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Reproductive Health in
POLICY & PRACTICE

CASE STUDIES FROM BRAZIL, INDIA, MOROCCO, AND UGANDA

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by
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ORDERING INFORMATION

To request additional copies of this report or the reports of the case studies from Brazil, India, Morocco, or Uganda, please contact PRB (see address on back cover). Reports for Brazil and Morocco will be available in their original language (Portuguese and French, respectively) and in English.

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Summary

The fifth anniversary of the United Nations International Conference on Population and Development (ICPD) gives governments and nongovernmental organizations (NGOs) an opportunity to review progress toward the conference's twenty-year goals. The 180 nations that met in Cairo in 1994 agreed to a Programme of Action that outlined a new approach to population issues. The Cairo program enlarged the scope of earlier population policies and called on governments to take action in many areas to promote individual and social well-being. It also called for family planning services to be provided in the context of comprehensive reproductive health care.

To assess how the Cairo program is being implemented in diverse settings, senior researchers in Brazil, India, Morocco, and Uganda conducted case studies that document changes in reproductive health policies and services, as well as in the political and social environment in which initiatives are carried out. They also analyzed how resources have been raised and allocated to support reproductive health programs.

Has Cairo made a difference? In all four countries, the ICPD reaffirmed efforts that were already under way to provide family planning as part of a broader health approach. The Cairo process was, at times, a catalyst for action, for example, when nationally prescribed targets for specific family planning methods in India were eliminated and the Brazilian debate on abortion was advanced. Not surprisingly, progress on reproductive health and women's status is uneven across and within countries, and none of the countries have addressed all of the Cairo goals.

The studies reveal major changes in the political, social, and economic environment in which reproductive health goals are pursued. In all of the countries studied, there is greater openness in political decisionmaking, a growth in NGO activity, and increasing visibility and influence of the women's rights movement. All of these changes appear to reinforce the implementation of the Cairo agenda. There is also increasing decentralization of authority from national to local governments and some major reforms in the way that health systems operate. These trends may help or detract from efforts to make reproductive health services universally available; in either case, they need to be well understood for progress to continue.

Changes have also taken place at the service level. Attempts have been made to improve the quality of services (for example, by offering a wider array of contraceptive methods), to increase the integration of family planning and other health services, and to expand services to under-served groups. Still, much remains to be done. In spite of some encouraging beginnings—which are described in this report—more progress is needed in addressing the needs of adolescents, in expanding access to treatment for the consequences of unsafe abortion, and in providing services that address (even modestly) reproductive cancers, infertility, and AIDS. The interpersonal skills of health practitioners also need to be strengthened if women are to be fully informed of their choices and supported in making the decisions that best suit their needs. Such changes mean overcoming habits of a lifetime, including the effects of gender and social-class biases that practitioners and clients bring with them to the clinic.

Given that progress is inevitably uneven, observers may argue about its extent. It is easy point to areas of unfinished business, such as the need to move from policies and pilot projects to widespread practice, and the need to address socially divisive issues like adolescent sexuality and unsafe abortion. Further progress in all areas of implementation will require more resources and better use of existing resources, persistence in the face of overwhelming odds by all those who advocate change, and effective partnerships among governments, donors, researchers, and advocates. Ultimately, consumers themselves must become the driving force behind decisions on reproductive health policies and services.

Introduction

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, representatives of 180 countries reached a new consensus about how world population issues should be approached. They agreed that population policies should address social development beyond family planning, especially the advancement of women, and that family planning should be provided in the context of comprehensive reproductive health care. Such care includes family planning; safe pregnancy and delivery services; prevention and treatment of sexually transmitted infections (STIs); information and counseling on sexuality; and other women's health services.

Earlier UN conferences had looked at population from a broad, societal point of view, emphasizing problems such as rapid population growth and the slow pace of economic development in southern countries. Many governments supported family

planning programs as a means to address these issues. By the time of the Cairo conference, there was growing concern that some policies and programs placed too much of an emphasis on reducing fertility and population growth and focused too narrowly on a single intervention: family planning programs. Critics maintained that these programs were insufficiently concerned with improving the lives of individuals, especially women.

The heart of the Cairo agenda is simple: Responding to the needs of individuals will help solve the aggregate problem of rapid population growth. Addressing a broad array of individual needs, however, is complicated in practice. The Cairo Programme of Action contains a few hundred recommendations in the areas of health, development, and social welfare. Since the Cairo conference, governments and NGOs have faced the challenge of how to implement the new agenda on the ground. And few models exist in the developing world for providing comprehensive and complex services in resource-poor settings.

Nevertheless, in some countries, attempts have been made to integrate family planning with other services, to eliminate contraceptive "targets" as a means of measuring staff performance, to develop new reproductive health strategies, and to revise laws affecting women's status and rights. In an effort to capture some of these experiences, the Population Reference Bureau (PRB) coordinated a project to conduct case studies in four countries—Brazil, India, Morocco, and Uganda. Specialists in each country carried out the studies, with advice from

Table 1
National demographic and health indicators

	BRAZIL	MOROCCO	INDIA	UGANDA
Total population in millions (mid-1998 estimate)	162.1	27.7	975.0	21.0
Percent urban	78	53	26	14
Total fertility rate (births per woman)	2.4	3.1	3.5	6.9
Percent of married women using contraception	77	59	41	15
Infant mortality rate (per 1,000 live births)	41	62	72	81
Number of females enrolled in secondary school per 100 males	134	75	65	59
Per capita GNP (US\$, 1996-97)	4,400	1,300	380	300

Sources: Carl Haub and Diana Cornelius, 1998 World Population Data Sheet (Washington, DC: Population Reference Bureau, 1998); and Lina Parikh and Barbara Shane, 1998 Women of our World (Washington, DC: Population Reference Bureau, 1998), and country reports.

an international steering committee. (Project participants are listed in Appendix 1.)

Why these four countries? First, they were selected for their diversity—in terms of geographic region, level of development, health and social conditions, and culture. (Table 1 provides demographic and health information for each country.) Second, each was known to be implementing new policies and programs consistent with the Cairo agenda. The project organizers believed that policymakers elsewhere would be interested to learn from these experiments and their successes and failures that occurred along the way.

The case studies are selective in their approach. Among the central recommendations of the Cairo conference—and what distinguishes it most clearly from other UN conferences—are those related to reproductive health. Project organizers were especially keen to learn the extent to which the new spirit of meeting individual reproductive health needs was being translated into action on the ground. The case studies therefore focused on changes in reproductive health policies and services, and how resources have been raised and used to provide these services. In some instances, notable changes in the broader social and economic context—especially changes affecting women’s status—are also described. The researchers used a variety of

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methods to collect information, including reviews of existing data, interviews with policymakers and health care providers, and focus group discussions with users of reproductive health services.

While there are common threads among the case studies, they did not follow a single set of questions. Each study describes national trends in broad terms, then pursues issues of special interest in greater depth. In each case, researchers selected a small number of communities and health facilities in the country to illustrate specific successes and obstacles in implementation. The sample cases are not intended to represent the country as a whole.

Similarly, this synthesis report highlights lessons of special interest from the country studies, but does not provide a comprehensive summary. There is no substitute for reading the individual case studies, which are as rich and complex as the countries that they represent. (Case study summaries appear in Appendix 2 and information about ordering the full reports is found on the back of the title page.) We hope that the case studies and the examples we have chosen to highlight here will be helpful to countries facing similar opportunities and challenges in other parts of the world.



Assessing Change



Five years after the Cairo conference, policymakers, researchers, and advocates have an opportunity to review progress to date in meeting the conference's goals and to identify remaining challenges. We must recognize, however, that progress on such a broad agenda is hard to quantify. And, even if it could be quantified, it would be hard to say which changes could be attributed directly to Cairo. A number of factors complicate our assessment.

First, the Cairo conference represents a process rather than a single event. Preparations for the conference took several years and involved discussions around the world. The thinking and emerging policies and programs in a number of countries influenced the international discussions that, in turn, influenced national events. In all four case-study countries, Cairo is credited with being a catalyst of national action but by no means the only or initial influence in the move towards reproductive health approaches. In particular, national developments and advocacy groups in both India and Brazil influenced the Cairo conference. One could say that Brazil and India influenced the conference as much as they were influenced by it.

Second, a series of UN conferences has had a cumulative effect on national and international policies related to health and social development. In addition to Cairo in 1994, these conferences include the 1993 UN Conference on Human Rights in Vienna; the 1995 World Summit on Social Development in Copenhagen; and the 1995 Fourth World Conference on Women in Beijing. A common element of these conferences has been the promotion of women's rights, an issue that has moved to center stage in many countries.

Third, the process of implementation is complicated and does not always proceed in a straight line.

In all four case-study countries, Cairo is credited with being a catalyst of national action but by no means the only or initial influence in the move towards reproductive health approaches.

National priorities are continually reexamined, and commitments made at international conferences are one of many demands on policy-makers' attention. Policy and program advocates might make advances in a particular area, only to have them reversed by another constituency emerging on the policy scene. Progress is also uneven within countries, given the varying economic and social conditions that exist in different regions and communities.

Finally, the diffusion of new ideas and new ways of doing things takes time. We found

several examples in the case studies. For example, it is easier to write a new medical training curriculum than to change the attitudes of doctors toward their patients, and it is easier to provide services to married women than to reach out to unmarried women or adolescents. It is also easier to change laws addressing women's status than to change the social conditions that give rise to women's inequality.

Bearing these caveats in mind, we believe that important changes are under way. The remainder of the report documents some of these changes, as well as the factors that have helped or hindered progress.



The Broader Context



Major changes are taking place in much of the developing world that affect the context in which international population and health policies are conceived and implemented. Among the most important changes are: greater openness in political decisionmaking; decentralization of authority from national to local governments; the increasing political importance of women's issues; and institutional and financial reforms in the health sector.

THE POLICYMAKING PROCESS

Brazil, Morocco, India, and Uganda all demonstrate increased openness in political decisionmaking, decentralization of authority from national to local governments, and growth in the importance of NGOs, also known as "civil society." In some ways, these changes complicate the decisionmaking process, but they make it more likely that citizens will affect and accept the decisions that are made and press for their implementation.

In Brazil, the case study authors note that, "Since the 1980s, democratization has definitely lengthened the policy decisionmaking process. But it has also given voice to the advocacy community and allowed for debate of the reproductive health and rights agenda. The adoption of this agenda by other actors and voices would not have occurred without open political debate about its meanings."

Similarly, the devolution of authority from central to local or regional governments entails both challenges and opportunities. Since the community participates more directly in setting priorities, developing programs, and allocating resources, decentralization should result in programs and policies that are more responsive to local needs. But responsibilities may be transferred before local governments have the capacity to manage them, and local communities may be slow to perceive or act on national-level priorities—for example, reducing the spread of

Since the Cairo and Beijing conferences, there is greater discussion of gender issues, or the differences in men and women's socially prescribed roles... As a result, many new policies and programs attempt to reduce gender inequalities.

HIV infections. As a result, progress on national objectives is bound to be uneven across states and localities. Still, the process of decentralization is unlikely to be reversed in the foreseeable future, and it poses an interesting challenge to UN conference organizers. National representatives engage in conference discussions and sign on to international agreements, yet local authorities are increasingly responsible for implementing these agreements. They may have quite different priorities.

Recently, NGOs have grown in number and influence in the policymaking process. In Morocco, 76 NGOs (one-third established since 1994) now

work on issues related to women and development. In other countries, NGOs are credited with influencing the latest generation of national policies. Partnerships that broaden the base of support for new policies and programs are also increasing—for example, collaboration between government and NGOs and cooperation within the NGO sector among academics, advocates, and service organizations. And there is no question that national and international policy meetings have become livelier and more diverse in the 1990s with the growing presence of NGOs. At the same time, not all NGOs in developing countries are truly indigenous, grassroots organizations. Some are arms of government and some represent interests from abroad.

THE POLITICAL IMPORTANCE OF WOMEN

Thanks largely to the activities of women's rights advocates, the situation of women has moved to the forefront of both national and international policy debates. Since the Cairo and Beijing conferences, there is greater discussion of gender issues, or the differences in men and women's socially prescribed roles. Governments and donor agencies increasingly acknowledge the inferior legal, social, and economic positions of women and their detrimental effects on national development. As a result, many new policies and programs attempt to reduce gender inequalities.

There are signs of real change in the status of women—at least on paper. Uganda's new Constitution guarantees the political participation of women by reserving 30 percent of all electoral seats for them. The government has also adopted several other new policies: The National Gender Policy aims to take into account gender in all aspects of development; the Land Act provides a new mechanism for women to own land; and the Universal Primary Education policy reserves one-half of all school enrollments for girls. Similarly, recent legislation in India reserves one-third of the seats on local governing bodies for women, and Brazil has established a quota reserving 30 percent of seats for women on national and local parliamentary bodies. It will take time, however, for communities to adapt to these changes, and a number of social barriers stand in the way of their effective implementation.

REFORMS IN THE HEALTH SECTOR

Equally dramatic changes are taking place in the organization and financing of national health systems. Reform is often a condition of receiving funds from international financial institutions, such as the World Bank, and is also prompted by the increased need for economic austerity. As in the case of political decentralization, health sector reform may assist or detract from progress in meeting reproductive health goals.

On the positive side, reforms often aim to channel public subsidies toward the neediest citizens and emphasize the provision of low-cost primary health care services over expensive, high-tech interventions. Also, in most settings, health reform requires managers to consider more integrated approaches to service

delivery than in the past. Such reforms are generally consistent with the Cairo agenda. On the other hand, in striving to allocate overall health resources more effectively, planners weigh the various components of reproductive health care (family planning, prevention of sexually transmitted diseases, and maternity care) against a host of other health needs (combating malaria, tuberculosis and childhood diseases, and dealing with problems related to smoking, drug abuse, and injuries). Some elements of reproductive health may receive priority attention in government

Box 1

The women's movement in Morocco

Despite a constitutional guarantee of equal political and legal rights, Moroccan women suffer great disadvantages. They are much more likely than men to be illiterate (90 percent versus 60 percent in rural areas and 50 percent versus 25 percent in urban areas); far less likely to participate in the labor force (one-third of women versus 80 percent of men); and have fewer rights than men in relation to marriage, divorce, and inheritance. These disadvantages are codified in the personal status laws and reinforced by social custom.

Recently, important legal and policy changes have taken place.

The government established a special ministry to deal with issues related to childhood and the family. NGOs focusing on women's issues and advancement, including microcredit schemes for poor women, have proliferated. The personal status laws have been revised, and steps have been taken to try to combat illiteracy and reduce domestic violence. The changes in the personal status laws mandate that marriage may be concluded only with the wife's full consent, that polygamy may be practiced only with the knowledge of the first and subsequent wives, and create legal restrictions on the husband's right to unilaterally divorce his wife. Advocates for women criticize these reforms on the grounds they do not go far enough, and it is likely that the changes have not yet affected women's daily lives, especially in rural and isolated areas.

budgets if needs appear urgent and affect a large proportion of the population; other elements may not. Those who hope to influence resource allocation for reproductive health need to understand and participate in debates on health financing, including priority setting.



Policies in Support of Reproductive Health

While they are but one element in program implementation, national policies provide important impetus and guidance to local initiatives. The case studies analyze the evolution of national reproductive health policies over the last five years. In all four countries, governments have drafted and debated an impressive array of new legislation and strategy documents.

BOX 2

The abortion debate in Brazil

In Brazil, the adoption of the Cairo agenda did not represent a major policy shift, as the country had adopted a comprehensive reproductive health program a decade earlier. The conference served, however, to amplify the Brazilian debate on abortion and expand access to abortion services. The Programme of Action called for the provision of safe abortion services where legal and for compassionate care for the complications arising from unsafe abortion, whether legal or not.

Reproductive health and rights advocates in Brazil had worked since 1985 to ensure access to abortion services in the two cases permitted by law: when a woman's health was at risk or she had been raped. Doctors were reluctant to provide the procedures, both because of a lack of information about the legal provisions and because of their own personal convictions. In the early 1990s, a legislative provision was submitted to the Brazilian Congress, calling on the public health system to make abortion universally available in these narrowly defined, but legal, circumstances. In 1995, in the aftermath of the Cairo and Beijing conferences, a new "right-to-life" provision was presented to Congress. A special committee debated and rejected the provision, sparking a heated public debate on abortion. In 1997, a congressional committee approved access to legal abortion, prompting both conservative reactions and a national mail-in campaign to lawmakers on the part of reproductive rights advocates.

On the one hand, the debate has led to harsh confrontations between reproductive rights advocates and conservative religious coalitions. On the other hand, open debate has increased understanding among health managers and professionals of the need for and meaning of legal abortion services. As one health manager in Recife said, "We have used the [Cairo] argument: abortion is a public health problem, when it is legal it must be safe, and incomplete abortion must be subject to adequate and compassionate care." Since 1994, the public health system has expanded support for legal abortion services from two to 12 locations and has made improvements in the quality of post-abortion care.

The Indian case study provides the most dramatic example of a major national policy shift—the removal of centrally mandated targets from the national family planning program. Several factors contributed to this change. The government recognized that India's family planning program had stalled in terms of lowering the birth rate. The focus on sterilization ignored the birth-spacing needs of younger women, and the target system contributed to false reporting of contraceptive use. At the same time, women's groups and NGOs were increasingly voicing concerns about the poor quality of services and their heavy reliance on sterilization as the main method of contraception. The international donor community also strongly supported a rethinking of the government's policy. Soon after the Cairo conference, health officials in India experimented with the removal of method-specific targets and, in 1996, the government abolished the use of nationally prescribed targets for acceptors of different family planning methods throughout the country.

In Brazil, a flurry of policy debates preceded and followed the Cairo conference, the most heated of which concerned abortion (see Box 2). In Morocco, changes in policies affecting women's status have marked the most significant departures from the past (see Box 1, page 11). In Uganda, in addition to the changes noted on the preceding page, new population and adolescent policies have been drafted since 1994.

Brazil and India offer insights into the time and process necessary for policies to be diffused and adopted throughout an entire country. In Brazil, it has taken over



S. SPRAGUE, MOROCCO

10 years for health reform to move from the level of national policy to real change on the ground. Key ingredients of progress observed after 1995 have been the persistence of the advocacy community and the strengthening of local health systems. In India, where national policy changes were debated very little before they were decreed, evidence from communities indicates that it may be some time before the changes are widely understood and adopted in practice. Local health care providers are just beginning to understand what the policy changes mean and how new procedures might work. The contrast between Brazil and India suggests that wider policy debate leads to wider acceptance of policy changes.

Not surprisingly, case study interviews reveal that a relatively small number of government officials and NGO representatives are fully conversant with the Cairo recommendations. In general, the responsibility for implementing reproductive health programs has been primarily with health officials whose mandate has expanded from maternal and child health programs, including family planning, to include reproductive health more

broadly. Other ministries, such as those concerned with population, women's affairs, or youth, have contributed to policy development. But they have generally been in weaker positions than the ministries of health to initiate and define new policies.

The Cairo Programme of Action has provided policymakers at all levels with language and concepts to help them promote the new reproductive health agenda. In Ceará, Brazil, the director of the women's health program observed: "We have constantly used Cairo language in our dialogues with health managers, health agencies, and health professionals. Cairo language has been a critical political instrument."

Cairo has also produced greater high-level political awareness of and support for reproductive health; a donor community willing to support new initiatives; and increased national debate and NGO activity. Where health ministries have taken advantage of these opportunities, concrete changes can be seen.



Improvements in Reproductive Health Services

The Cairo Programme of Action defined reproductive health in a comprehensive fashion for the first time in an international policy document. The definition states that “reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. . .” It goes on to state that reproductive health care should enhance individual rights, including “the right to decide freely and responsibly” the number and spacing of one’s children, and the right to a “satisfying and safe sex life.”

Operationally, reproductive health care encompasses many elements, including family planning information and services, prenatal care, safe delivery and post-natal care, prevention and treatment of infertility, abortion (where not against the law), care for complications of unsafe abortion, prevention and treatment of STIs, including HIV/AIDS, elimination of harmful practices such as female genital mutilation, and other women’s health services such as diagnosis and treatment for breast and cervical cancers. The Programme of Action calls on all countries to provide these services through the primary health care system by the year 2015.

An agenda of such ambitious proportions cannot be implemented overnight, especially in poor countries. All the case study countries have made significant strides toward the Cairo goals, but none has been able to address all of its elements. “We could not take Cairo wholesale, even if we wanted to,” said a program manager in Uganda, “until the systems are ready and people are in place to handle the workload.” The comprehensive definition has been used mainly in developing national strategy documents; at the operational level, each country has tackled those elements where improvements seem most feasible.

PRE-CAIRO EFFORTS BOOSTED

The Cairo conference revitalized efforts that were already under way to improve the quality of family planning services. These efforts include: offering clients a greater choice of contraceptive methods;

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improving the ability of practitioners to provide information and counseling; and reaching underserved groups, such as adolescents and men. As noted in Box 4 (p. 18), the most radical change in service delivery has occurred in India, where the government has abolished centrally determined program targets.

Important changes have occurred in the area of contraceptive choice. In India, recent service statistics and interviews with providers reveal that the longstanding reliance on sterilization is beginning to change.

Women are now more aware of reversible methods of contraception and are beginning to ask for them. In Brazil, primary health programs are providing more reversible methods to under-served populations, and sterilization procedures may decline now that the government has placed ceilings on the numbers of Caesarean sections that can be performed in public hospitals. (Women often seek the two procedures at once.) In Morocco, where the family planning program had provided mainly oral contraceptives, interviews with women reveal an increased awareness of other methods, such as intrauterine devices and hormonal injections.

In terms of the broad array of services included under the rubric of reproductive health, attempts were being made before Cairo to increase access to services to prevent the spread of STIs and to ensure “safe motherhood,” including care for obstetric emergencies. Safe motherhood initiatives have existed for some time but have received relatively little funding or high-level attention. The following efforts reflect renewed commitments to improving maternal health:



S. SPRAGUE: BRAZIL

- ◆ In Uganda, public education has increased awareness among midwives, traditional birth attendants, health practitioners, and community leaders of the importance of safe pregnancy and delivery. New systems of supervision and referral are being tested to speed transport of women to hospitals when they need emergency care.
- ◆ The Moroccan health ministry has added nutritional supplements in iron and iodine to address the high incidence of anemia among pregnant women. It has also strengthened infrastructure and training at hospitals that deal with obstetric emergencies.
- ◆ Both prenatal and delivery services in Brazil have improved; between 1995-97 alone, prenatal consultations in the country rose by 51 percent.

POST-ICPD PROGRAM INITIATIVES

As interest in reproductive health grew in the aftermath of the Cairo conference, governments and NGOs developed a number of new program initiatives. Some were made possible by new funding from donors; others emerged within existing health budgets. Many initiatives are too new to be evaluated, but their existence deserves mention.

- ◆ In 1995, the Moroccan government developed a national policy and program to address STIs/HIV. The program includes free anonymous screening and collaboration with NGOs in service provision.
- ◆ In Brazil, the public health system is now supporting legal abortion services in 12 locations and strengthening services that provide post-abortion care. Linkages have been built between the reproductive health and HIV/AIDS prevention programs. In 1996, a pilot cervical cancer screening project began in five state capitals, and in 1998, a national cervical cancer prevention program was launched.
- ◆ In Uganda, special outreach programs for young people are operating in most districts in the country, encouraging safer sex and responsible parenthood. A new program to replace the practice of female genital mutilation with safer, alternative rituals has shown some early success.
- ◆ Along with abolishing targets, the Indian government has instituted a new program, the “reproductive and child health” initiative.

Table 2
Highlights of reproductive health service improvements

	EXISTING PROGRAMS STRENGTHENED	NEW INITIATIVES SINCE 1994	AREAS HARDLY ADDRESSED (OR NOT AT ALL)
Uganda	Family planning, STI/HIV, and maternal health services: quality improvements and integration	Adolescent sexuality, post-abortion care, efforts to eradicate female genital mutilation	Infertility, cancers, AIDS treatment
India	Greater attention to maternal health in family welfare program	Family planning target-free; more contraceptive choices; reproductive and child health initiative; HIV/AIDS	Abortion, adolescents, reproductive tract infections
Morocco	Quality improvements in family planning and maternal health	National STI/HIV program; private-sector collaboration in family planning; greater choice of contraceptive methods	Abortion; sterilization, infertility and menopause services; services for adolescents and men
Brazil	Quality improvements in prenatal and obstetric care, linkages between STD/HIV program and RH services; integration of adolescent services in primary health programs	Legal abortion services, quality post-abortion care; efforts to reduce rate of C-sections; access to reversible contraceptive methods; national cervical cancer prevention program	Regulation and quality of private sector services; more effective prevention of HIV among women

AREAS STILL TO BE ADDRESSED

The examples of service improvements shown in Table 2 reveal how countries with different income levels and traditions are able to address a range of reproductive health needs. Some of the areas that have received the least attention appear to be those that health planners consider unaffordable (e.g., treatment of AIDS, cancers, or infertility), or those that are deemed controversial or socially unacceptable (e.g., addressing unsafe abortion or providing services to adolescents). In Brazil, the wealthiest country in our study, most elements of reproductive health have been introduced or tested at some level of the public health system. But case-study authors note that program components need stronger linkages, and greater efforts are needed to ensure the quality of care in the private sector, which serves nearly one-third of women.

On socially controversial issues, even where little progress has been made in terms of programs and services, there are signs that public discussions are now taking place. For example, violence against women, rape, and male responsibility in the family are increasingly discussed in public meetings, and some pilot projects have begun to address them. In Brazil, the expansion of abortion services in the case of rape is taking place under the framework of gender-violence prevention. But in general, it will take time before these new initiatives will be fully inte-

grated in large-scale programs.

ADDRESSING ADOLESCENT NEEDS

Adolescents deserve special mention both because of their large and growing numbers and because they are often sexually active and are therefore exposed to the risks of unwanted pregnancies, unsafe abortions, and STIs. Unfortunately, public health systems in most countries have neglected their needs.

In Uganda, where the rate of pregnancy among adolescents is one of the highest in Africa, UN agencies, NGOs, and private foundations have supported small, community-based programs to provide reproductive health information and services to teens in many parts of the country. The Ugandan government now has a draft adolescent health policy to provide guidance to health care providers and to incorporate adolescent programs into mainstream health services and other relevant programs. In general, however, adolescents do not seek care or will not use the same services as adults. Or health providers may be too overworked to reach out to young people and may not approve of their behavior. In Morocco, the government does not officially support reproductive health services for teens because of religious prohibitions on premarital sex, but some NGOs have developed special activities oriented toward adolescent needs.

In Brazil, a national adolescent health policy was established in 1988. Although its implementation has been uneven across the country, some best practices can be found. In Ceará, the women's health and adolescent programs are working closely together, and in Recife and Cabo, all family health programs have specific activities for teenagers. There is evidence that when comprehensive care is offered—including pregnancy care, post-natal care, and access to a range of contraceptive methods—the teens develop a strong attachment with the service. As one nurse reported: “They hear everything, they follow what we say, they become like daughters.”

SERVICE INTEGRATION

The Programme of Action calls for better linkages among all reproductive health services to address individual health needs in a more holistic fashion. Service integration is not entirely new in any of the countries studied; most had previously combined family planning and maternal and child health programs in the public health system. Nevertheless, there are signs that service integration is increasing, and this integration has taken different forms.

In Uganda, health centers now provide, on a daily basis, family planning, prenatal and post-natal care, STI/HIV counseling, nutrition education, and childhood immunizations. Previously, specialized providers had offered different services only on designated days. Clinic nurses see this integration as a “mixed blessing.” On the one hand, their workload has increased without a comparable increase in pay. On the other hand, they report that integration saves time for both providers and clients, and the increased responsibilities have enhanced the status of providers. Interestingly, the case study notes that integration has proceeded more rapidly in health centers than in hospitals, though the latter provide a wider range of services. Reports in Uganda also show that more clients are using the family planning and STI treatment services—both previously stigmatized in some communities—now that they

BOX 3

Combating STIs and HIV in Uganda

The HIV/AIDS epidemic in Uganda has posed a major challenge to social and economic development and prompted an unprecedented government response. It is estimated that 1.5 million Ugandans are infected with HIV (out of a total population of 21 million) and that one million children have been orphaned by AIDS deaths. The age group most affected by AIDS (ages 15 to 50) occupies a critical position in family support systems, the labor force, and leadership in society.

The government recognized early the devastating impact that AIDS would have on development, and the key role of STIs in fueling its spread. With financial support from major donors, it instituted a multi-sectoral strategy, beginning in the late 1980s, involving the Ministries of Health, Labor, Gender, Defense, Education, Information, and Agriculture. Programs include public information campaigns, research, voluntary testing and counseling, safe blood for transfusions, school health programs, home-based care of people living with AIDS, and a nationwide campaign to treat STIs. The STI/HIV control program is supported by the World Bank and emphasizes outreach to under-served groups, especially young people, and involvement of parents and local communities.

The Uganda AIDS Commission, which coordinates policies and programs throughout the country, includes parliamentarians, government officials, and religious leaders. The case study authors note that, “The deliberate government openness to the STI/HIV problem has facilitated collaborative research in HIV/AIDS care and control from which the international community stands to benefit.”

These efforts are seeing results. Almost the entire adult population is now aware of the dangers of HIV and, in some parts of the country, rates of infection among women seeking prenatal care have decreased by one-third or more. Moreover, the STI/HIV campaign has led to greater openness in dealing with sexual health problems and has increased the commitment of the government to providing reproductive health services to every segment of the population.

are part of a broader package (see Box 3).

In Brazil, the women's health program (*Programa Assistência Integral a Saúde da Mulher*, or PAISM), designed over a decade ago but not implemented, is now integrated in the public health system as part of a larger strategy of basic health care. Originally designed to meet a range of reproductive health needs, until 1996 it oper-

ated in relative isolation from the national health system. Through the process of health reform and decentralization, the program's concepts have begun to be incorporated into basic health services at the municipal level. In different ways, the

Uganda and Brazil cases show that innovations may advance more quickly and effectively at lower levels of the health system.

WOMEN'S PERCEPTIONS OF SERVICES

As well as documenting service improvements, each case study tried to find out whether women thought the services were meeting more of their needs. The researchers received mixed responses.

There are small signs that improvements are benefiting women, as noted in the examples above. In Uganda, the integration of reproductive health services in local health centers has made life easier for some women: One pregnant woman said, "These days it is much better coming here because they treat for everything daily... it saves money." In India, providers and clients noted that the reduced pressure to achieve family planning targets meant more time to discuss family health matters. In Brazil, innovative approaches to post-abortion care have been a breakthrough in terms of responding to women's health and emotional needs.

On the other hand, the studies contain many examples of women's complaints about the inadequate treatment or lack of information they receive in health facilities. Research on client satisfaction in Morocco revealed a number of communication problems between providers and clients. Some of these problems stemmed from the hierarchical (superior) attitudes of providers, and from a lack of female practitioners. Women's criticisms revealed two major areas of frustration: "Why don't they explain the details of contraceptive methods to us?" and "Why are we only offered family planning and not other care?"

It would be hard to exaggerate the importance of improving client-provider relations along with improvements in other aspects of services. As programs develop, complaints about services may actually increase, as women become more educated about what they want and need from the health system. Women's complaints and requests may then become the main impetus for addressing weaknesses in services.

BOX 4

The target-free approach in two states in India

In Tamil Nadu and Rajasthan, family planning targets are no longer handed down from the central government but are determined locally with the help of an eligible couples register. A new community-assessment manual helps grassroots workers identify couples' needs for family planning by segmenting them in terms of how many surviving children they have and whether they currently use contraception. An auxiliary nurse-midwife in Tamil Nadu explained that, "When we enumerate the eligible couples in our population, we ask a question about the number of living children and, on the basis of that, we advise women with one child to use a temporary method and those who have more children to undergo sterilization."

Different states and communities determine the family planning workload differently, but they do translate the workload into targets and expect the workers to achieve them. The needs of the clients and the opinion of the health worker are still secondary to the process. Nevertheless, both clients and health workers report some satisfaction with the new approach. Clients report that, "The health worker is not pushing contraceptives alone." Workers report that targets are now more realistic and that they are not scolded for not meeting them, as they had been in the past. In particular, some workers feel that the former family planning targets did not allow them to concentrate on other maternal and child health services. "Now the pressure is off and we are able to inquire about women's health, their children's health. We are also better accepted in the community. People do not identify us only as family planning workers but consult us about ailments of all family members."

In Tamil Nadu, training in the new reproductive and child health approach has been initiated and includes previously neglected topics such as quality of care, informed choice, and assessment of community needs. Rajasthan has only just begun retraining health workers. Community-level planning has not developed in either state to the extent the central government envisioned, and it is too early to tell how well the new concepts will take hold, especially in a country as large and diverse as India. Nevertheless, government officials in these two states are making attempts to redress some of the limitations of the old approach.

Factors that Help or Hinder Change

The case studies identify a number of factors that have facilitated changes in policies and programs related to reproductive health. Many of these factors relate to changes in the social, political, and economic context in which programs operate, such as health reform, NGO advocacy efforts, and high-level political commitment.

In Brazil, health reforms have paved the way for improved reproductive health services by establishing a universal health care system that emphasizes decentralized decisionmaking, equity and access, and primary health care. Moreover, Brazilian advocates persevered for years in keeping reproductive health and rights on the national agenda, despite short-term setbacks. In Morocco, a growing civil society—in particular, groups dedicated to advancing the status of women and addressing HIV/AIDS—has helped to advance the reproductive health agenda.

High-level national leadership and support from international donors have also played an important role—for example, the forthrightness of the Ugandan government in addressing the HIV/AIDS crisis and the recognition of the Indian government that radical change was needed in its family planning program. Moreover, no progress would be possible without an openness to change on the part of managers and front-line workers in the health system—many of whom have shown a willingness to consider new ideas and approaches and a commitment to improving the services offered to clients.

The studies also describe fundamental barriers to improving reproductive health, which affect some countries more than others:

- ◆ Bureaucratic divisions and poor communication within health ministries (e.g., between departments concerned with family planning and STIs) and among different government ministries (e.g., health and women’s affairs) impede the implementation of holistic approaches to improving health and reducing gender inequalities.
- ◆ Health provider attitudes are slow to change. Many public sector employees are underpaid

In some places, institutional cultures have never placed a high value on individual or “consumer” rights.

and overworked; some are said to show little concern for the needs of the clients that they serve. In some places, institutional cultures have never placed a high value on individual or “consumer” rights.

◆ Health ministries, medical schools, and training programs tend to emphasize the technical aspects of reproductive health and give inadequate attention to

the social context in which health decisions are made (for example, the inability of women to seek urgent medical help in their husband’s absence, or to negotiate condom use to protect themselves from STIs).

- ◆ Governments are often reluctant to confront controversial issues such as abortion, adolescent sexuality, or STI/HIV prevention, because of opposition from traditional or conservative groups.
- ◆ In many countries and regions within countries, infrastructure and human resources are extremely weak. Remote and poorly educated communities often have little accurate information about reproductive health problems and the means to address them.
- ◆ Every service improvement and new program initiative requires training or retraining health personnel. Upgrading the skills of thousands of health personnel is a mammoth undertaking that will take much time.

The progress that has been made seems all the more remarkable, given such barriers. A final barrier is the inadequacy of financial resources and the misuse of existing funds, both of which prevent many improvements from taking place.

Resources for Reproductive Health

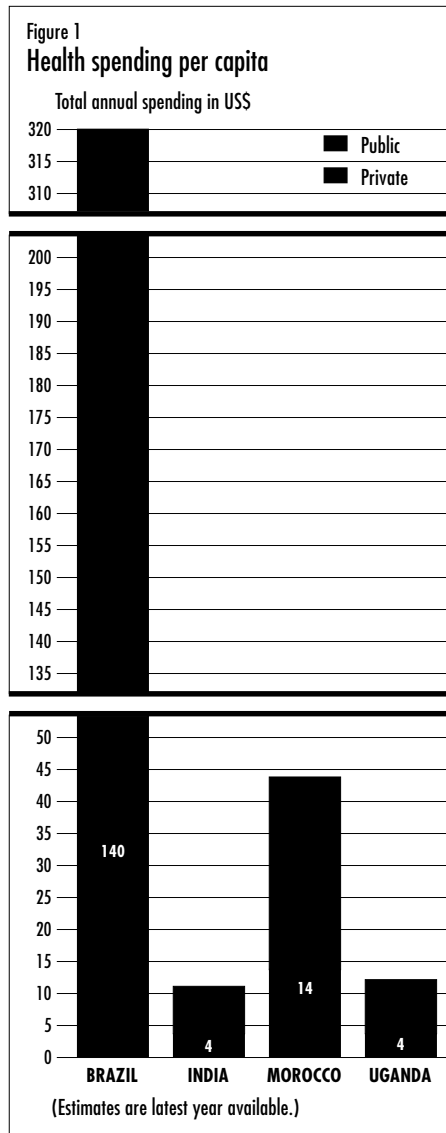
The case studies examine trends in reproductive health expenditures over the past few years, including allocation among program areas and attempts to target particular groups. The analysis sheds light on the priorities and roles of government, the private sector (NGOs, commercial organizations, and consumers), and international donors.

LEVELS AND TRENDS IN OVERALL FUNDING

The Cairo Programme of Action called for a major increase in worldwide spending for reproductive health programs, from around US\$5 billion in the early 1990s to US\$17 billion by the year 2000. These totals include spending from all sources (government, consumers, and donors). The large increase was needed for several reasons: to improve the quality of existing programs, to add new programs (e.g., treatment of STIs), to meet increased demand for services, and to accommodate the growing number of people of reproductive age.

The case studies document some increases in government and donor funding, but not of the magnitude envisioned in Cairo. The studies reveal less about private spending, leaving us with an incomplete picture of resource flows. While government expenditures are usually published annually, health spending by private individuals is only measured periodically in surveys. Moreover, it is difficult to obtain detailed data on either public or private expenditures—for example, breakdowns that would distinguish family planning from other reproductive health services.

Information on total health spending provides some parameters within which to consider possibilities for reproductive health improvements. Annual per capita health spending varies widely, from a low of US\$12 in India and Uganda to US\$320 in Brazil (see Figure 1). The differences are striking



and must be kept in mind when reviewing progress to date. In Uganda, reproductive health care consumes about 60 percent of the government's primary health care budget. But one or two dollars per person buys little modern health care, even accounting for the fact that salaries are low. Resource constraints are similar in India.

With regard to funding trends, the Brazilian government has approved budget increases for the health sector each year since 1995 and set aside fairly substantial funds for service improvements in 1997, even during a period of economic austerity and health sector reform. In India and Morocco, there has been consistent growth in the government's health budget, but after accounting for inflation and population growth, per capita increases have been minimal or nil. In Uganda, the government has had trouble fully funding its budgetary commitments in the health sector because of weak tax collections.

International donors have committed funds for new reproductive health initiatives in Uganda, India, and Morocco. In India, the World Bank is supporting the new Reproductive and Child Health approach, and in Morocco and Uganda, bilateral and multilateral donors have underwritten much of the upgrading of infrastructure, personnel training, and pilot projects. In all cases, the governments are expected to finance staff salaries and most operating costs.

INVESTMENT TRADE-OFFS

While more resources are needed, the case studies provide evidence that existing funds could be used more effectively. As noted in the Brazil study, “Local level managers often say that limited financial resources are not the major obstacle to improving reproductive health services. In their evaluation, the commitment of managers, the training and attitude of health professionals, and the ‘curative biases’ of the system are more relevant at this stage.” A number of imbalances in the allocation of resources appear in one or more of the country studies:

- ◆ Some public health systems have devoted more resources to relatively costly curative care in hospitals than to cost-effective preventive services in local health centers. The result is that a few people receive expensive treatments, while a great many have little or no access to health care at all.
- ◆ Relatively well-off urban dwellers often consume disproportionate shares of public health resources because they live close to facilities and are more likely to seek care. The poor and those living in remote and rural areas have least access and are therefore least likely to benefit from public health subsidies.
- ◆ Investments in infrastructure (clinics and equipment) have not always been matched by equivalent investments in personnel and training. Facilities may then be unable to operate or may operate with staff lacking the necessary motivation and skills.
- ◆ Some health systems require doctors—whose services are scarce and expensive—to provide contraceptives and other reproductive health services that could safely be provided by nurses or paramedics.

While some imbalances stem from habits or rigidities in the system, others stem from different judgements about priorities, efficiency, and equity. Greater public debate, decentralization of health authority, and public scrutiny of funding decisions may help ensure adequate discussion of these issues, identify obvious instances of waste, and promote more effective use of resources.

In countries such as India and Uganda, with very low per capita income and therefore a low tax base,

total public and private spending on reproductive health falls far short of even the most conservative estimate of need. Therefore, while it is possible to debate funding priorities, it is important to recognize that overall progress will be limited until the resource base improves. In more advanced countries like Morocco and Brazil, greater availability of resources has made it easier to debate whether the investments have been balanced appropriately.

THE ROLE OF INTERNATIONAL DONORS

Donors can play a critical role in initiating or catalyzing local action. Recent funding commitments—and the technical inputs that accompany them—have helped to shape the new generation of reproductive health programs. The influence of external funding often far exceeds its size. In Brazil, where donors provide only a small fraction of the national health budget, a World Bank loan to support the national HIV/AIDS program has given a boost to reproductive health programs. The case study also describes the role of donors in research and advocacy activities, where small inputs can have a large influence over program directions. In the other three countries, donors have underwritten major portions of programs designed to improve health infrastructure and train workers, as well as providing contraceptives and other commodities.

At the same time, the studies raise concerns about whether donor priorities unduly drive national directions, and whether programs can be sustained if donor funds are withdrawn. In Uganda, where donors provide about 90 percent of the development budget, there are concerns about whether programs have been designed in ways that will allow local managers to take them over after assistance ends. In Morocco, increasingly regarded by donors as too rich for large-scale support, the government is finding it difficult to replace external funds and commodities that the largest donor will soon phase out. Several possibilities exist to improve the sustainability of reproductive health services: establish cost recovery (fee-for-service) systems so that health centers can meet their operating costs; establish insurance and public assistance programs to enable more citizens to use the health system; and encourage the private sector to provide services for those who can afford to pay.



Looking Ahead

Has Cairo made a difference? Absolutely. Different observers may argue about the extent of progress that has been made. But the case studies make clear that change is possible even in the face of obstacles such as entrenched bureaucracies, widespread poverty, and public reticence toward issues related to sexuality. An openness and commitment to change—from the highest levels of political leadership to ordinary citizens—seems essential, regardless of the environment in which policies and programs operate.

Several notable accomplishments examined in these case studies provide hope to those who work for change: India's reversal of a thirty-year national policy on family planning targets; the reexamination of the socially divisive topic of abortion in Brazil; the dynamism of the women's movement in Morocco; and the Ugandan government's bold efforts to confront the devastation of the AIDS epidemic.

Much remains to be done. The scale of the problems to be addressed is tremendous—given the size of reproductive-age populations, the complexity of delivering an array of services, and the need for profound changes in attitudes. And even the changes that have taken place could be reversed, unless the momentum is sustained. Some extremely difficult tasks still lie ahead:

- ◆ Moving from policies, laws, and guidelines to widespread practice;
- ◆ Addressing the social dimensions of reproductive health;
- ◆ Reaching under-served populations, such as adolescents;
- ◆ Tackling politically contentious issues—for example, unsafe abortion;

Continued progress will require partnerships among advocates, practitioners, and academics—both within and outside government. Data on needs and program effectiveness are essential if we are to weigh priorities and make wise investments.

- ◆ Changing behaviors that lead to HIV transmission, and alleviating the consequences of AIDS in resource-poor settings;
- ◆ Changing health providers' attitudes to be more empathetic toward clients;
- ◆ Making the best use of existing resources, through wise public investments and partnerships with the private sector; and
- ◆ Improving infrastructure and human resource capacity in the poorest areas.

No single actor or institution can bring about all of these changes. Continued progress will require partnerships among advocates, practitioners, and academics—both within and outside government. Data on needs and program effectiveness are essential if we are to weigh priorities and make wise investments. Ultimately, consumers should be the driving force behind future improvements in reproductive health and other social services. We look to a future when they can be their own best advocates.

Appendix 1

Project Participants



CASE STUDY TEAMS

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Appendix 2

Summaries of Country Case Studies



Brazil Case Study

Sonia Corrêa, Sergio Piola, and Margareth Arilha

In Brazil, a comprehensive approach to reproductive health (or PAISM, Programa Assistencia Integral a Saude da Mulher) was defined in 1984 and included nearly all of the elements of reproductive health care called for 10 years later in the Cairo Programme of Action. In addition, Brazil's 1988 Constitution recognized reproductive self-determination as a right and defined the State's responsibilities in providing a full range of reproductive health services, including family planning. In that sense, the adoption of the Cairo agenda did not imply a major policy shift, as may have been the case in other countries. However, Brazil's earlier experience with implementing a reproductive health approach strongly influenced developments in the post-Cairo period.



In the late 1980s, political turmoil and economic crisis in Brazil hampered health reform, reproductive health policy initiatives, and the implementation of constitutional rights. As late as 1995, public health services still lacked basic interventions such as prenatal and maternity care, and cervical and breast cancer screening and treatment. The PAISM comprehensive agenda remained a stand-alone program, never funded or implemented as part of the country's unified health system. And it lacked important linkages that would have made it more effective, such as with the Adolescent Health Program, the National HIV/AIDS Prevention Program, or the Family Health Program.

More positive developments occurred after 1994. Brazil has experienced reasonable institutional stability and a political climate favorable to the ICPD agenda, and reproductive health and rights issues gained greater visibility as a result of the 1995 Fourth World Conference on Women in Beijing. In the last five years, the management structures of the unified health system have undergone reforms. In spite of the economic austerity climate, the government has approved additional health financing, advanced basic health approaches through a combination of family health and community-based strategies, and accelerated the decentralization of health services.

In this environment, a large number of service improvements have taken place. Reproductive health care is increasingly integrated with municipal-level primary health services. Basic interventions such as prenatal and maternity care have improved: Between 1995 and 1997, prenatal consultations increased by 51 percent nationally. Legal abortion services are now available in 12 sites, and the quality of post-abortion care is improving. Adolescent services

and prevention and treatment of STIs/HIV are better integrated with family planning and reproductive health services. Access to reversible contraceptive methods is expanding in primary health programs in many settings. Finally, national cancer-screening programs have been launched, and cervical and breast cancer screening increased 14 percent and 44 percent respectively between 1995 and 1997.

LESSONS LEARNED

Several factors can be credited with facilitating the process of change. First, since the 1980s, Brazil's political system has opened up to allow for greater participation of civil society. Greater democracy has lengthened the policy decisionmaking process, but it has also given voice to the advocacy community and allowed for debate of the reproductive health and rights agenda. More recently, open political debate persuaded other actors to adopt the agenda.

Second, reforms in the health sector have paved the way for the integration of reproductive health services in the unified health system. The major principles underlying health reform—universal access, comprehensive care, equity, decentralization, and social accountability—have proved to be a prerequisite for effective implementation of a comprehensive reproductive health approach.

Third, a committed and expanding reproductive health and rights advocacy community has influenced national policies from the establishment of PAISM in 1984 to the present day. The ability of the advocacy community to interact with the Ministry of Health and Congress, as well as to move into policy-related positions—as health managers and providers—has worked in favor of reproductive health goals.

On the other hand, progress in Brazil has been uneven because of a combination of issues. At the national policy level, economic stabilization programs have lowered the priority placed on social services, and opposition from conservatives has

stalled efforts to make legal abortion services more widely available. At the operational level, inefficiencies in the public health bureaucracy and the relative importance of private providers in providing contraceptives and other services have prevented the development of a unified, comprehensive strategy.

THE INFLUENCE OF FINANCIAL RESOURCES

Total health spending in Brazil is estimated at US\$50 billion, or about US\$320 per capita—at the high end of the scale for developing countries. The public sector accounts for 43 percent and the private sector accounts for 57 percent of spending. The federal government spends a small proportion of its total budget on reproductive health: \$1 billion in 1997, including the cost of childbirth procedures (US\$500 million) and HIV/AIDS treatment costs. Between 1995 and 1997, federal government spending on reproductive health grew by 34 percent. However, this increment is due almost entirely to the increase in funds for supplying STI and AIDS medications.

In this context, local level managers presently say that limited funding is not the major obstacle to improving reproductive health services. In their view, the commitment of manag-

ers, the training and attitude of health professionals and the curative biases of the system are more relevant at this stage. At the same time, their own policy experiences—after decentralization of the health system—show that the impact of additional resources can be tremendous.

International donor funds are minimal in relation to total national expenditures. In 1996, donor funding for reproductive health was about US\$28 million. However, international resources have been critical in the national HIV/AIDS program as well as in providing technical support to the women's health program in Ceará. Moreover, donor funds remain critical for policy research initiatives, data collection, and the sustainability of NGO efforts.

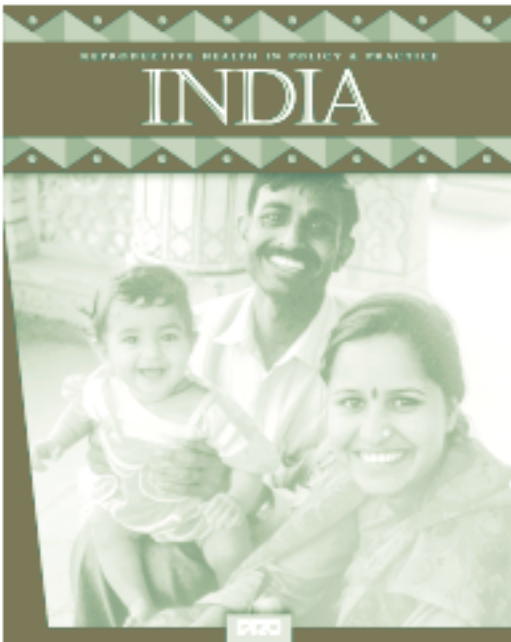
The major principles underlying health reform—universal access, comprehensive care, equity, decentralization, and social accountability—have proved to be a prerequisite for effective implementation of a comprehensive reproductive health approach.



India Case Study

Leela Visaria and Pravin Visaria

India was the first country in the developing world to initiate a state-sponsored family planning program, more than 45 years ago, to lower the country's population growth rate. From the early 1960s, centrally determined targets for contraceptive acceptance dominated the management of the program. The government's zeal to achieve these targets met with increasing criticism over the years. Just a few years after the ICPD, a major national policy shift occurred: The "Target-Free Approach" announced in 1996 eliminated national targets for contraceptive acceptance. Instead, the new approach called for planning at the community level, where grassroots workers would set targets for themselves after assessing the needs of individual clients.



FACTORS THAT ENABLED POLICY CHANGE

Several factors contributed to India's "paradigm shift." In the early 1990s, government planners recognized that the family planning program had stagnated. There was a clear inconsistency between the slow decline in the birth rate and the reported rise in the number of family planning acceptors in various states across the country, indicating that over-reporting of acceptors was common. At the same time, the excessive concern with fulfilling numerical targets was accompanied by a lack of concern for quality and an absence of motivation to provide basic health services. Women's groups and other NGOs repeatedly raised concerns about the narrow range of services offered and lack of concern for clients' needs. Some donor agencies shared these concerns and sponsored research and seminars to bring women's health needs to light. The ICPD provided these groups with an opportunity to pursue their agenda with government officials at national seminars. The evidence generated from the process provided the impetus to revamp the program.

IMPLEMENTATION OF THE NEW APPROACH IN TWO STATES

The case study examines the process of implementation of the government's new approach in the state of Rajasthan, in the northern part of the country, and in Tamil Nadu, in the south. Although they have different economic and social characteristics (Tamil Nadu is the more advanced of the two), both state governments are committed to implementing the new approach to family planning. The study examines issues such as the way in which the workload of the public-sector health workers is determined, whether the program has become more responsive to the needs of clients, and whether the range and quality of services has improved.

The family planning workload (or targets for contraceptive methods) of the grassroots-level workers in both states is decided on the basis of the

number of living children of the couples living in their area of work. The workers have to motivate or encourage the couples to accept the method that is supposed to be best suited for them. With minor variations, both states follow a “client segmentation” approach to determine their targets. As a general rule, workers encourage couples with two or more children to accept sterilization and those with fewer children to accept temporary (or reversible) contraceptive methods. While the health workers still have to report their performance in quantitative terms to higher authorities, they say that they are not reprimanded for not meeting the targets, as they were in the past. Interviews and focus group discussions indicate that clients in both states perceive that the pressure to accept sterilization has lessened, and that health workers inform and encourage couples to accept reversible family planning methods.

Annual service statistics show that in the year following the introduction of the target-free approach (1996-97), the number of family planning users declined in the country as a whole—possibly because the pressure to distort the statistics had disappeared. However, during 1997-98, use of all methods increased, thereby allaying the fears of many skeptics that contraceptive use would decline in a target-free environment.

OTHER REPRODUCTIVE HEALTH SERVICES

In Tamil Nadu, immunization services, prenatal check ups, health-worker visits to villages, and mothers’ meetings to discuss wide-ranging issues have all increased significantly in the last seven or eight years, even prior to Cairo. The workers in Tamil Nadu enjoy a better status as health care providers than they did as family planning providers. In Rajasthan, improvements have also begun, but at a slower pace than in Tamil Nadu.

At the same time, abortion services, which are legal in India, and facilities for the treatment of reproductive tract infections are yet to be initiated in public health facilities in both states, or in the whole country. Safe abortion services are unavailable in public health centers, as they require trained

medical doctors who are usually unavailable in small towns and rural areas. Consequently, most women seeking an abortion go to private practitioners who charge high fees. Similarly, very few public health centers offer screening or treatment for reproductive tract infections (such as sexually transmitted diseases). If a woman complains of possible symptoms, nurses can only advise women to go to a private practitioner.

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PROGRAM FUNDING AND FUTURE PROSPECTS

With respect to resource flows for the family planning program, the study focused on actual government expenditures during the 1990s. The data show that in real terms, the program has not mobilized a much larger volume of public resources since Cairo. However, the recently negotiated assistance from the World Bank for the reproductive health program will provide new funds for improving the range and quality of services throughout the country. Moreover, review of expenditure data from 1992

to 1997 reveals a marked reallocation in favor of spending to strengthen the delivery of family welfare services in urban and rural areas, along with related maternal and child health activities.

While the role of the central government in development planning is beginning to diminish, the state governments are likely to continue to make strong efforts to strengthen social services. It is likely that health and family welfare will, along with education, receive a high priority in this process. In the years ahead, the health sector is expected to provide a wide range of reproductive health services, taking into account the needs of the community and concerns about quality. However, additional progress will require significant efforts to strengthen infrastructure, retrain the workforce, and muster financial resources.





Morocco Case Study

Radouane Belouali and Najib Guédira

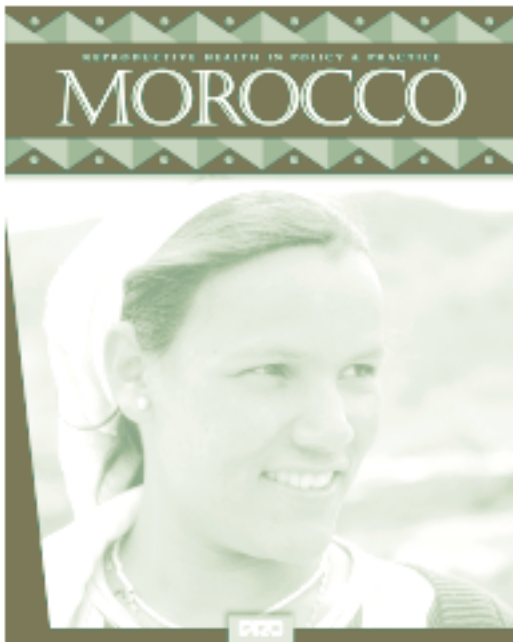
For more than 30 years, Morocco has had a population policy that supports programs aimed at birth spacing. During the last two decades, the family planning program has gone through many phases aiming to extend services to rural populations, offer a wider range of contraceptive choices, and improve the quality of services. The family planning program has always been integrated with broader health services for women and children. The Cairo conference helped to reinforce this approach, and more recent initiatives have aimed to add or strengthen services in other areas of reproductive health—notably those related to safe motherhood and sexually transmitted infections (STIs).

Despite these efforts, problems persist. Family planning services are financially dependent on donors, particularly for contraceptive supplies. The program emphasizes a limited range of contraceptive methods (oral contraceptives account for 70 percent of use), and family planning use in rural areas is still only about half the level in urban areas. In the area of safe motherhood, maternal mortality rates are still considered too high, prenatal care is of insufficient quality, and obstetric care is rare. The expansion of infrastructure to overcome these problems is seriously hampered by the insufficient number of gynecologists (less than 200) and midwives (less than 500) available to assist the 700,000 expected deliveries per year.

The case study shows that the Cairo recommendations and the resulting focus on reproductive health issues have helped to strengthen some current activities as well as introduce new activities. New developments include the expansion of infrastructure for maternal health services, improvement of the coverage of reproductive health care, changes in women's status, and the creation of NGOs working for the advancement of women's rights.

GROWING IMPORTANCE OF THE WOMEN'S MOVEMENT

In Morocco, discrimination against women has cultural, religious, legal, and economic roots. In rural areas, 89 percent of women are illiterate, and almost 75 percent of girls do not go to school. Women also tend to hold the least skilled and lowest paying jobs. These conditions persist even though women and men have the same constitutional rights and women have some legal protections. In 1992, the women's movement was instrumental in improving women's status and legal rights in areas such as marriage, divorce, and polygamy. These actions have raised the veil on many areas in which women face discrimination. In addition, public discussions are now taking place on several difficult issues, such as violence against women.



The women's movement considers the legal changes of the early 1990s to be insufficient. Seventy-six NGOs (one-third started after 1994) now work toward women's empowerment and their participation in development. The climate after the Cairo and Beijing conferences, combined with decisionmakers' changing attitudes, have encouraged these NGOs to play a dynamic role in the development of policies and programs.

SERVICE IMPROVEMENTS AND OBSTACLES

Following the ICPD, the government has focused on making improvements in three core services that fall under the rubric of reproductive health: family planning, maternal health, and STIs. The health ministry has strengthened the maternal health program by adding nutritional supplements of iron and iodine. Indeed, 45 percent of pregnant women suffer from anemia. A new, separately managed program has also been set up to address the growing incidence of STIs and AIDS. It includes free, anonymous testing for HIV and involves NGOs in service provision.

The issue of abortion is difficult to address because of cultural and traditional beliefs. Abortion is prohibited (except to save the mother's life), surrounded by silence, and considered a sin—although an estimated 130,000 abortions are performed per year. Similarly, little progress has been made in addressing the health consequences of adolescent sexuality, due to traditional and religious prohibitions on premarital sex. Studies are currently under way to provide decisionmakers with information on the scope of unmet need related to infertility, menopause, and cancers, as well as information on women's perceptions of these unmet needs.

FINANCING REPRODUCTIVE HEALTH FOR ALL

In Morocco, household out-of-pocket spending finances about one-half of all health care, and the government and health insurance pay for the other half. Access to health care is inequitable. The wealthiest households consume a disproportionate share of public and private health services in the country. Government subsidies are also distributed unevenly: While the top one-fifth of households benefit from 45 percent of the Ministry of Health's budget, the bottom 20 percent receive only 7 percent. This inequity penalizes the poorest people, particularly in rural areas. But since the early 1990s, and especially since the Cairo Conference, the Moroccan government has begun to give greater attention to these issues, due in large part to the participation of civil society and the efforts of the women's associations.

Since the ICPD, international agencies have also played a major role in promoting reproductive health and have provided additional funds. Donors have had a large impact on the budget allocated to reproductive health services—the budget increased 150 percent in less than seven years. International aid finances investments like equipment and training and pays for some drugs and contraceptives, while the Moroccan government pays salaries and most other operating expenses. These findings raise a central question: If international cooperation is the trendsetter in the expansion of reproductive health, what will be the future of these activities if donors withdraw support, as they likely will in the next few years? A number of solutions exist to make reproductive health care more widely available and financially sustainable. These solutions must be pursued immediately, in the context of a holistic view of development and health, and with the participation of government, civil society, and public and private professionals.

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Uganda Case Study

Florence Mirembe, Freddie Ssegooba, and Rosalind Lubanga

Only recently emerging from the devastation of a major civil war, the Ugandan government is committed to improving the health and well-being of the population using the available capacity and resources in the country. Uganda faces major reproductive health problems that include high infant and maternal mortality, high fertility, and high rates of teen pregnancies and unsafe abortions. It is estimated that between 1.5 million and 2 million Ugandans are infected with HIV/AIDS.

In the last five years, Uganda has undergone many political, legal, and institutional changes that have influenced all development activities. Some changes have been conducive to improving the status of women and reproductive health. These include the new constitution, which guaran-

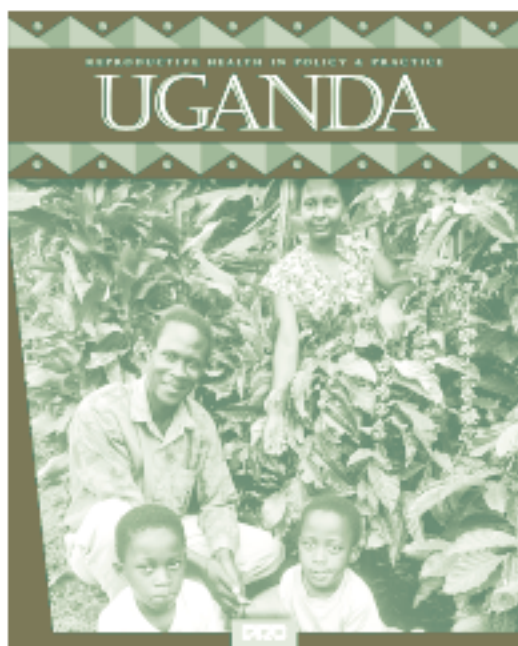
tees women's political representation, and several national policies in the areas of population, gender equality, and universal primary education (which promotes girls' education).

Within the broad reproductive health framework adopted at the ICPD, the Ministry of Health is focusing on the major priority programs that most affect the population. These programs include safe motherhood and child survival, family planning, prevention and management of sexually transmitted infections (STIs) and HIV/AIDS, capacity building, adolescent health, infrastructure development and information education and communication (IEC). Though most programs have been in place since before the ICPD, most have changed focus to incorporate aspects of the Cairo Programme of Action.

IMPROVEMENTS IN REPRODUCTIVE HEALTH SERVICES

Family planning programs have helped to increase contraceptive use from 5 percent of married couples in 1990 to 15 percent in 1995. The rate is thought to be much higher currently. Family planning programs have also begun to provide more comprehensive services, including care for STIs, prenatal care, and childhood immunizations, as opposed to "vertical" contraceptive services alone. This has led to obvious increases in service use, especially for under-served client groups such as men and adolescents.

Uganda has also adopted a multi-sectoral strategy to fight the high prevalence of HIV and STIs. The open government policy on the HIV problem has enabled national and international efforts to innovate and organize to address the problem at all levels of society. As a result of massive information, education, and communication campaigns, as well as research and voluntary counseling and testing, more than 90 percent of adults know about HIV/AIDS. Most current programs are targeting behavior



change, especially among young people. There are indications of a declining trend in HIV incidence and an increase in condom use in general.

More attention has also been given recently to safe motherhood, child survival and nutrition, and post-natal and post-abortion care. Efforts to improve these services have included training and retraining of providers, equipping health facilities, and mobilizing communities. Systems are also being piloted to refer pregnant women to hospitals in the event of life-threatening complications of labor and delivery.

REPRODUCTIVE HEALTH FINANCING

The government's contribution to the health sector has been increasing but is still low, given the low tax base in the country (per capita income is only about US\$300). The government spends only about US\$4 per capita annually on health, but surveys indicate that per capita health spending from both public and private sources increased from US\$8 in 1993-94 to US\$12 in 1996-97.

The government's creation and subsequent increase of a primary health care grant to local governments is testimony of its commitment to community health, which benefits mostly women and children. Reproductive health programs are primarily donor-financed—donors pay for about 90 percent of all investments. This raises serious questions about how programs will be sustained after donor funding ends.

Nevertheless, health programs are currently attracting about 22 percent of all development assistance to the country, an increase from 13 percent in 1993-94. Family planning, safe motherhood, and prevention of HIV/AIDS and STIs have attracted more funding in the last five years. More funding has also gone into universal primary education, agriculture, road construction, and poverty alleviation programs, which also have an impact on the population's health status.

ASSESSMENT OF PROGRESS AND OBSTACLES

The study reveals a supportive policy environment for reproductive health and rights whose benefits are yet to be felt at the community level. Major challenges to implementation include a lack of skilled manpower, infrastructure, and community awareness. There are few trained professionals at the national and district levels who can implement health-sector reforms and reproductive health programs. The available manpower is not deployed in favor of the primary health care system that serves the majority of the population. Information provided to individuals seeking care, and service choice and quality are unsatisfactory.

Reproductive health programs—and indeed all development programs—are now implemented in a decentralized fashion, with funding and management responsibilities in the hands of local governments. In this context, the coordination of donors, NGOs, and the commercial sector is essential to ensure donor funds are distributed equally to different communities and to ensure access to priority services. The study team observed weaknesses in coordination at both the national and local levels.

Universal access to reproductive health services can only become a reality when the entire system's capacity is strengthened. Efforts are needed to develop human resource capacity and infrastructure—in particular, roads and communications systems. In order for these changes to occur, resources must be made available and coordinated well in the health sector and other sectors that influence the health system.

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