

# Reproductive Health Policies and Programs In Eight Countries: Progress Since Cairo

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**Context:** Although many countries adopted the Programme of Action drafted at the 1994 International Conference on Population and Development (ICPD) in Cairo, little is known about countries' experiences with revising reproductive health policies and implementing programs since then.

**Methods:** In-depth interviews were conducted in 1997 with stakeholders in eight countries—three in Asia (Bangladesh, India and Nepal), three in the Middle East and Africa (Jordan, Ghana and Senegal) and two in Latin America and the Caribbean (Jamaica and Peru).

**Results:** While all but two of the countries have adopted the ICPD definition of reproductive health and all have initiated policy reforms to reflect a new focus, less has been accomplished in implementing integrated reproductive health programs. Several challenges face all eight countries as they continue to design reproductive health programs: improving knowledge and support among stakeholders; planning for integration and decentralized services; developing human resources; improving quality of care; and maintaining a long-term perspective regarding the implementation of the Cairo agenda.

**Conclusions:** The next critical steps needed for moving from policy formulation to program implementation are to help countries set priorities for establishing integrated reproductive health interventions, to increase financing for services and to develop strategies for delivering them.

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Since the International Conference on Population and Development (ICPD) held in Cairo in 1994, many countries have worked to adopt the recommendations set down in the conference's Programme of Action. To date, however, the experiences of individual countries in revising their population policies and programs to focus on improving reproductive health have rarely been documented.

In this article, we present case studies from eight countries conducted to assess their progress in implementing the Cairo Programme of Action. These countries—Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru and Senegal—span a di-

verse range of cultural, social, economic and family planning program contexts. For reasons of space, we cannot discuss at length the reproductive health contexts in each country, although they are clearly relevant to the policy and programmatic issues that are the focus of the case studies.\*

## Methodology

The eight case studies were conducted between July and December 1997 by staff from The POLICY Project, a five-year project to improve the worldwide policy environment for family planning and reproductive health. The data were gathered from in-depth interviews with 20–35 key individuals in each country, using a standard, but flexible, interview guide. Interviewees included representatives from government ministries, parliaments, academic institutions, nongovernmental organizations (NGOs), women's groups, the private sector, donor agencies, U.S. technical assistance organizations and health care centers.

This article describes the information gleaned from these interviews on progress

in implementing reproductive health policies and related program activities in each country, including that country's definitions of reproductive health and priorities; how policies have developed; the participation of stakeholders in policy-making; which groups have supported and opposed the new reproductive health approach; the role of the private sector and of NGOs; how services are being implemented; the sources of funding for reproductive health; and the challenges that remain. The content of the interviews reflects the situation at the time the interview took place and the data are presented by region.

Table 1 summarizes the progress each country has made in six stages of the process of adopting and implementing reproductive health programs: officially adopting the ICPD's definition of reproductive health,<sup>†</sup> fully involving stakeholders in the making of policy and the planning of programs; receiving support for reproductive health care from stakeholders; establishing priorities among the many elements that make up the reproductive health agenda; implementing a national reproductive health program; and mobilizing resources to support a reproductive health program.

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\*For a more detailed discussion, see: Hardee K et al., *Post-Cairo Reproductive Health Policies and Programs: A Comparative Study of Eight Countries*, POLICY Occasional Paper 2, Washington, DC: The Futures Group International, 1998.

†A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. (See: United Nations, A/CONF.171/13, International Conference on Population and Development, Cairo, Egypt, Sept. 5–13, 1994.)

## Asia

### Bangladesh

Rapid population growth has been a concern in Bangladesh for decades. As one respondent commented, “the [1973] population policy is the only policy that has been consistently followed [by the government] for the past 25 years.” Progress in family planning has been impressive, with contraceptive prevalence among married women aged 10–49 having risen from 7% in 1975 to 49% in 1997.<sup>1</sup> However, the maternal mortality ratio remains high—from 450 to 850 maternal deaths per 100,000 live births, depending on the estimation technique used.<sup>2</sup>

In terms of policy, the major impact of the Cairo recommendations has been to induce Bangladeshi policymakers to adopt an integrated service delivery structure, abandoning the vertical structure of the past. The government also adopted the ICPD definition of reproductive health.

A wide range of stakeholders, including the Ministry of Health and Family Welfare, collaborated in drafting the Comprehensive National Reproductive Health Strategy, part of the overall Health and Population Sector Strategy.<sup>3</sup> As a donor stated, “Everybody...is involved in policy-making.” Opposition to instituting a reproductive health focus is limited to a few religious groups, women’s health groups who reject hormonal methods of contraception and others.

The overall health and population strategy advocates moving from vertical projects to a client-centered package of essential services, so that all reproductive health elements are integrated with routine services provided at one service delivery site.\* Currently, the public-sector program is shifting from doorstep contraceptive provision to services offered at static clinics.

The package of essential services involves integrating the directorates of family planning and health within the Ministry of Health and Family Welfare. Currently, these directorates have their own vertical delivery structures and rarely coordinate their efforts; however, there is little political will to force integration. As a donor representative stated, “Our program will not remain successful if there is no integration....How to integrate is a key issue.” Many NGOs, which have more flexibility than government programs, are beginning to implement integrated reproductive health services at their clinics.

The quality of government services in particular needs to be improved when clinical services are expanded. As a respon-

**Table 1. Amount of progress made from 1995 through 1997 toward reaching various goals of the Programme of Action adopted at the 1994 International Conference on Population and Development (ICPD), eight developing countries**

Country	Adoption of ICPD definition	Full participation of stakeholders	Full support for repro. health	Establishment of priorities	Implementation of national program	Government mobilization of resources
Bangladesh	***	***	***	**	**	***
India	***	**	**	**	**	*
Nepal	***	*	*	*	**	*
Jordan	**	**	**	*	*	*
Ghana	***	***	***	**	**	*
Senegal	***	***	**	*	**	**
Jamaica	***	**	***	*	**	**
Peru	**	**	**	**	*	***

\*Little or no progress. \*\*Some progress. \*\*\*Much progress.

dent averred, “Cairo assumes that there is already a good service delivery system in place, but the system in Bangladesh has many problems. Without trained health personnel,... Bangladesh is really starting at the beginning.... Workers don’t know how to handle reproductive tract infections.” The process of educating and training health workers has started, although training institutions need to include reproductive health and the essential services package in their curricula.

Respondents claimed many clients felt that the current family planning program does not adequately meet their needs, noting that providers lack a “client focus” and simply deliver the services that the provider thinks the client needs. Many respondents said that clients receive higher quality services from NGO clinics and private providers than from government sources.

Funding levels for reproductive health have been increasing in real terms in Bangladesh. Donors fund approximately 63% of the total development budget. One donor representative remarked, “Maybe there is too much money here.... Bangladesh has a big program, and the government and the NGOs can play donors against each other. This system sometimes leads to inefficiencies.”

To increase financial sustainability, the government plans to introduce small user fees for public-sector services, which will gradually rise to recover a larger proportion of costs. Nonetheless, some respondents do not consider sustainability to be essential; as one donor representative observed, “Frankly, I don’t see financial sustainability as a problem—the donors and their money will always be here.”

Overall, as indicated in Table 1, Bangladesh has made substantial progress in implementing certain goals of the Programme of Action—particularly in policy adoption, involvement of stakeholders and mobilization of resources. Less

progress has been made in the tasks of setting priorities and of implementing the Cairo recommendations nationally.

### India

Although India has had a population policy in place since the early 1950s, its family planning program, which has relied on method-specific targets set by the central government since 1967, has not been uniformly successful. As of 1992–1993, 41% of married women aged 13–49 used a method, with female sterilization accounting for 75% of all modern method use; the maternal mortality ratio stands at 570 maternal deaths per 100,000 live births.<sup>4</sup>

The clearest impact of the ICPD has been India’s elimination of method-specific targets, an action taken in April 1996. As a government official commented, “Cairo did influence our policies and programs, but India was aware of the problems linked with the target approach.” Unfortunately, the abrupt nationwide elimination of targets, when no alternative had been adequately planned or implemented, led to declines in contraceptive use and caused confusion in some parts of the country.

Historically, NGOs have had little influence on national policy in India, although this may change when plans to integrate reproductive health are instituted. According to a donor representative, “At the ICPD conference...the NGOs and the government communicated at a much better level—a new policy direction emerged [but] it has had more of an impact on rhetoric and at the policy level in India, with not much

\*The reproductive health services covered in Bangladesh’s essential services package are maternal health care (including prenatal care, delivery and postnatal care, menstrual regulation and postabortion complication care); adolescent health care; family planning; the management and prevention of reproductive tract infections and sexually transmitted diseases, including HIV; and child health care (including an expanded immunization program, control of acute respiratory infections and diarrheal diseases, and prevention of malnutrition).

change at the programmatic level.”

There is still opposition to instituting a reproductive health approach in India; for example, an advocate for a demographic approach insisted, “The target-free approach was precipitated by Cairo. This approach is negative for India...[which is] still choking with population pressure.” According to a donor representative, “The government was unable to meet the needs even within family planning... and now the shifts to broader reproductive health service provision. Is it feasible?”

As a result of Cairo, India is committed to several new initiatives, although many respondents questioned whether the reproductive health approach will ever fully be implemented. Components of these initiatives were incorporated into the 1997 Reproductive and Child Health Project,<sup>5</sup> which, with World Bank collaboration, is initiating a district-based planning approach to create an integrated health delivery system.

India has defined a basic package of essential reproductive and child health services\* as part of its new approach. Many respondents, however, felt that unfamiliarity with the new interventions, such as those for sexually transmitted diseases (STDs), and the lack of experience with them would impede their implementation: “Why do something on a large scale in which we have no program experience? Government is approaching the reproductive health issues very simplistically and trying to do things too fast,” stated an NGO representative.

The new approach is further hampered by many long-standing problems. In government health facilities, for example, high staff turnover represents an obstacle to expanding reproductive health services: “One big constraint is related to manpower and the nonavailability of qualified individuals willing to work below the district level.... We need to augment the number of nurses,” explained a ministry official. Several respondents feared that auxiliary nurse midwives already had too many responsibilities (more than 40 tasks).

\*The elements of India’s basic package services include the prevention and management of unwanted pregnancy (including abortion and family planning services, with social marketing and distribution of the pill and condoms); maternity care (including prenatal, delivery and postpartum services); child health care (including breastfeeding promotion, nutrition counseling, immunization services, growth monitoring, acute respiratory infection detection and management, vitamin A supplementation and diarrhea management); and prevention and management of sexually transmitted diseases and reproductive tract infections (including detection and antenatal screening for syphilis).

“How much is feasible for her to do?” commented a population organization representative.

Despite the introduction of the new approach, numerous other problems with services—i.e., the inadequacy of infection prevention, of counseling and of follow-up care and the overwhelming predominance of a single method (female sterilization)—have yet to be addressed.

India’s program has some built-in cost recovery capabilities—one social marketing concern, the Social Marketing Corporation, charges fees for contraceptives, as do some NGOs, and private commercial providers charge for curative services, such as treatment of STDs. However, because such a large percentage of the population lives below the poverty line, respondents felt that the program would continue to need major subsidies. With structural adjustment measures underway, the Indian government will probably not be able to make a sufficient financial commitment to implement the reproductive health approach, and some observers expect donor funds to increase and play an even larger role in supporting the program.

Thus, India’s success in implementing selected aspects of the Cairo Programme of Action has been mixed. The government moved quickly to adopt the concept of reproductive health and to change national policies accordingly, but only some progress has been made in many of the areas highlighted in Table 1, and the resources needed if words are to be turned into action have been slow to materialize.

### Nepal

The government of Nepal, one of the poorest and least developed countries in the world, faces formidable geographic barriers to delivering health care services. Nepal’s family planning program has made modest progress, with modern contraceptive prevalence having increased from 3% of married women aged 15–49 in 1976 to 26% in 1996.<sup>6</sup> The country’s maternal mortality ratio remains quite high—ranging from 539 maternal deaths per 100,000 live births, as calculated by the surviving-sister method,<sup>7</sup> to 1,500 per 100,000, using estimates derived from the general fertility rate and the proportion of births that are assisted by a trained attendant.<sup>8</sup>

Although Nepal drafted a Reproductive Health Strategy in 1996,<sup>9</sup> a government official said, “The reproductive health policy has been conceptualized and intellectualized, but no guidelines have been developed regarding how to approach services.”

Nepal’s Reproductive Health Strategy, which includes all of the reproductive health components outlined in Cairo, is very ambitious. As a U.S. technical assistance worker remarked, “All components of reproductive health are in place but it does not function.... The Family Health Division needs to determine which set of interventions it can realistically provide.”

Few stakeholders are involved in policy-making. For example, despite the fact that NGOs are very active in Nepal (with the Nepal Family Planning Association among them) and that an NGO coordinating council was established in 1995, one representative commented that “NGOs are not really involved in development of plans. Government does not truly consider the NGOs their partner. Such talk is jargon.”

Support for reproductive health among policymakers is generally low. As one Ministry of Health official complained, “First it was known as MCH, then family health and now reproductive health. Half the money just goes into disseminating the new concepts and counseling health workers.”

Most respondents cited the lack of trained staff as a crucial impediment. As one ministry official commented, “Workers who were trained five years ago need to undergo refresher training. We need to change their mindset because a lot has happened since then.”

Some respondents felt strongly that reproductive health is an inappropriate focus for Nepal, given the government’s inability to provide even the most basic health care. Most health facilities still lack basic amenities such as running water and latrines.<sup>10</sup> Nonetheless, the Ministry of Health is keen to identify a set of realistic priorities within the constraints of the existing health infrastructure and resources.

Most respondents said that Nepal has insufficient funds to embark on expanding reproductive health programs. Currently, donors fund 58% of primary health care activities in Nepal. However, many donors are cutting back or at least not increasing resources. In addition, as one NGO respondent stated, “The Ministry of Health is not in a position to dictate its terms to the donors, with the result that different donors are committed to different subcomponents.” Another NGO representative commented, “Many more resources are needed. Cost recovery efforts are small, even within the NGO sector.”

In Nepal, then, progress toward the Cairo goals has been slight in all areas other than policy adoption (Table 1). In

particular, support for reproductive health services is limited, stakeholders are little involved and resources have so far not been mobilized behind the implementation of such services.

## The Middle East and Africa

### Jordan

Although Jordan established its National Population Commission in 1973, family planning services only became available from the government in 1980. By 1997, the contraceptive prevalence rate was 53%.<sup>11</sup> Jordan's current maternal mortality ratio is relatively low—44 deaths per 100,000 live births.<sup>12</sup>

Jordan has reached no consensus definition of the term “reproductive health.” Support for a broader definition—which includes maternal and child health activities—has increased over the past several years among national leaders, health ministry staff, religious leaders and the public. No organized support for or opposition to the reproductive health approach exists in Jordan.

The National Population Commission and its members from NGOs and universities make the nation's population and reproductive health policy. They have succeeded using a low-key technical approach—that is, making politically and socially acceptable advances through the work of small expert groups, and then building a wider consensus for these advances. Currently, a small technical group from the commission is using this approach to revise Jordan's 1996 National Population Strategy<sup>13</sup> to reflect some of the ICPD recommendations.

A number of respondents noted the challenges facing the joint work of the commission and the health ministry. For example, some senior ministry officials believe that they should have complete control over policy-making and over donor funds.

While roughly one-half of the Jordanian respondents agreed that Cairo had brought about positive change, one ministry official noted, “We [recently] changed our terminology from ‘family planning’ to ‘reproductive health’.... In practicality, we still deliver maternal and child health and family planning.” Another ministry representative noted, “There is no difference in the offering of services before and after ICPD.... We need the infrastructure [to incorporate new services].”

An NGO respondent described the problem of integrating all components of reproductive health care: “People don't know how to integrate. They are asking for a model. It is not just physical inte-

gration, but system integration.” Among the NGOs, the Jordan Association for Family Planning and Protection has started introducing new services, such as STD screening and management, early detection of breast and cervical cancer, infertility counseling and information for youth.

According to some respondents, service providers need continuing education and training in reproductive health and family planning, and some still need to be convinced of the benefits of family planning and reproductive health. A few respondents underscored the problem of the lack of female physicians, especially in rural areas, which prevents many women from seeking reproductive health services out of embarrassment over being examined by a man.

Opinions on the adequacy of current funding levels were mixed. One government official noted that limited donor funding was behind Jordan's inability to implement population policy. In contrast, a representative from a U.S. technical assistance organization implied that funding was currently adequate: “Funding levels are not bad now, but in the future they may be different with the new implementation plan.”

Overall, Jordan's record so far in advancing the reproductive health agenda is mixed (Table 1), with some progress in adopting policies and in involving and building support for reproductive health programs, but little movement in setting priorities for implementing or finding resources for reproductive health services.

### Ghana

In Ghana, public and private family planning activities in the 1960s and 1970s were followed by a hiatus until the mid-1980s, when renewed efforts expanded the program. As of 1994, 20% of married women practiced contraception, and the maternal mortality ratio was 742 maternal deaths per 100,000 live births.<sup>14</sup> The practice of female circumcision is still relatively common—an estimated 30% of Ghanaian women have been cut.<sup>15</sup>

In 1996, as a result of the ICPD recommendations and a 1995 Ministry of Health assessment of health facilities, a wide range of stakeholders collaborated in drafting the Reproductive Health Service Policy and Standards,<sup>16</sup> and the process of policy formulation was highly participatory. As one NGO representative remarked, “Yes we have input.... The process is quite open, and we can come in with our interests.”

Moreover, a member of the National Population Council added, “For the 1994

National Population Policy, we worked with the Ministry of Health and all stakeholders.... We took a draft to the community to get their input and then revised the policy as final.”

A U.S. technical assistance worker noted that there was very little objection to a reproductive health approach, only a lack of awareness, and that once people become informed, a consensus emerges. Another technical assistance worker explained that workers at a health post “may be baffled if you ask about reproductive health if they have not read the guidelines. But if you ask about each element, then they will say they offer them all.”

As the Ministry of Health disseminates its revised policy guidelines, it educates providers about them. The new standards set down in the 1996 policy document apply to all providers (public, NGO and private), and among the policies of the eight countries, they provide the most extensive “blueprint” for reproductive health service delivery. According to a Ministry of Health respondent, “People wanted guidelines... [including] job descriptions and protocols. The policy spells out some of these things.” The ministry intends to hold workshops to formally introduce providers to the new policy.

Integrated services have developed gradually in Ghana. Reproductive health is not subsumed under one division in the Ministry of Health, but is offered through established referral systems between maternal and child health, family planning, STD care and postabortion care. One university representative, noting that integration was proving difficult, commented, “What to integrate at what level? Some kind of framework is in the reproductive health policy. But you need to look at what is available at each level and [the Ministry of Health] hasn't done this.” Respondents argued that integration does not mean simply adding more responsibilities to health workers' case loads.

Several respondents pointed out that there are many barriers to effective counseling, including the unavailability of space for private conversations, health workers' lack of time and the lack of appropriately trained personnel. According to a technical assistance representative, “What is needed is counseling skills. Real counseling, not just advice.”

Ghanaian NGOs are currently expanding their services to include more components of reproductive health, although resources are lacking. As a representative from the Planned Parenthood Association of Ghana noted, “We use a holistic look at

women's reproductive health problems. We are doing a bit in our clinics...We haven't been able to do much [with STDs]...so we refer to government hospitals....We don't have the money."

Ghana is also attempting to decentralize its health system, with district assemblies being given funding and planning authority to develop government initiatives and provide social services to their communities. As one government official noted, "There is new change on the ground....We need to really lobby [the district health assembly] on why health is important, because there are so many other causes."

A National Population Council member asserted that the government has started to fund more population activities, while others noted that the role played by donors and NGOs is crucial in underserved areas, especially at the district level. Under Ghana's new health budgeting system, donors contribute to a common government fund that is then allocated according to locally set priorities. A government official said, "This way donors respect you more. They quickly find out if you don't [have a specific plan] and then they will push their own agenda." Despite these efforts, respondents noted that Ghana lacks sufficient funds to implement a national reproductive health program.

In summary, Ghana has made great strides in some of the Programme of Action's goals, particularly in policy development and involvement of stakeholders. Efforts to translate those developments into action have been slowed primarily by a lack of resources (Table 1).

### Senegal

A 1920 French law that prohibited the promotion of contraceptives hindered the development of family planning in Senegal until the law was repealed in 1980, when the government began its national program. In 1988, Senegal adopted Francophone Africa's first population policy.

Contraceptive prevalence remains quite low in Senegal, however, with just 8% of married women using a modern method in 1997.<sup>17</sup> Maternal mortality is still high—an estimated 510 maternal deaths per 100,000 live births (for the period 1979–1992),<sup>18</sup> and an estimated 20% of Senegalese women have undergone circumcision.<sup>19</sup>

Reproductive health, introduced as a result of Cairo, is a new concept in Senegal. Even after many workshops were held to disseminate the idea, the concept remains unclear to many people. Most respondents felt that reproductive health is replacing

family planning, both as a term and as a programmatic approach. Some respondents were concerned that the importance of reducing Senegal's high total fertility rate (5.7 lifetime births per woman<sup>20</sup>) might be lost in the new reproductive health focus. One respondent observed, however, "even if it is vague, reproductive health is at least more culturally acceptable than family planning." The health-related elements of the Cairo recommendations are more accepted by Senegalese than are the components focused on reproductive rights and women's rights.

In 1997, in response to Cairo, the government drafted its Program of Priority Actions and Investments in Population, 1997–2001, of which reproductive health is one of three main components (the other two are advocacy and population and development).<sup>21</sup> The reproductive health document proposes activities for all components of reproductive health, with no attempt to set priorities. A U.S. technical assistance organization representative described it as "a wish list [that] the Government of Senegal is shopping around to the donors."

The policy-making process is highly participatory in Senegal, and has been enhanced by the government's decentralization program, started in 1997, which should open up the process further. In that year, the government started transferring financial resources and planning authority for nine of its official departments, including health, to locally elected councils.

Senegal is strongly Islamic and socially conservative, so support for a reproductive health focus tends to be muted. While many respondents felt that opposition from conservatives and Islamic leaders has been overcome in recent years, political leaders and program managers remain very cautious and are afraid to take initiatives that might be seen as controversial. Moreover, the majority of locally elected leaders, whose support has become important thanks to decentralization, know little about reproductive health.

In the three years following Cairo, Senegal developed detailed plans for instituting a reproductive health focus, but implementation is just beginning. Several pilot projects are addressing the specific reproductive health needs of youth and men, and the need to eradicate the practice of female genital mutilation and provide postabortion care.

The Ministry of Public Health and Social Affairs is integrating services at pilot health centers in Senegal's 10 regions. At one such health center, a doctor reported,

"We are tending toward integration." In his clinic, all services were available each day of operation, except for vaccinations, which were offered on designated days each week. In contrast, at other health centers in Senegal, a single provider alternates delivery of various maternal and child health and family planning services on separate days.

Confusion persists about the concept of reproductive health; for example, although a doctor had heard of it, he was not entirely sure of its meaning and noted, "It is a new term, but we have been working in family planning, STDs and AIDS, and maternal health for a long time. I am not clear what it means in practice. Maybe it means we will be getting more money?"

In Senegal, many people have no access to services whatsoever. Several respondents said that the infrastructure frequently goes unused because of a lack of staff, particularly in rural areas—with fewer nurses and midwives working in the public sector each year—and that the ministry does not manage the personnel situation well.

Several respondents said that nationwide NGOs (i.e., the Association for Family Well-Being) set the standard for quality of care. Small community NGOs and women's groups also contribute significantly, particularly in work with youth, men, postabortion care, AIDS and female genital cutting.

According to respondents, the government is increasing funding for health in general, but donors still provide the vast majority of funding for reproductive health care. While cost recovery efforts are increasing, some respondents expressed concern that prices vary widely across communities, and may be out of reach for some populations.

Senegal, then, has made some initial progress in moving toward the delivery of reproductive health care (Table 1), but has done little priority-setting and is hindered by resource constraints and by caution over proceeding too quickly with potentially controversial approaches.

### Latin America and the Caribbean Jamaica

Jamaica has offered family planning services through a national program since the late 1960s. Contraceptive prevalence is high, at 64% in 1997, with a correspondingly low maternal mortality ratio of 120 maternal deaths per 100,000 live births.<sup>22</sup>

Jamaica's National Plan of Action on Population and Development (1995–2015)<sup>23</sup> includes a chapter on reproductive rights

and health, which is not, however, a blueprint for action. "There is a vision of how all these things should be, but... things are proceeding in a piecemeal way," according to a government representative. A donor representative remarked, "Jamaica did a lot to support ICPD, but the translation of those programs back home has been spotty."

Three government agencies share responsibility for policy-making in the area of family planning and reproductive health, including the Planning Institute of Jamaica, the National Family Planning Board and the Ministry of Health. Although the government is attempting to involve NGOs in policy-making, their actual level of participation is unclear. As one NGO representative remarked, "In meetings the government gets [NGO] recommendations for policies... But what notice the government agencies take is another matter; hopefully it goes where it should end up."

The traditionally strong government support for family planning has increased since the ICPD. The provision of reproductive health services for young adults incites the most vocal opposition; the argument that such services are needed to counter the rising prevalence of teenage pregnancies is muting that criticism somewhat, however.

Few Jamaican professionals can define the term reproductive health. Moreover, one government representative commented, "Those most familiar with reproductive health aren't implementers. Those who went to all the conferences don't have time to put it all together."

There are no explicit plans to implement a reproductive health program. Although Jamaica's well-developed network of private providers means that family planning and maternal and child health services are accessible to most women, the program does not serve adolescents (currently a high priority in Jamaica) and men particularly well.

Family planning and maternal and child health services are integrated in the Ministry of Health. As one government representative said, "Integration takes place at the service delivery level. Maybe family planning and maternal and child health services are offered on different days, but the staff is the same. Clients need to know which days to get which services." According to another official, the government has discussed integrating STD and family planning services, with the rationale that, "Realistically, we should start with the big ones—then it will be easier to integrate other reproductive health elements."

Jamaica's family planning association recently participated in a program to integrate STD services into family planning. The program, which included training to help providers break down their biases against STD clients, succeeded in increasing condom use without lengthening the time providers spent with clients.<sup>24</sup>

Staffing shortages and high staff turnover continue to constrain services in public primary health care centers. As a government representative lamented, "There needs to be a critical mass of trained providers to reach the community with reproductive health." However, she continued, "...donors don't want to fund more training."

The government provides no extra funding for reproductive health activities outside the budget for primary health care. As donors are reducing their funding in Jamaica, the government is picking up some of the expenses (e.g., for contraceptives). Most respondents noted that uncertain funding was a constraint to expanding programs, with many echoing the sentiment that "we could do more if we had more funding."

All respondents noted the need to increase sustainability. Although the government is trying to shift family planning users to the private sector, the Ministry of Health is committed to providing free services to at least 40% of the population, as a safety net for the poor.

Prospects for progress on reaching ICPD goals in Jamaica seem promising, with support for reproductive health care from various stakeholders and a positive policy climate. However, Jamaica's government has been unable to establish priorities, and has no firm plans to implement a reproductive health program.

### *Peru*

Until the mid-1970s, Peru considered population growth to be good for economic growth and national security. Gradually, however, a new awareness developed of the possible negative consequences of rapid population growth, and in 1985 the Population Policy Law was passed. Under the leadership of the current president, Alberto Fujimori, the government expanded the national family planning program and in 1995 legalized sterilization as a method. Contraceptive prevalence (64%) is relatively high, although traditional methods account for nearly one-third of all use;<sup>25</sup> maternal mortality is high by Latin American standards—280 deaths per 100,000 live births for the period 1989–1996.<sup>26</sup>

Respondents disagreed over whether the increasing integration of reproductive health into plans and policies in Peru reflected a true shift in philosophy or only a change in terminology. Peru's primary plan to develop reproductive health programs, its Program for Reproductive Health and Family Planning (1996–2000),<sup>27</sup> reflects this new orientation, but some respondents felt that the gap between what is said and what is done remains large.

Coordination of activities between different population institutions shifted from the National Population Council, which was disbanded in 1996, to the Ministry for the Promotion of Women and Human Development, which President Fujimori created partly in response to a commitment he made at the 1995 Fourth World Conference on Women. Many respondents reported that there is no clear division of roles between the new ministry and others, and that coordination is poor.

Expanding access to family planning, both by improving geographic coverage and by broadening the range of available methods, is a top priority for the government. While most nongovernment respondents recognized the need to improve access, some were concerned that the government was placing too much emphasis on lowering population growth and not enough on meeting reproductive health needs. At the time the interviews were conducted, the government's promotion of sterilization was particularly controversial; in response to mounting criticism, the Ministry of Health instituted safeguards, beginning in February 1998, to ensure that women could make a free and informed choice of contraception.

Primary opposition to reproductive health programs in Peru comes from the conservative political and religious sectors. President Fujimori, whose personal support has been critical to the expansion of programs, is strongly committed to reproductive health services, and to family planning in particular. Several respondents commented, however, that Peru needed "to create a culture of reproductive health" that goes beyond the agenda of any given government.

NGOs in Peru are numerous and highly developed, and most respondents reported that these organizations and the government are beginning to work more closely together. Other respondents cautioned, however, that nongovernmental participation in policy and program development has actually decreased in recent years: The highly centralized style of the current government "does not lend it-

self to the enfranchisement of other groups," according to one respondent. Collaboration tends to be more informal than formal, and is often greater at the local level than at the national level.

Although Peru's health services were delivered through vertical programs as recently as five years ago, most reproductive health services, with the exception of STD and AIDS control, are now provided under the umbrella of the Directorate of Social Programs of the Ministry of Health. Respondents said that family planning is such a high priority, however, that it is administered vertically, and that the ministry does not have a strategy to integrate the delivery of reproductive health services, although officials are working to strengthen linkages among various components. A ministry representative said that at the health center level, there are still separate rooms for different services, adding, "You will not see a sign that says 'Reproductive Health.'"

NGOs working in Peru tend to emphasize gender issues, quality of care, reproductive rights and sexual health. For example, the U.S. Agency for International Development funded a women's NGO to implement a project with rural women to encourage them to define their priorities in reproductive health.

A shortage of trained health personnel limits access to reproductive health services in many remote areas of Peru. The Ministry of Health is addressing this issue by paying personnel a supplement to work in underserved areas, but workers are frequently unable to provide high-quality care due to limitations in their time and skills. As one NGO remarked, "The nurse is required to be lawyer, psychologist and social worker all in one, but she receives no training to play all of these roles."

The government has greatly increased the resources allocated to reproductive health, particularly to family planning. Although support from donors remains significant, they have become more marginal, and the government now has more control over resources and priorities. One donor respondent described the diminishing financial role of donors as one to "...help the government extend services to places where there are none, and to work with the Ministry of Health in a cooperative way to improve the quality and range of services." Although the NGOs are increasingly trying to improve cost recovery efforts, the Ministry of Health is actually eliminating fees for some reproductive health services, emphasizing increased access over improved financial sustainability.

Thus, only some progress has been made in Peru toward implementing policies and approaches that would advance the ICPD goals. Although the government has made resources available for reproductive health and family planning services, collaboration and involvement with stakeholders has been weak.

## Discussion and Implications

These eight case studies show that excellent progress has been made in placing Cairo on national health agendas. Of the eight countries, only Jordan and Peru did not adopt the Cairo definition of reproductive health verbatim. Most countries have attempted to set some priorities among the elements of reproductive health.

Family planning is a top priority in all of these countries, followed by maternal and child health care and by STD prevention and care. Abortion and postabortion care and adolescent programs are also receiving increasing emphasis in some countries. Reproductive tract cancers and infertility are receiving less attention, and gender-based violence remains outside the scope of most programs. Bangladesh, India and Senegal have adopted a package of essential (or minimum) services. The reproductive rights aspects of Cairo have received far less attention than the health aspects.

Policy dialogue has occurred at the highest levels in all countries. One positive outcome has been that a wide range of stakeholders has become involved in the policy process. Before Cairo, Bangladesh and Ghana had stronger traditions of NGO participation in policy-making than did the other six countries, although Indian women's advocacy groups were vocal in their opposition to some aspects of family planning prior to Cairo. In Peru, representatives of NGOs indicated they had a larger voice in decision-making before Cairo than afterward. Some opposition, from varying sources, to a reproductive health approach remains in these countries. Putting reproductive rights on the agenda will require a continued effort in all eight.

While these countries have devoted considerable attention to formulating policy in the years since Cairo, implementation of programs is just beginning. Most respondents said that the conference recommendations provided the impetus to design new programs or redesign existing ones using a client-centered approach to integrated care.

Respondents stressed that although NGOs tend to reach fewer people than

government entities, they have reoriented their programs in innovative ways to encompass reproductive health. Small NGOs with localized areas of operation can be very flexible in adapting programs to their clients' needs—when funding is available. Also, NGOs can work more easily than government organizations in especially sensitive areas of reproductive health, such as adolescent issues and gender-based violence.

While Cairo provided an international endorsement for addressing reproductive health and rights, it did not provide a blueprint for implementing the Programme of Action. Several challenges face countries as they move from policies to programs. Although a core group in each country supports reproductive health programs, the message still needs to be disseminated to a wider base of stakeholders, including providers and clients.

While these countries assumed that Cairo called for integrated reproductive health services, many had not fully considered the complexity of administrative and service integration, which requires careful planning from the national ministry down to the smallest health post.<sup>28</sup> Institutional constraints and coordination problems among organizations have impeded progress. Respondents from each country except Ghana noted confusion in organizational roles and responsibilities. Integrating reproductive health services at the same time that their management and financing are being decentralized only exacerbates the complexities of both activities.

In most countries, respondents mentioned human resources challenges such as staff shortages and work overload, as well as a lack of trained providers, especially female ones. Improving the quality of care, particularly as programs expand or integrate reproductive health services, remains another formidable challenge to implementation.

With only three years having passed since Cairo, many respondents said that it was too soon to tell if reproductive health policies and programs were succeeding. That countries would report only limited progress in implementing the Programme of Action is not surprising; it took more than a generation to adopt family planning programs worldwide, and that task is far from complete. To expect countries to build support for, adopt and implement an expanded plan of reproductive health services in three years is unrealistic.

The countries studied are struggling with the issues of prioritizing, financing and implementing reproductive health in-

terventions. Bangladesh, India, Nepal, Ghana, Senegal, Jamaica and Peru are taking beginning steps toward implementing a reproductive health approach, while Jordan's focus continues to be primarily on family planning.

The ICPD participants recognized the need for significant additional resources if reproductive health programs are to be implemented. Indeed, respondents in each case study, except Bangladesh, noted funding constraints. However, most of these countries are seeking ways to improve the sustainability of their reproductive health programs. The donors' role was generally viewed positively; however, many respondents were concerned that donors promote their own priorities in reproductive health.

In half of the case studies, the level of participation and political support for reproductive health may be insufficient for these countries to move easily to the next stage of implementation, so continued efforts in advocacy and in broadening policy-making are needed to speed the process. Blanket implementation of the constellation of services called for at the ICPD is unlikely to occur in the near future in most of these countries.

The key to progress is setting priorities and phasing in interventions, such as improving services and creating linkages among the elements of reproductive health. Budgeting, allocating resources to programs and financing additional reproductive health services cannot proceed effectively until the next critical stages take place—helping countries to set priorities for reproductive health interventions, increasing funds for services and developing workable implementation strategies.

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## Resumen

**Contexto:** Si bien muchos países adoptaron el Programa de Acción emanado de la Conferencia Internacional sobre Población y Desarrollo (CIPD) de 1994, celebrada en el Cairo, se sabe poco acerca de las experiencias que luego tuvieron al revisar sus políticas de salud y al implementar sus programas. **Métodos:** En 1997, se realizaron entrevistas detalladas con grupos de personas interesadas que desempeñan un rol importante en la materia en ocho países—tres países de Asia (Bangladesh, India y Nepal), tres del Oriente Medio y Africa (Jordán, Ghana y Senegal) y dos de América Latina y el Caribe (Jamaica y Perú).

**Resultados:** En tanto que todos los países, excepto dos, han adoptado la definición de salud reproductiva emanada de la CIPD y todos han iniciado reformas políticas que reflejan el nuevo enfoque, los logros han sido menores en la implantación de los programas de salud reproductiva integrados. Los ocho países enfrentan varios desafíos a medida que continúan diseñando sus programas de salud reproductiva: mejorar el conocimiento y el apoyo de los interesados; planificar la integración y descentralización de los servicios; desarrollar los recursos humanos; mejorar la calidad de la atención de salud; y mantener una perspectiva a largo plazo con respecto a la implantación del programa de el Cairo.

**Conclusiones:** Los próximos pasos necesarios para pasar de la etapa de formulación de políticas a la implantación del programa, serán de asistir a los países a que fijen sus prioridades para establecer actividades de salud reproductiva integradas, de incrementar el financiamiento de los servicios y de desarrollar estrategias para ponerlos al acceso de la comunidad.

## Résumé

**Contexte:** Beaucoup de pays ont adopté le Programme d'action de la Conférence internationale sur la population et le développement tenue au Caire en 1994 (CIPD), mais leur expérience de la révision des politiques d'hygiène de la procréation et de la mise en œuvre des programmes est, depuis lors, peu documentée.

**Méthodes:** Des entrevues en profondeur ont été menées en 1997 avec des représentants intéressés dans huit pays—trois en Asie (Bangladesh, Inde et Népal), trois au Moyen-Orient et en Afrique (Jordanie, Ghana et Sénégal) et deux en Amérique latine et aux Caraïbes (Pérou et Jamaïque).

**Résultats:** Bien que tous les pays sauf deux aient adopté la définition de l'hygiène de la procréation de la CIPD et que tous aient entrepris des réformes politiques aptes à refléter leur nouveau point de mire, les progrès sont moindres en termes de mise en œuvre de programmes d'hygiène de la procréation intégrés. Plusieurs défis attendent les huit pays dans l'élaboration continue de leurs programmes: amélioration des connaissances et du soutien parmi les intéressés; planification de l'intégration et de services décentralisés; développement des ressources humaines; amélioration de la qualité des soins; et entretien d'une perspective à long terme de mise en œuvre des objectifs du Caire. **Conclusions:** Les prochaines étapes critiques nécessaires au passage de la formulation politique à la mise en œuvre des programmes devront aider les pays à définir la priorité d'interventions d'hygiène de la procréation intégrées, accroître le financement des services et développer les stratégies aptes à assurer leur prestation.