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CAIRO+5: MOVING FORWARD IN THE EYE OF THE STORM

In the first half of 1999, the United Nations will assess what has been achieved by way of implementing the recommendations of the International Conference on Population and Development–Cairo 1994. The process is known as Cairo+5 and will start in February in The Hague, where NGO and youth fora will precede a first governmental meeting. March 22th–30th in New York, a Special Session of the UN Commission on Population and Development will debate the Secretary General’s Draft Report on ICPD Implementation, which is expected to highlight key areas for future action. The final stage of negotiations is scheduled for a Special Session of the UN General Assembly in late June.

The Cairo consensus represented a major paradigm shift with respect to the population debate and related policies. But agreements reached with respect to gender and reproductive rights were built on agreements on women’s rights that were previously reached at the UN conference on human rights in 1993 in Vienna. In turn, commitments on gender equality and reproductive health made at the World Summit on Social Development (WSSD) in Copenhagen in 1995 were fundamentally based on ICPD definitions, while the Beijing Platform for Action of the Fourth World Conference on Women expanded on the Vienna agreements on women’s human rights, Cairo recommendations on reproductive health and rights and the WSSD macro-economic agenda. Cairo+5 is an important global policy

exercise in itself. Given the close substantive linkages among the four conferences mentioned above, it will also have strategic implications for what happens later at Copenhagen+5 and Beijing+5.

THE MEANING OF THE CAIRO AGREEMENTS

Population policy has always been contentious. Clashes between different perspectives and points of view occurred at both of the previous World Population Conferences, at Bucharest in 1974 and in Mexico City in 1984. Never before Cairo, however, were there so many sets of actors discussing population policies in the public arena. The resulting transformation of the public debate was profound. ICPD shifted policy direction away from demographically driven approaches and towards policies oriented towards human rights, social well-being and gender equality, with particular emphasis on reproductive health and rights.

During and after ICPD there were some complaints in the Southern NGO community that development issues were being short-changed by the battle over abortion.² The negotiation of Chapter III, «Interrelations Between Population, Sustained Economic Growth and Sustainable Development», of the ICPD Programme of Action were, in fact, tense and difficult. A climate of growing distance between North and South that has characterised the 1990s vitiated the atmosphere of all the UN

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² In fact the struggle over abortion was no more protracted in actual fact than the negotiation over migration, but this was not highlighted by media coverage. It was more than ironic that some South-based journalists and others were willing to dichotomize women’s health and rights from development, perhaps without realizing that they were falling thereby into the Holy See’s world-view!

conferences of this decade. Group of 77 positions were much less cohesive than in the past. Given this context, the agreed text of Chapter III contains a good deal favourable to the South. It acknowledges the right to development as a universal and inalienable right and as an integral part of fundamental human rights, and argues that «*structural adjustment programs ... (be) so designed and implemented as to be responsive to social and environmental concerns*».

Chapter III speaks strongly to the problems of inequality within and between nations, and to the needs of poor women everywhere. Its section on sustainability defines as its objective the need to reduce unsustainable consumption and production and agrees that the North should lead in sustainable consumption and effective waste management.³ It argues in favour of investment in human beings and the need to strengthen food security. Thus, although concise, the ICPD agreements on population, development and the environment in fact established a sound basis for the Copenhagen WSSD negotiations. The latter could, as a result, be made sharper and clearer with respect to requirements for an enabling economic environment: the acknowledgment of the detrimental impacts of structural adjustment programmes, the importance of debt reduction and the value of the 20/20 initiative.

Most important, however, is that ICPD was a critical watershed for women. For the first time outside conferences specifically for women, the world community made a major directional change in policy that was initiated and supported by women and that can work in women's interests. Chapter IV, «Gender Equality, Equity and Women's Empowerment», abandons the old and neutral language of women's status for a more proactive acknowledgment of gender power relations. It contains strong sections on women's empowerment including economic rights, on the girl child including opposition to son-preference and sex-selection, against female genital mutilation, infanticide, trafficking and child prostitution and pornography, and in favour of programmes to educate men towards more responsible behaviour.

Chapter V, «The Family, Its Roles, Rights, Composition and Structure», acknowledges the existence of a variety of family forms and defines the policy objectives as being to support families, to provide social security for child-rearing, and to protect the rights of women and children within families. Recognising the worsening conditions of poor families due to declining social expenditures (consequent on budget cuts), it argues for special support especially for single-parent households. Chapter VI similarly

addresses the needs of those hitherto under-served by policies and programmes: children and youth, the elderly, indigenous people, and the disabled.

Chapter VII, «Reproductive Health, Reproductive Rights and Family Planning», occasioned the most protracted negotiation. Starting with WHO definitions of reproductive and sexual health⁴ the chapter goes on to define reproductive rights as the right to make reproduction decisions free of discrimination, coercion, and violence. The chapter states that reproductive health services (including sexual health and family planning) should be linked to the primary health care system, and should include making abortion safe (where it is not against the law), treating reproductive tract infections, sexually transmitted diseases, and infertility, in addition to maternal and child health services and counseling men and youth for responsible sexual behaviour. The chapter supports the decentralisation of services, improvement of quality in family planning programmes, and has a strong statement against any form of coercion in family planning programmes including targets, quotas, incentives and disincentives.

Chapter VIII, «Health, Morbidity and Mortality», was relatively uncontroversial except for paragraph 8.25 that addresses the problem of abortion. Although the text was considerably watered down from its initial versions, it acknowledges unsafe abortion as a major public health concern. It states that women should have access to services to manage the complications of unsafe abortion under all circumstances. It also contains an enabling statement requiring abortion to be safe in circumstances in which it is not against the law. A year later in Beijing, the Platform for Action added a sentence to the ICPD text on abortion which reads as follows: «*Member states should consider reviewing existing punitive legislation*» (with respect to abortion) (IV WCW paragraph 106 k).

The ICPD Programme of Action also defined targets in terms of financing its various components: USD 17 billion to be reached in the year 2000. Family Planning expenditures were estimated at USD 10.2 billion and reproductive health services (excepting family planning) at USD 5 billion, HIV/AIDS at USD 1.3 billion, and research, data collection (including decennial censuses) and policy analysis at USD 500 million. Overall, about 65% of the total of USD 17 billion was supposed to go towards the delivery system. It was also recommended that the share of external finance should rise from its then figure of about 20% to roughly one-third of the total. Thus, regarding North-South sharing of the financial responsibilities, it was indicated that, in 2000, USD 5.7 billion should come from external donors and the rest from domestic resources.⁵

³ There is much in Chapter 3 that those interested in social and economic equity can support. For instance, minority women from the US were delighted when, as a result of informal advocacy, the US amended para 3.16, which defines the objective of raising the quality of life, to include poor women in both developed and developing countries as deserving of special attention.

⁴ The definition of sexual health was considerably abbreviated in the final version of the ICPD Programme of Action to meet the objections of Iran and Pakistan.

⁵ A valid point that has been raised with respect to resource allocation by UNICEF, among others, is that resource needs for broad primary health care, child survival, primary education, and for other aspects of women's empowerment remain unspecified. In 1994, the expectation was that this would be addressed in a consistent manner by the Social Summit. As we know, the most clear outcome in this regard at Copenhagen was the 20/20 Initiative.

The ICPD Programme of Action also established fairly clear guidelines concerning the institutional frames and principles for monitoring and accountability of ICPD implementation, something that did not happen consistently at all the conferences of the 1990s.

PARTNERSHIP MONITORING AND ACCOUNTABILITY MECHANISMS: ICPD RELEVANT AGREEMENTS

ICPD recommendations on Partnership and Monitoring and Accountability mechanism are found in Chapter XV. Among the various agreements reached in Cairo, two can be seen as guidelines to assess progress made since 1994:

Paragraph 15.8. *Governments and intergovernmental organisations, in dialogue with non-governmental organisations and local community groups, and in full respect for their autonomy, should integrate them in their decision-making and facilitate the contribution that non-governmental organisations can make at all levels towards finding solutions to population and development concerns and, in particular, to ensure the implementation of the present Programme of Action. Non-governmental organisations should have a key role in national and international development processes.*

Paragraph 15.9. *Governments should ensure the essential roles and participation of women's organisations in the design and implementation of population and development programmes. Involving women at all levels, especially the managerial level, is critical to meeting the objectives and implementing the present Programme of Action.*

1994–1998: PROGRESS AND BOTTLENECKS

The DAWN network has assessed post-ICPD policies in Bolivia, Brazil, Nicaragua, Peru, Puerto Rico, India, Malaysia, Thailand, Indonesia, Viet Nam, Lao, Cambodia, Philippines and Fiji.⁶ What emerges from this exercise in policy analysis is a mixed picture of both progress and bottlenecks.

Although variations do exist across countries, policy shifts in at least some started even before Cairo. In Brazil, India, and the

Philippines, the Cairo agenda was anticipated some years previously. But even in these countries, the ICPD provided a major fillip to the changes taking place. In other countries such changes as have occurred were largely mobilised by the preparations for the Conference. In Southeast Asian countries (other than the Philippines), governmental officials declare that policies were already in line with ICPD directions even before 1994. These statements are questioned by health activists from the region. While it is true that a number of Southeast Asian governments had effective social development and anti-poverty policies in the two decades prior to the current crisis, it would probably be appropriate to say these policies were more in line with the agreements of the First World Population Conference held in Bucharest in 1974 than with the Cairo agenda *per se*. The Cairo agenda builds on the Bucharest agenda in emphasizing the importance of social development policies but goes considerably beyond it through its emphasis on reproductive and sexual health, reproductive rights, gender equality and women's empowerment. In all the countries analysed from 1995 on, the ICPD agenda appears to have been strengthened by pre- and post-Beijing processes.

The case studies demonstrate that since 1994 policy discourses have moved from demographic imperatives towards a health approach. In many countries—Bolivia, Thailand, Philippines, Fiji—family planning programmes have been renamed Reproductive Health Programmes. In India, a potentially more radical change has occurred. In 1996 the three decades old programme implementation method of setting targets for contraceptive acceptors was removed. Even in the case of Brazil, where a national comprehensive women's health policy has been in place since 1984, Cairo and Beijing have meant a booster, particularly with respect to abortion. Services to provide abortion in the cases permitted by law—rape and threat to the woman's life—have expanded rapidly.

These developments should not be underestimated. The political and economic climate prevailing in the last four years has not been favourable to the Cairo agenda. Across Latin America, most especially in Central America and Puerto Rico, religious forces, particularly the Catholic hierarchy, have been openly attacking the Cairo and Beijing agendas. In Asia and the Pacific, the moral conservative reaction is not so open and clear—the exception being the Philippines. But governments are clearly oversensitive with regard to reproductive rights, sexual health, adolescent health and abortion.

Implementation efforts everywhere are taking place in an entirely unsatisfactorily economic environment. Across the South

⁶ The case studies were by the following researchers: Brazil, Sonia Correa, relying on another study performed in collaboration with Sergio Piola and Margareth Arilla; Bolivia, Ximena Machicao; Fiji, Margaret Chung; India, Gita Sen, Vanita Mukerjee, Vimala Ramachandran and Anita Gurumurthy; Nicaragua, Ana María Pizarro; Peru, Cecilia Mandelengoitia; Philippines, Gigi Fransisco; Puerto Rico, Isabel Laboy and Alicia Warren; Uruguay, Cristina Grela and Alejandra López. A regional review of South East Asia countries – Malaysia, Thailand, Indonesia, Lao, Cambodia and Viet Nam was graciously shared with DAWN by Rashida Abdullah from ARROW. A separate exercise involving a set of African countries is under way.

deep inequality patterns and poverty levels have worsened after 1994. Reproductive health policies are being implemented amidst state and health reforms that, in many cases, imply cuts in social investments and privatisation of services. After 1997, the global storm of financial instability has directly affected both South East Asia and Latin America.

But in spite of these various constraints, the movement forward was clear everywhere, at least until early 1998. In various countries efforts are being made to overcome the lack of integration between the various components of a reproductive health policy—MCH, contraceptive assistance, STD and HIV—AIDS prevention. Greater attention is being given to maternal mortality. In India, policy makers, providers and health activists are struggling with the tremendous challenges of turning upside down a long established vertical and narrow family planning programme. In various countries initiatives are developing to respond to adolescent needs. Additionally, as a result of Beijing, in all countries policy-makers, NGOs and the media are talking of gender, violence against women, affirmative action, and political quotas.

There are striking positive examples of institutional arrangements in which governments, non-governmental organisations including the reproductive health and rights advocacy community, and international agencies are interacting and jointly discussing how to implement the Cairo agreements. In Brazil, monitoring mechanisms are built into the structure of the health system through the health councils. Together with the National Commission on Population and Development created to track ICPD implementation, health councils have been crucial to sustain the ICPD related policies. In Peru a tripartite negotiating mechanism that involves the Ministry of Health, feminist organisations and donor agencies has been created to follow ICPD implementation. In Bolivia, monitoring and accountability efforts have taken place at the level of the National Maternal Mortality Commission. In Uruguay, linkages have been built between the advocacy community and both the national health system and the municipal one in the capital, Montevideo.

Positive as these signs may be, it is also clear that much remains to be done. There is still a lack of clarity regarding such key ICPD concepts as gender, women's empowerment, and male responsibility. Similar problems are to be found in the case of sexual health and reproductive rights. Where sexual health is being adopted as a concept, it is basically translated as STD/HIV prevention. In most settings, reproductive rights are interpreted merely as right or access to reproductive health services, leaving aside other critical dimensions such as informed choice and reproductive self determination. Reaction and confusion is also evident in the area of adolescent needs.

One area where movement has been slow is abortion. Among the countries analysed by DAWN, only Brazil has achieved clear

breakthroughs.⁷ In Bolivia—in the context of health reform—reproductive health and rights advocates have managed to ensure that post abortion treatment will be reimbursed by public funds. In India and Viet Nam, where abortion is legal, there is greater recognition of the need to improve existing services. But in Fiji where there is room to improve abortion services—the procedure is allowed in the case of rape and physical or mental risks—ICPD has not mobilised initiatives in this direction. In Central America it is probably fair to say that there has been some retrogression. On the whole, progress has been relatively meager, and there is considerable need to move more rapidly.

The findings also indicate that effective improvement of reproductive health services has been very limited, especially in the case of urban poor and rural populations. In many contexts, vertical family planning programmes are being reorganised or simply renamed as reproductive health. These vertical packages do not always establish necessary linkages with other strategic areas, eg, HIV—AIDS prevention or cervical cancer screening. Other recurrent obstacles to improving the quality of services in either family planning or reproductive health more broadly are the inadequate training, bureaucratic mindset, and gender—insensitive attitude of health managers and providers.

A major issue for ICPD implementation is insufficient understanding of how good quality reproductive health services can be expanded in the context of health reforms as they are currently being framed and implemented. The World Bank, which has now replaced WHO as the major donor in the health field, strongly emphasises the importance of health sector reform. This involves reaching an agreement between the government and all the donors within a country to adopt a three-pronged approach involving: a) common sector wide policies and strategies; b) a prioritised public expenditure approach, based on cost effectiveness exercises using burden-of-disease and DALYs⁸ measures, and the identification of a package of «essential services»; and c) a common management framework.⁹

While the value of a common approach cannot be denied, it also reduces the flexibility available to governments and donors to experiment with other approaches. Given the technocratic hegemony of the World Bank and its growing financial dominance in the health field, this is a discomfiting probability. It means that those less wedded than the World Bank to cost-effectiveness as the principal criterion for health interventions might have fewer policy or programme avenues open to them. The case studies also demonstrate that agencies, managers and advocates involved with reproductive health programming are not interacting adequately with the sectors designing and implementing health reform, either globally or at country level.

Last but not least, monitoring and accountability mechanisms have not been established everywhere. In most countries, the

⁷ Significant forward movement in ensuring women access to legal abortion has been made since ICPD in countries such as South Africa and Guyana.

⁸ Disability—Adjusted Life Year—expresses years of life lost due to premature death and years lived with a severe and long-lasting disability.

⁹ Sen and Gurumurthy, 1998, *op. cit.*

observed progress can be mostly attributed to the persistent efforts of the reproductive health and rights advocacy community. In some cases, such as Nicaragua and Puerto Rico, these efforts are being undertaken with very weak institutional support. In other countries such as Cambodia, Lao, Viet Nam and Fiji, international agencies have played a stronger role as ICPD stakeholders. On the whole, policies are moving more swiftly in the right directions wherever governments, agencies and reproductive health and rights NGOs are cooperating and consulting, or accountability mechanisms have been established. Effective cooperation and dialogue between at least two of the three major sets of stakeholders appear to be needed to push forward the ICPD agenda: government + NGOs, or government + agencies, or agencies + NGOs. It is also clear that the NGO role gains greater centrality where government resistance to ICPD implementation is greater.

CAIRO+5 IN THE GLOBAL SCENARIO OF 1999–2000

In the best of circumstances the advancement of the Cairo+5 agenda will not be an easy task as it involves further semantic struggles, macro policy transformations, and micro interventions to change the quality of services as well as the mindset and attitudes of providers. The global economic and political scenario for 1999–2000 provides a sobering reminder of just how difficult this is going to be. A year ago no one could have foreseen the magnitude of the earthquake set off by the Asian financial crisis. There was little expectation that the financial upheaval would spread so rapidly and extensively into other regions including the heart of the global financial system itself. One immediate impact of the current economic hurricane has been the reduction of health budgets in countries—like Brazil, Malaysia and Thailand—where domestic expenditures in primary and reproductive health had been expanding.

Additionally, as we have seen, Southern governments have met their ICPD financial commitments much better than have the donor countries. Consequently, strong positions can be expected on the part of G-77 countries in The Hague and beyond. In 1994, even if the global economic climate was not easy, the Cairo consensus was made possible after a careful building of North–South bridges around the reproductive health and rights agenda. Prevailing political conditions today cannot so easily propitiate the atmosphere of dialogue that became known as the «Spirit of Cairo». It is vital to recall that in all the UN conferences of the decade, fundamentalist forces have systematically taken advantage of the political climate that followed the widening of North–South breaches:

FINANCING REPRODUCTIVE HEALTH SERVICES

Data collected at the global level suggest that recipient governments have come closer to the financial commitments agreed on in 1994 than donor countries in term of population related aid. This reflects in part the greater importance of domestic expenditures in the basic infrastructure of the health system. At country level, the collection of consistent data on resource allocation for implementing ICPD is not exactly an easy task. A more substantive analysis has been possible only in the cases of Brazil and India. In spite of this limitation, the studies indicate that in the majority of the 15 DAWN study countries in which policies have been analysed, reproductive health programmes *per se* remain heavily dependent upon international assistance. In countries like Bolivia, Philippines and Peru, the national programmes have been renamed «Reproductive Health» programmes but the bulk of resources are still going to family planning. In other settings—India is one example—resources are channeled in ways that do not favour the effective overcoming of major epidemiological problems. The reduction of maternal mortality, for example, requires that investments in primary health programmes be combined with the improvement of referral systems and obstetric assistance. But in the current scenario, donors are reluctant to fund infrastructure, and structural adjustment requirements curtail domestic investment. But the sharper insight with respect to resource allocations is that quality of expenditure is as critical as the amount of resources invested. This applies both to Brazil where federal expenditures in reproductive health has reached USD 1 billion in 1996, as well as to India, where investments are less than one US dollar per capita. Additional international and domestic resources are necessary but not sufficient. The potential impact of «more money» is clearly conditioned by policy, management and accountability factors.

«In Rio the Holy See put itself forward as a champion of the South, arguing that poverty and inequality were greater problems than population growth *per se*. Clear even then was the effort by the Holy See to use the North–South divide to attack family planning programs and thereby the availability of both contraception and abortion in the South».¹⁰

¹⁰ Sen, 1995, *op.cit.*

The potential dark side of the Cairo+5 political scenario, however, must be balanced with unusual signs that can also be mapped in the global economic debate. If one year ago few would preview the extension of the coming crisis, no one—other than the «usual suspects» of environmentalists, women’s organisations, trade unionists, left-liberal development organisations and thinkers—seriously thought that the ideological consensus that has ruled the world economy for the last two decades would crack apart. Today the strongest supporters and beneficiaries of the «globalised» economy are on the defensive and are pulling back from unbridled globalism to call for better management of the world economy and greater inclusion of those who have been marginalised.

Nervousness grips not only global financial markets but also the highest levels of OECD governments. The spectacular growth miracle of Southeast Asia has been succeeded by an equally spectacular collapse that has threatened the entire global system. In the process, cherished neoliberal beliefs of the last two decades are being challenged from the very heart of the system. Not only have the normally pliant governments of Malaysia and Hong Kong imposed some version of capital controls, not only has Russia unilaterally rescheduled its debt, but doubt has crept in within the Bretton Woods organisations themselves. A number of mainstream economists and influential public figures¹¹ have criticised the IMF for refusing to alter the recession-inducing advice it has been giving to the beleaguered economies of Southeast Asia, and for throwing billions of dollars into the ever-widening breaches of a collapsing dike with very little effect.

But the single most important criticism of the Washington consensus has come from the World Bank’s chief economist and vice-president, Joe Stiglitz. In his lecture at Helsinki in early 1998, and a series of other talks and written papers, Stiglitz has criticized the IMF for its wrong-headed approach, and argued for a post-Washington consensus—one that would impose stronger controls on capital movements, that would not use national recession as an instrument to bring countries into line with the global order, and that would focus more on human development needs and inclusion of the marginalised. It is ironic that the World Bank, which enforced structural adjustment programmes throughout the world during the 1980s and much of the 1990s should now be attacking the very premises of its own previous actions. But this split in thinking between the highest levels of the Bank and the Fund is probably the most important sign that the days of pure neoliberalism are over.

This climate has definitely created space for a range of civil society initiatives to bring greater transparency and accountability to the global political economy. The Cairo+5 negotiations, particularly in those aspects that are strongly dependent upon a deeper transformation of the cracking neoliberal paradigm—as is the case of international cooperation trends and health reform premises—should be seen as a challenging but fertile opportunity to raise the profile of women’s concerns and needs at the core of the debates about changing the global order.

STEPS TO BE TAKEN

Conclusions, although preliminary, can be drawn from this exercise. An overarching one is that ICPD has certainly triggered major changes not only in population policies, but also in development debates more generally. While the pre-Cairo policy scenarios were extremely heterogeneous across countries, after 1994 convergent positive trends and similar obstacles can be identified with respect to ICPD implementation. Consequently, in view of key future actions to be taken, a minimal agenda can be defined to orient the Cairo+5 debates and negotiations.

- Consistent and systematic clarification of key ICPD concepts and recommendations;
- Conceptual and practical strategies to address reproductive health needs and expand services—as defined by Cairo—in the context of health reform debates and implementation;
- Creation and sustenance of functional, transparent and democratic mechanisms for monitoring and accountability at community, local, national and international levels, guaranteeing the participation of women as users and advocates;
- Creative combination of efforts aiming at increasing financial resources for ICPD implementation with clear and sharp criteria to ensure quality of expenditures at all levels.
- Implementation of both Paragraph 8.25 of ICPD Programme of Action and Paragraph 106 k of the Beijing Platform of Action to ensure women’s reproductive self determination and universal access to safe abortion procedures.

● DAWN – Development Alternatives with Women for a New Era.

¹¹ Among the economists are Jagdish Bhagwati, Jeffery Sachs and Paul Krugman; influential public figures include Henry Kissinger and George Schultz.