Some thoughts on ICPD+5
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In June 1999, the Twenty-first Special Session of the United Nations General Assembly reviewed the implementation of the Programme of Action of the International Conference on Population and Development (ICPD), which had been adopted in Cairo in September 1994. This represented the culmination of a series of activities to mark the fifth anniversary of what has become known as the Cairo consensus — though consensus is something of a misnomer in the light of the controversies that marked the whole process. Following this introductory commentary, the articles by Lush et al. (pp. 771–777) and Wheeler (pp. 778–779) bring different perspectives to the debate on population and development, one from the point of view of the underlying philosophy, the other from a more technical and practical standpoint.

Wheeler asks whether something vital was lost in the process of reaching the Cairo consensus. He has a point. Though billed as a conference on population and development, detail about the nature and content of population policies is sketchy. The final document to emerge from the discussions at the Twenty-first Special Session of the UN General Assembly explicitly eschews making specific recommendations regarding population goals. It “does not quantify goals for population growth, structure and distribution” policies, confining itself instead to a general statement that “early stabilization of world population would make a crucial contribution to realizing the overarching objective of sustainable development”(1).

This tentative and restrained statement illustrates how much has changed since the 1960s when UNFPA was conceived and established with a mandate to raise awareness about the population “problem” and to assist developing countries in addressing it. At that time, the talk was of “standing room only” (2), “population bombs” (3), “demographic entrapment”(4) and scarcity of food, water and renewable resources (5). Concern about population dates back much further of course, to Malthus and his contemporaries and their analysis of the relationship between population growth and food availability. The Malthusian philosophy found a particular echo in India, which in 1952 was one of the first developing countries to establish a national family planning programme with clearly specified demographic objectives and numerical contraceptive targets. The Indian political and social elites did not question the premise that their huge and growing population threatened food supplies and progress (6). Similar sentiments were expressed in China and in East Pakistan, which later became Bangladesh (7). By the 1980s, such concerns had been globalized and population concerns were expressed in terms of their environmental impact and the “carrying capacity” of the whole planet.

Concern about burgeoning populations (particularly in the developing world and among the poor) coincided with the rapid increase in availability of technologies for reducing fertility — the contraceptive pill became available during the 1960s along with the intrauterine device (IUD) and long-acting hormonal methods. It is no accident that in 1972 WHO established the Special Programme of Research, Development and Research Training in Human Reproduction (HRP), whose original mandate was focused entirely on research into the development of new and improved methods of fertility regulation and issues of safety and efficacy of existing methods. Modern contraceptive methods were seen as reliable, independent of people’s ability to practise restraint, and more effective than withdrawal, condoms or periodic abstinence. Moreover, they held the promise of being able to prevent recourse to abortion (whose practice was generally dangerous) or infanticide. Thus panic about the reproductive elan of the world’s poor was harnessed to a technological fix.

Population policies became widespread in developing countries during the 1970s and 1980s and were supported by UN agencies and a variety of nongovernmental organizations (NGOs), of which the International Planned Parenthood Federation (IPPF) is perhaps the best known. The dominant

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paradigm argued that rapid population growth would not only hinder development, but was itself the cause of poverty and underdevelopment (8). Almost without exception, population policies focused on the need to restrain growth; very little was said about other aspects of population, such as changes in structure or in patterns of migration. Given that family planning programmes had their genesis among the social and economic elites, it is perhaps hardly surprising that what resulted was based on top-down hierarchical models and that their success was judged in terms of numerical goals and targets — numbers of family planning acceptors, couple–years of protection, or numbers of tubal ligations performed. Donors, anxious to demonstrate that their aid money was being well spent, encouraged such performance evaluation indicators. In the drive for efficiency and effectiveness, they supported the establishment of free-standing “vertical” family planning bodies, generally quite separate from other related government sectors such as health, and which were often set up within the office of the president or the prime minister as a mark of their importance.

What was the impetus behind the paradigm shift that Cairo represents and that has been reinforced in the recent special session of the UN General Assembly? Three elements are of particular importance. The first was the growing strength of the women’s movement and its criticism of the overemphasis on the control of female fertility — and by extension, female sexuality — to the exclusion of women’s other needs. It is no coincidence that women’s groups from India have been among the most eloquent and articulate exponents of this critique. India’s family planning programme was criticized for some flagrant abuses, such as the forced sterilizations that occurred during the Emergency Period of 1975–76. In the meantime, other aspects of women’s health, in particular of their reproductive health, such as safety during pregnancy and childbirth, were neglected.

A second key development was the advent of the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) pandemic. Suddenly it became imperative to respond to the consequences of sexual activity other than pregnancy, in particular sexually transmitted diseases (STDs). But perhaps more important, it became possible (and essential) to talk about sex, about sexual relations outside of marriage as well as within it, and about the sexuality of young people. For over 20 years, family planning programmes had operated as though sexuality was not an issue, as though the control of women’s fertility was simply a technological challenge, and as though the social and behavioural context and the underlying power relations between women and men were of no consequence. By the early 1990s, however, this was no longer possible.

A third development, which brought a unity to the others, was the articulation of the concept of reproductive rights. An interpretation of international human rights treaties in terms of women’s health in general and reproductive health in particular gradually gained acceptance during the 1990s. This culminated in the clear and unambiguous statement in the ICPD Programme of Action that “reproductive rights embrace certain human rights that are already clearly recognized in national laws, international human rights documents and other consensus documents” (9). Three rights in particular were identified:

- the right of couples and individuals to decide freely and responsibly the number and spacing of children and to have the information and means to do so;
- the right to attain the highest standard of sexual and reproductive health;
- the right to make decisions free of discrimination, coercion or violence.

Subsequent articulations of reproductive rights have gone further, so that, for example, maternal death is defined as a “social injustice” as well as a “health disadvantage” thus placing an obligation on governments to address the causes of poor maternal health through their political, health and legal systems (10).

These strands became fused in the concept of reproductive health which was first clearly articulated in the preparations for Cairo and which has become a central part of the language on population. The new paradigm reflects a conceptual linking of the discourse on human rights with that on health. It proposes a radical shift away from technology-based, directive, top-down approaches to programme planning and implementation. In April 1996, less than two years after ICPD, the Government of India took the dramatic step to declare all of India target-free and, in October 1997, launched a nationwide reproductive and child health programme to provide comprehensive, good quality services, planned and monitored in a participatory and decentralized manner. Other countries around the world, from Bangladesh to Brazil, from China to Chad, from Sri Lanka to South Africa, have taken a similar stance.

Will it work? And what will be the consequences? Wheeler asks whether concern for demographic outcomes should be abandoned. Will it be possible to achieve stabilization of global population growth while attending to people’s reproductive health needs and respecting their sexual and reproductive rights? Perhaps at least part of the answer lies in the demographics themselves. The fertility transition is already well under way. While world population continues to rise by some 78 million people each year, this is to a great extent the result of existing population momentum — the large pool of sexually active, potentially reproductive young people is only now beginning to work through the demographic system. But there is no question that fertility levels have fallen and seem set to continue falling. In the 1950s, women had, on average, around five children each. Today that figure is closer to three. In 61 countries, fertility rates are already below...
replacement levels. The United Nations population estimates and projections have been revised downwards and it is predicted that the situation in countries with continuing high fertility is likely to converge rapidly towards that in those where fertility is already at or below replacement levels. Increasingly, concerns are voiced about population ageing and its attendant challenges for health and social and economic structures.

On the other hand, it remains unclear whether the conceptual shift will lead to real and sustained improvements in reproductive health, particularly among the poor. Lush et al. take a look at the realities behind the wording. The language is couched in terms of “comprehensiveness”, “integration”, “a full range of services across the life cycle”. It postulates a definition of reproductive health that is all-encompassing and vast. It urges attention not only to key pathologies (STDs, HIV, maternal mortality) but also to positive, life-enhancing aspects such as “a safe and satisfying sex life” and “the enhancement of life and personal relations” (11). How can such a concept be grafted onto the existing reality of vertical programmes, separate funding sources, selectivity, cost-effectiveness and resource constraints? Lush et al. observe with some bitterness that in 1999, 5 years on from Cairo, HIV infections continue to climb, maternal mortality remains high and avoidable, and millions of people around the world cannot control their fertility when they wish to do so.

Perhaps 5 years on is too soon to judge the situation. While there has been a generalized adoption of the Cairo wording, it is not clear that everyone is really talking about the same thing. Is reproductive health a central part of the human condition, an approach to programme development or a particular constellation of health services and related information (12)? Where exactly do the boundaries lie? Should reproductive health address only pathologies or should it take on the challenge of improving wellbeing also? Is reproductive health something that can be measured in any meaningful way and, if not, how will it be possible to translate the political imperatives into action on the ground? Is it conceivable to try to ascertain the burden of disease due to reproductive ill-health in the absence of any conceptual clarity on what it covers (13)?

Over the coming years, the debate will continue around these issues. But as Wheeler observes, the broad-based consensus that crystallized in Cairo has not been matched by financial resources, either on the part of developed country governments or, more particularly, on the part of donor agencies. Is this a matter of donor fatigue? Have other priorities become more pressing, such as environmental pressures, the globalization of the world economy, the traumas faced by economies in transition, the terms of world trade? Or is the failure to match the rhetoric with resources symptomatic of a more subtle unease about the Cairo agenda?

The second paragraph of the report of the 1999 Special Session makes a clear and bold statement. It acknowledges that “the goal of the empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself and is essential for the achievement of sustainable development”. This is a frank admission that what we are dealing with is a deeply feminist agenda. This may go some way towards explaining the continuing tensions, so vociferously expressed during the ICPD+5 process, between “conservative” and “progressive” groups.

It has been pointed out that in many ways Cairo represented the same kind of challenge to the established way of doing things as did Alma-Ata back in 1978. Primary health care was a potentially revolutionary concept that looked far beyond the customary boundaries of curative and preventive medicine and tried to address the underlying social causes of poverty, hunger and poor health. Primary health care fell victim to economics and was soon compromised by the adoption of selective interventions that attempted to bring technological fixes to health problems without addressing the underlying imbalances which create the problems in the first place (14). Is the concept of reproductive health destined to suffer the same fate?

Last year in Mexico, an international group of women issued a call to action asserting that the implementation of the ICPD consensus would be possible only in the context of “greater partnerships to overcome the constraints of inequity, inequality, injustice, and lack of accountability” (15). In many ways, Cairo and its aftermath represent the articulation of a profound democratic and egalitarian urge that remains unsatisfied, indeed, that is ever more seriously under threat by the realities of the growing divide between rich and poor. As Amartya Sen observed, in his address to the 1999 World Health Assembly, “the issue of social allocation of economic resources cannot be separated from the role of participatory politics and the reach of informed public discussion. ... The public has to see itself not merely as a patient but also as an agent of change. The penalty of inaction and apathy can be illness and death” (16). Cairo and the ICPD+5 process have provided just such an opportunity and for that, we should all be grateful.
References