesn't have to be new, but it has to reach a new target, a new height, and I hope that Europe can replace America as the key supporter of our endeavours towards self-help and self-sufficiency in the long term. We don't want you to be donors forever, because we don't want to be beggars forever. So help us to do so by helping us to help ourselves.

Annexes

Recommendations

International Dialogue on Population and Sustainable Development

Ways out of the Crisis-Reproductive Health in Need of New Ideas

October 14, 2003
GTZ house, Reichpietschufer 20,
10785 Berlin

Deutsche Stiftung Weltbevölkerung

gtz Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH

International Planned Parenthood Federation

kfw Entwicklungsbank

in cooperation with

Federal Ministry for Economic Cooperation and Development

SCHERING making medicine work

Condition 1 – Successes have been achieved in the field of sexual and reproductive health. Many programmes have been implemented since the UN Conference on Population and Development (ICPD) in 1994.

Action 1 – In the future, the success of reproductive health will depend on the way it is integrated, firstly, into comprehensive national frameworks for the eradication of poverty in developing countries; secondly, into the Action Programmes to achieve the UN Millennium Development Goals, and finally, into Poverty Reduction Strategy Programmes by the World Bank.

Condition 2 – After the major UN conferences of the 1990s, a certain conference fatigue has emerged.

Action 2 – The time for discussion is over. We need to draw conclusions and take action. Focussing on regional working groups and assessing the results are the way forward.

Condition 3 – It is an acknowledged fact that Overseas Development Aid funding is decreasing across the board, and that the forces of conservatism are growing.

Action 3 – Current political issues must not dominate the agenda. The international consensus achieved in 1994 is the foundation on which future action should be based.

Condition 4 – The level of population growth in some African, Asian and Latin American countries is still very high for those economies to sustain.

Action 4 – In view of this population development; family planning and reproductive health must remain specific, focused areas of action.

Condition 5 – Both HIV/AIDS campaigns and family planning strategies deal with a variety of issues: education, early marriage, sexual violence, the responsibility of men and access to reproductive health services.

Action 5 – Alliances with the international and national HIV/AIDS communities are of utmost importance. They constitute the perfect base for joint action.

Condition 6 – The current availability of contraceptives is insufficient.

Action 6 – Reproductive health projects should always take into consideration that a sufficient quantity of contraceptives should be available. The traditional instruments like social marketing and social franchising must be continued. Safe motherhood and birth spacing programmes should be given a higher profile at both national and international level.

Final recommendations for immediate action:

- stronger involvement of the media and better information and education on sexual and reproductive health issues
- national and local governments should mobilize Public Private Partnerships
- action HIV/AIDS prevention services should work closely with family planning associations and public health services

Press Reviews

Deutsche Welle radio
English programme "World in Progress"

Responsible editor: Anke Rasper
Interview: Michael Lawton

Ten years after the Cairo International Conference on Population and Development, it's a good time to look back at what has been achieved as well as to look ahead at what remains to be done. Most countries that signed up to the resolutions in 1994 have not kept their promises. There are more than six billion humans on earth now and the world's population keeps growing. Thus all over the world family planning and reproductive health are key issues when it comes to economic and social development. In a nutshell the idea is to give more families the chance to decide how big their families should be.

Having many children used to be the only chance for many poor families to make sure some survived and could care for their parents in old age. But today, if a family has less children who are well educated, they have much better chances to survive, remain healthy and live longer. Yet to make it possible for people to have more choices, programmes, information and access to adequate medical care is needed. Some countries like Thailand have already successfully adopted such programmes. Over the past decades they have managed to reduce their birthrates to two or three children per family instead of the previous five or six. Thus Thailand and other countries have achieved better living conditions for their people.

But different aproaches are needed for different countries and new challenges like AIDS to name only one. Michael Lawton met international experts debating success, failures and future strategies in family planning and reproductive health at a conference in Berlin.

Michael Lawton: Dr Steven Sinding, Executive Director of the International Planned Parenthood Federation, has given a rather mixed summary of what's been achieved since the Cairo Conference.

Steven Sinding: I think that we've continued to make good progress since Cairo in family planning. Although in recent years the amount of money being provided for family planning has actually declined quite dramatically. We made very little progress in reducing maternal mortality. In fact the numbers today are almost exactly the same as they were in 1994 and in 1987 in terms

of the proportions of women who are dying as a result of pregnanc-related problems.

Michael Lawton: But as you can hear, the summary is mostly negative, and that's largely because the countries who signed up to the Cairo Conference resolutions in 1994 haven't kept their promises. According to the plans, the countries of the world should have contributed some 17 billion dollars in the year 2000. In fact, they are contributing less than 10 billion. Only a quarter of that comes from the wealthy donor countries, while the rest comes from the developing countries. Reproductive health, as it's called, is obviously not at the top of the agenda for most governments. So there was a lot of complaining going on. But complaining isn't enough, of course, and the work has to go on. The American Catalyst Consortium, for example, has been drawing together research which shows convincingly that mothers and babies are likely to be healthier if mothers wait at least two years, and even better three years, between pregnancies. Well, you might have thought that was obvious. So I asked Victoria Baird of the Meridian Group International, one of the organizations involved in the Catalyst Consortium, whether they'd provided any studies to prove what everybody knew already.

Victoria Baird: The big news is the fact that there are these studies, and before there were studies it has always been a very simple basic idea. And it is interesting to present this to a group of professionals in family planning. We all say: "Yes of course we have always known that!" and yet I have had several people come up to me today and say: "Yes, but we never heard that there are, we never had these facts and figures." So we can take these people and say: "Look, here is the scientific proof!"

Michael Lawton: So now reproductive health professionals can go to policy makers and say, it's not just a feeling I have, here's the proof. And there are also figures in those studies that highlight just where the problem in its most dramatic form is. For example it's alarming how many young women between 15 and 19 years of age have a second baby within three years of a first. Studies in Latin America show that in several countries, some 85 to 95 percent of girls who have had one baby have another within three years. That highlighted another prominent issue in current thinking on reproductive health: how to talk to young people? Obviously those young women in Latin America have not heard or are not listening to the messages the health centres are sending out. Jörg F. Maas is executive director of the German Foundation for World Population and he's been particularly concerned with the challenge of providing services for young people.

Jörg F. Maas: If you look at the population at the moment with about 6,2 billion people living in the world, half of this number are people under the age of 25. So we feel that if you want to change the future of this world and if you want to change the future of some of these countries, especially in the developing countries, we need to focus on that target group. If you look at the situation in Africa and South East Asia, young people are the most vulnerable group when it comes to STD, sexually transmitted diseases, as well as HIV/AIDS and unprotected practices, because young people simply do not have access to information, and they don't have access to services.

Michael Lawton: But why can't young people simply go to the same doctor or clinic as older people?

Jörg F. Maas: It's embarassing if there is – let's say in Kenya – only one clinic in a very remote area. Maybe in the northern part of Kenya where young people are visiting the same clinic as their parents or their relatives. We need to deal with a privacy issue, when we talk about providing adequate access to services young people without embarrasing or rejecting them. We also heard about cases where young people were rejected by clinical staff members just because the staff members felt that young people that age simply should not have sex. We must have youth-friendly services.In order to reach out to young people, we must look at how most of us got sex education when we were young: we spoke with our peers first, and only when we had more pressing questions did we talk to our teachers or parents or whomever. And because of this we support family planning, HIV/AIDS prevention, when we train peer educators or peers, young people, to become educators of, and counsellors to, their own people.

Michael Lawton: So, among its many activities, the German Foundation for World Population supports, for example, football clubs in the Mathare slum district of Nairobi, Kenya, that get the reproductive health messages out to football-mad young men, or a chain of over a hundred youth clubs in Ethiopia, set up by Non-Governmental Organizations that are responding to the needs expressed by young people themselves.

Jörg F. Maas: A group for instance called Safer Generation just started their activities because five of their friends recently died of HIV/AIDS. So they felt if they could make a difference for their peers, and friends by providing adequate information that could save their lives then they would do so. More and more young people are getting involved in NGOs or starting up youth clubs because they feel they must start getting the message out themselves and that this is the only effective way of doing so.

Michael Lawton: "Peer education" is also the watchword of Mechai Viravaidya, a charismatic Thai politician who has revolutionized his country's

population policy. In the beginning, his organization trained a couple of midwives in each village in how to distribute contraceptives, then extended the scheme to local hairdressers and dressmakers, and then began to offer loans to people who didn't get pregnant for a certain time. When he started in the seventies, the birth rate was six children per family, and it's now down to 1.6. And what is more remarkable, he doesn't receive any funding from donor organizations in the wealthy west. His reproductive health activities are financed by a for-profit section that makes enough money to support the other programmes.

Mechai Viravaidya: NGOs can not succeed in the long term by begging. If our parents can't help us to help ourselves, so how can any of the donors? That's the way agencies have to work, and they have to plan a final exit from these countries. Like colonialization there has to be an end. So all NGOs around the word must begin to have a second arm, a separate legal entity, registered companies, pay taxes and do business. We call them businesses for social progress and use the profits of these companies to give to the NGO. As long as it is an honest business, it can make money. We have restaurants, we have construction companies, we have real estate companies – nothing to do with family planning, only with making money for our work in development, poverty reduction, and enviromental education.

Michael Lawton: But most NGOs around the world don't have the ability to think across categories like that. Although many do raise money from activities connected to their main task – by selling contraceptives to those who can afford them, for example – they'll never manage to fund themselves completely that way. But, says Tewodros Melesse, Regional Director, Africa Region, of the International Planned Parenthood Federation, even in a continent like Africa, where the problems of overpopulation, poverty and the AIDS pandemic come together most dramatically, the countries can't just rely on the begging bowl. They must show that the issue of reproductive health is a priority for them before they can expect anyone else to take them seriously.

Tewodros Melesse: African governments should be taking the lead. They should act to counter the perception that reproductive health is an agenda of the West or an agenda of the donor community. That's the only way that reproductive health, HIV/AIDS and population programmes in African countries are taken seriously by the population, when their own governments are committing their resources. Because the health budget is currently far below what is required for the whole continent. So if you want an increase in funding from the donor community, we must invest our own resources.

Michael Lawton: And convincing donors is getting harder, as donor countries cut their development aid budgets. Learning to live with less money will be one of the callenges of the next 10 years.

Presenter: And it looks like the financing situation is not going to improve in the next few years. But it is not only the funding for programmes that is presenting an challenge. Different polices and points of view play an important role as well. Especially with regard to the way problems are tackled by different governments, one example being the United States. Potentially a big donor of money for international aid programmes, the US policy on family planning has risked critisism with many family planning activists in recent years. Many say that fighting AIDS and giving people access to information about sexually transmitted diseases must be linked with programmes on family planning and reproductive health. Conservative Americans claim this would only promote abortion. Yet activists like Steven Sinding reject that view. He is the new Executive Director of one of the most influential organizations involved in family planning, the International Planned Parenthood Federation, IPPF, that was also mentioned in our earlier report. The IPPF is based in Britain, but has offices all over the world and provides help millions of people in many different countries. Michael Lawton asked Dr. Sinding, about the challenges the Reproductive Health field is facing.

Steven Sinding: We just have established a new global strategic plan, which has five priorities. We call them the five "a"s. The five "a"s are: HIV/AIDS, access for the poor and the excluded to RH-services, advocacy – because we recognize that as an NGO, we can not do everything by ourselves, we have to get governments involved, as well as abortion – particularly the problem of unsafe abortion which is a major killer. We view the five "a"s as the great unresolved challenges in reproductive health. But also many of these subjects, which are controversial – programmes for youth, abortion, even HIV/AIDS – are areas that many governments are reluctant to get involved in, so it is a natural field for non-govermental groups like the International Planned Parenthood Federation to focus on to ensure that governments do pay attention and that these difficult problems are not forgotten.

Michal Lawton: To what extent do you think governments have to take the lead and through political action and to what extent is it up to the individual? How much can you expect to achieve by convincing people to behave differently?

Steven Sinding: We actually have quite a lot of information related to that question. And what the data tell us is that most women want between two and three children. Today on average they have between three and four children. So there is a gap, an unmet need, that is equivilant to about one

child per woman. If we could close this gap, simply by making information and services available, there would be no need for population policies.

Michael Lawton: And what's stopping this from being achieved?

Steven Sinding: For most of that population which would have fewer children if they could, the primary obstacle is lack of effective access to inexpensive, save and effective contraception. In many parts of the world, that's a physical issue. In Thailand everybody in the country is within three kilometres of a source of contraception. In Uganda that figure is 15 kilometres. Equally important is cost. Without the resources that the countries committed at the time of Cairo, it's impossible to reduce the cost of delivering services to a level that is affordable for the poorest and those in greatest need of information services. It's not just a resource issue, however. There is a demand issue. There is no question that in many countries people still want large families, or they feel compelled by their religious leaders to stay away from contraception, even though they think it might be good for them. So it's a combination of reducing the barriers to access and of continuing to try to encourage people to understand that family planning is not a taboo.

Michael Lawton: You had to fight over many years with the opposition of the Catholic Church and certain Muslim circles to the whole idea of contraception and in recent years you have had to fight with the United States as well and its opposition to a policy that appears to be supporting abortion.

Steven Sinding: I respect the philosophical and moral basis upon which religious leaders oppose contraception.

Many of them believe, erroneously I think, that widespread promotion of contraception promotes promiscuity and contributes to the breakdown of a moral order as they define it. What we find is that when one offers individuals a choice, some opt to limit their fertility, and some don't, and one has to respect that. What we oppose is the attempt on the part of religious groups to impose their own morality on the entire population. What the US Government has done and what many in the Catholic Church attempt to do, is to prevent governments from providing information and services to enable people to make an informed choice, and we think this is wrong.

Michael Lawton: What is your response to the American Government, which sees the whole issue of reproductive health as basically a pro-abortion campaign?

Steven Sinding: Well, we say that's nonsense. When we look at the Cairo Programme of Action, the question of abortion is very, very carefully handled. What the document says is, where abortion is not against the law, governments should work to ensure that abortion is safe. That's a very clear

statement. It doesn't state anywhere that RH services must include abortion. It's quite to the contrary. The US Government is systematically misrepresenting what the Cairo Programme of Action says and it's doing so under intense pressure from a religious minority in the US that includes elements of the Roman Catholic Church, which have a significant standing in George Bush's Republican Party.

Michael Lawton: We are half way through the 20 year Cairo process. What do you expect the situation to be in 20 year's time? Will you be near to reaching the goals that were agreed upon?

Steven Sinding: That depends on a couple of things. It depends first of all, on whether George Bush is reelected and the role that the US Government assumes. It's hard to overstate the importance the US played in creating the Cairo consensus under the Clinton administration. And it's equally hard to overstate the damage that is being done to that consensus by the Bush administration. The second factor is the availability of funds over these next 10 years. A great deal of progress has been made at the level of getting policies right. Implementing those policies now that they are in place is going to require adequate resources and that's going to depend a lot both on the developing countries and the priority that they give to reproductive health whithin their own budgets as well as the generosity of the international community. These two aspects are interlinked: developing countries do to a considerable degree take their signals from what the donors are willing to finance, or from what they regard as being important.

Donor priorities will have an impact on the priority that developing countries give to reproductive health. There is a third factor, and that is whether or not the HIV/AIDS community and the reproducitve health community can more effectively combine forces and come together. There is a lot of money out there for HIV/AIDS if we can channel it through institutions that are focused on the whole range of reproductive health issues that families face, then I think that we can make enormous progress.

Presenter: That was Steven Sinding, Executive Director of the International Planned Parenthood Federation, talking to DW's Michael Lawton.

[International dialogue in Berlin on population policy]

Ten years of the Cairo Action Programme – no reason to celebrate

Following the disappointing results of the Johannesburg World Summit on Sustainable Development 10 years after the Rio 'Earth Summit', the United Nations has tired of celebrating decadal anniversaries. No big official event is planned for the 10th anniversary of the Programme of Action adopted in September 1994 at the UN International Conference on Population and Development in Cairo. The world body is limiting itself to regional conferences and is leaving the main initiative to the NGOs that are preparing an extensive interim assessment of the 20-year programme.

Studies + Reports

That there will be no 'Cairo plus 10' is due not only to the general 'conference fatigue'. It is also because the USA - which was a driving force of the action plan 10 years ago – has under the Administration of Bush Junior made a 180-degree turn on population policy. This was discussed at the Second Population Policy Dialogue of the GTZ, the German Foundation for World Population (DSW), the KfW, the Schering pharmaceuticals company and the International Planned Parenthood Federation (IPPF) in Berlin on October 14. IPPF President Steven Sinding said Washington, in line with the Vatican, had in the meantime interpreted the Cairo vocabulary, especially the term "reproductive health", as an encouragement of unrestrained sex and legitimation of abortions.

Photo: Tilmann Elsner

An invitation to unrestrained sex? The USA has largely backed off from a population policy which aims to educate people, not only preaches abstinence to them.

The dialogue participants were unanimous in calling on the industrialised nations for a stronger financial and political engagement in international population policy. They heard that of the US$ 17 billion the rich countries pledged in Cairo to 2000, only half has been paid in so far. Contraceptives, staff and material for education campaigns and advisory services on pregnancy are lacking everywhere. In Africa, for example, there is still no condom factory, and foreign products, particularly those from Thailand, often are not accepted. Family planning concepts, such as the Optimal Birth Spacing Initiative (OBSI) of USAID, which aim at achieving longer intervals of three to five years between births, must be promoted more strongly. In Latin America and the Caribbean, for instance, maternal mortality has declined by more than 14 per cent in recent years as a result of extending the space between births to an average of two to three years. Worldwide, 585,000 women die each year due to unacceptable conditions during pregnancy and giving birth.

Johannes Wendt

Familienplanung und Reproduktive Gesundheit vernachlässigt

(di) Auch zehn Jahre nach der Bevölkerungskonferenz von Kairo sind Familienplanung und Reproduktive Gesundheit noch immer „Stiefkinder der öffentlichen Finanzierung", so der Befund der Gesellschaft für Technische Zusammenarbeit (GTZ). Eine gemeinsam mit der Deutschen Stiftung Weltbevölkerung, Kreditanstalt für Wiederaufbau, International Planned Parenthood Federation (IPPF) und Schering in Berlin durchgeführte Tagung zum Thema stellte die Entwicklungsorganisation unter den Titel: „Wege aus der Krise – Reproduktive Gesundheit braucht neue Ideen".

Nach Einschätzung von Steven Sinding (IPPF) läuft der anhaltend schlechte Zugang zu Gesundheits- und Aufklärungsprogrammen besonders in ländlichen Gebieten nicht nur den in Kairo formulierten Zielen zuwider, sondern untergräbt auch die Millenniumsziele. Sinding beklagte, dass die in Kairo getroffenen Finanzierungsvereinbarungen nicht eingelöst werden. Nur rund die Hälfte der in Kairo veranschlagten Mittel – 17 Milliarden im Jahr 2000, ansteigend auf jährlich 23 Milliarden bis 2015 – stünden tatsächlich zur Verfügung. Das Thema Reproduktive Gesundheit sei durch andere Themen verdrängt worden. Der konservative „backlash" in den USA in Aufklärungsfragen, die damit verbundenen Zahlungsausfälle für den United Nations Population Fund sowie die Stagnation der öffentlichen Entwicklungsfinanzierung (ODA) verhindere Fortschritte zusätzlich. Die Abtreibungsdebatte in den USA nannte Sinding eine „Attacke gegen die armen Frauen der Welt".

Als gangbaren Weg, um aus Stagnation und Krise herauszukommen, verwies Mechai Viravadaya, Vorsitzender der Population & Community Development Association (Thailand) auf Kampagnen nach thailändischem Muster. Wo neun Ärzte auf eine Million Menschen kommen, „funktioniert das Westmodell nicht", sagte er und empfahl die Bemühungen Bangkoks, Familienplanung zu einer breit angelegten gesellschaftlichen Angelegenheit zu machen. Im Land verteilen zum Beispiel selbst Polizisten oder Taxifahrer Kondome, Familienplanung wird wirtschaftlich belohnt.

„Kairo ist kein gängiges Thema", resümierte die SPD-Abgeordnete und Entwicklungspolitikerin Karin Kortmann den deutschen Bewusstseinsstand. Immerhin beinhalte das Aktionsprogramm 2015 der Bundesregierung auch diese Aspekte. Zugleich gingen die Haushaltskürzungen nicht zuletzt zu Lasten der reproduktiven Gesundheitsvorsorge. Kortmann wandte sich gegen eine „verstaubte Vatikanideologie" und wünschte sich ein verstärktes Augenmerk des Parlaments auf Fragen der reproduktiven Gesundheit.

● (ck) **Globalisierung verursacht nicht nur Risiken, sondern auch Chancen für die Bevölkerungsentwicklung**, erklärte Franz Nuscheler, Direktor des Instituts für Entwicklung und Frieden (INEF), Duisburg, bei einer Fachtagung der Deutschen Gesellschaft für die Vereinten Nationen Anfang November in Berlin über Wege aus der Bevölkerungs- und Ernährungsfalle. So könne die kulturelle Globalisierung von Werten, besonders von Frauenrechten, auch das generative Verhalten beeinflussen. „Das ist eine unbedingt positive Wirkung", so der Entwicklungsexperte.

Gentechnik als Lösungsweg für das Ernährungsproblem sei mit Vorsicht zu betrachten, meinte

Programme

International Dialogue on
Population and Sustainable Development

Ways out of the Crisis-
Reproductive Health in Need of New Ideas

October 14, 2003
GTZ house, Reichpietschufer 20, 10785 Berlin

10:00 am Registration

11:00 am Welcome
Opening

An outline

11:30 am Topic I

Family Planning and Reproductive Health:
Where is the international community headed?

Dr Steven Sinding, Director-General, International Planned Parenthood Federation (IPPF), London

New Approaches, New Ways? Two Examples

12:15 pm Topic II

Birth Spacing:
Presenting the "Catalyst Consortium" programme

Victoria Baird, Director, Meridian Group International, Washington, D.C.

12:45 pm Topic III

CELSAM: Family planning for young people in Latin America

José Luis Corral Ruiz, Executive Director, Centro Latino-americano Salud y Mujer (CELSAM), Mexico

1:15 pm Lunch break

2:15 pm **Workshops with Output in Preperation of Cairo plus 10**

Input and moderation:

Topic I **Dr Wolfgang Bichmann,** Vice President, Sector and Policy Division Health/Sub-Saharan Africa, Kreditanstalt für Wiederaufbau, (KfW), Germany

Topic II **Dr Assia Brandrup-Lukanow,** Director, Division of Health, Education and Social Protection, Deutsche Gesellschaft für Technische Zusammenarbeit, (GTZ), Germany

Topic II **Dr Jörg F. Maas,** Executive Director, German Foundation for World Population, (DSW), Germany

4:30 pm **Presentation of Results**

Dr Wolfgang Bichmann, Dr Assia Brandrup-Lukanow, Dr Jörg F. Maas,

5:30 pm Coffee break

6:30 pm **Plenary Discussion**

Visions – Ways out of the crisis – challenges prior to Cairo plus 10

Input and moderation

Mechai Viravaidya, Senator and Chairman of the Population & Community Development Association, (PDA), Thailand

Guests:

Safiye Cagar, Director of the United Nations Population Fund, (UNFPA), Geneva

Karin Kortmann, Member of the German Bundestag, Germany

Dr Gunta Lazdane, World Health Organization, (WHO), Copenhagen

Dr Steven Sinding, Director-General, International Planned Parenthood Federation (IPPF), London

8:30 pm Reception

Curricula Vitae

Dr Steven W. Sinding

is Director-General of the International Planned Parenthood Federation. Immediately prior to joining IPPF, Dr Sinding was Professor of Population and Family Health at the Mailman School of Public Health, Columbia University, a position he assumed in September 1999, and Adjunct Professor of Public Policy at Columbia's School for International and Public Affairs.

From 1991 to 1999, Dr Sinding served as Director of the Population Sciences programme at the Rockefeller Foundation. He served in 1994 as a member of the United States delegation to the International Conference on Population and Development at Cairo.

Victoria Baird

is the founder and director of Meridian Group International, Inc. (Meridian) which is dedicated to promoting family planning, reproductive health, gender equality, and socio-economic development. A key focus for Meridian is spearheading the development of innovative public/private sector partnerships. Prior to founding Meridian, Ms. Baird was Director of USAID's Social Marketing (Somarc) project where she directed marketing initiatives in 31 countries throughout Asia, Africa and Latin America. Ms. Baird began her career in the private sector where she worked with major international corporations such as Colgate Palmolive, Estee Lauder and Lever Brothers.

José Louis Corral Ruiz

is Regional Market Expansion Manager of Centro Estratégico Canada Latinomérica (CECLA). He is responsible for the development of, and new strategies for, the Latin American market. He is also Executive Director of Centro Latinomamericano Salud y Mujer (CELSAM), Latin America. He is in charge of concept development, integration into the NGO's area, as well as funding; the objective of his work is providing information, education and orientation in the field of women's health in Latin America.

set up the Population and Community Development Association (PDA) in 1974. Today, PDA is the largest Non-Governmental Organization in Thailand. Mechai Viravaidya has hold several ministerial positions, including that of Deputy Minister of Industry, Speaker of the Government and Minister for Tourism, Information, Economic Cooperation and AIDS Prevention. Mechai Viravaidya is an internationally recognized consultant. He lectures at the Harvard University. Currently, he is involved in preparing the XV International AIDS Conference that is scheduled to be held in July 2004 in Bangkok, Thailand.

List of Participants

Family name	First name	Institution	Town
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Claeys	Vicky	International Planned Parenthood Federation, Europe	Brussels

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Hauert	Christiane		Hamburg
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