Chapter 1
Global Reproductive Health and Rights: Reflecting on ICPD

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More than a decade after the enthusiasm that launched the 1994 International Conference on Population and Development (ICPD), there is growing concern about the status of ICPD. Does it have the same purchase today as it did in the immediate post-Cairo period? While many gains have been achieved because of ICPD (Countdown 2015 2007; UNFPA 2004a, b; Haberland and Measham 2002; UNFPA 1999), the health and development issues that brought the nations of the world to consensus persist. Approximately half a million women die in childbirth annually; the AIDS epidemic is increasing in both scale and scope; declining fertility rates in much of the world have not translated into improved standards of living. Over one billion people live in extreme poverty and have inadequate access to health care. The post-ICPD world is still one where women do not exercise control over their bodies. Women and girls are forced into marriages and into sexual relations. Their spouses and families make decisions about when and whether they can leave the home, be it to go to work or to obtain health care. Their governments do not protect them from domestic violence. And in too many places women who belong to ethnic or other minorities are subjected to involuntary sterilization and other forms of violence.

Should more have been accomplished, more than halfway through ICPD's twenty-year Programme of Action? And in looking toward its fifteen- and twenty-year reviews, how might ICPD's potential be finally realized? The Programme of Action laid out an innovative and broad framework for population and development. Following the Cairo conference, 179 nations agreed to the Programme of Action's sixteen chapters (UN 1995). The Programme explicitly addressed a comprehensive

set of population and development goals and objectives to be achieved through universal provision of a range of reproductive health services by 2015.[1] Specifically, the consensus document called for "sustained economic growth in the context of sustainable development; education, especially for girls; gender equity and equality; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health" (para. 1.12). Prior to ICPD, the international lexicon and national policies addressing population focused on the control of fertility, understood entirely as women's fertility (Hartmann 1998), and births averted and reductions in family size were important measures.

The Programme of Action was fundamentally important because it laid out a radically different approach to the population "problem," stating that population concerns could not be separated from other economic and social development agendas, particularly the need for women's empowerment. ICPD transformed population and development into reproductive health, defining it as

> a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. (para. 7.2)

Reproductive health, it stated, should be delivered by services through the primary health care system and also by advancing gender equality and ensuring a woman's ability to control her own fertility. In other words, beyond reflecting a range of multidisciplinary perspectives and promoting ambitious goals, the ICPD contained what has come to be known as the "Cairo Paradigm," which shifted population policy away from fertility regulation and toward the notion of reproductive health, predicated on the exercise of reproductive rights and women's empowerment. The extent to which this paradigmatic shift still resonates is an important measure of ICPD's relevance.

In addition to a paradigm, ICPD is also referred to as a "consensus" as well as a "compromise." As we argue in this chapter, we believe all of these dimensions are contained in ICPD and contribute to its endurance, but also to its vulnerabilities. ICPD is an innovative model for understanding the connections between health, human rights, population, and development. It was produced out of consensus forged after two years of local, national, regional, and international preparatory meetings. And it is a product of a compromise among different groups—feminists, public health professionals, development econo-

mists, demographers, environmentalists, faith communities, donors, and governments.

Some of these differing perspectives can be understood by appreciating the words that circumscribe and define the "field" of reproductive health and rights. Sexuality and reproduction sit, after all, at the intersection of health and human rights. Political and programmatic tensions run through the vocabulary used throughout all discussions of "reproductive health," "sexual health," "reproductive rights," "sexual rights," gender, population, and even development. While examination of how these different terms play out is beyond the scope of this book, we recognize the importance that language and terminology have had in creating both consensus and division in policy making related to reproductive health. According to Sonia Correa, one of the architects of ICPD, the terminology "reproductive health" and "reproductive rights" reflects agreed-to compromises within the global women's health movements (Correa 1997). She notes that "in a number of . . . contexts, reproductive health policies since 1995 may simply be semantic re-interpretations or refinements of conventional maternal and child health or family planning programs" (Correa 1997: 110). However for progressive advocates, sexual and reproductive health and rights are a political and transformative platform that seek to redefine "the spheres where sexual and reproductive needs are defined . . . the domains in which gender power relations are played out, and . . . subjective views of women's bodies and reproduction" are negated (110). As such, redress of power imbalances through the identification of women's subjection based on sexual difference (and the social significance that was made of that difference) has been a common point of departure for women's health and rights activists, among others.

A striking example of the implications of language in the realm of reproductive health has to do with understandings of sexual health, sexual rights, and sexuality. Although ICPD does not include any explicit mention of sexual rights, the notion of sexual health and rights has gained renewed attention since 1994, particularly as AIDS became a feminized epidemic and international movements organized around issues like female genital mutilation (Klugman 2005; Miller 2000). There remains no consensus around the meaning of sexual rights—it includes identity politics and choice of sexual partner but also embraces notions of inherent rights to sexual pleasure—but recent efforts by WHO have helped to delineate working definitions for sex, sexuality, and sexual health (WHO 2006a).

Efforts to interpret the meaning of sexual health as it relates to reproductive health will continue to be circumscribed by and influenced by political and social constraints. For many countries, the very notion of

"sexual health" remains too political to contemplate despite the real public health pressures of the global HIV/AIDS epidemics. Whether and how reproductive health embraces sexuality and sexual health is an ongoing challenge for ICPD, although not necessarily an unmovable obstacle (see Gruskin, this volume).

Language and terminology aside, there is general consensus about the paradigm shift that reproductive health generated. However, despite its promise and some demonstrated achievements in promoting women's education, development, health, and rights (Countdown 2015 2007; UNFPA 2004b), ICPD and the field of reproductive health have fallen short of what its supporters had hoped the field would accomplish (World Bank 2007). Concerns about the relevance of ICPD are warranted given the broader health and development environment, which has created a challenging set of conditions in which reproductive health must operate. In particular, the conservative political environment emanating from the United States, a prioritization of poverty reduction on the development agenda, and the increasing shift to global health approaches challenge the continued implementation of ICPD. ICPD faces new tests, perhaps even threats to its continued international political salience. The reservations expressed in 1994 by the Holy See and a few Islamic states have come back to bite with a vengeance, when coupled with the changed position of the U.S. government—ICPD's major supporter in 1994 and its major backtracker in 2004. The trend toward more conservative politics in the United States and elsewhere has had major implications for how the international community prioritizes reproductive health issues, including the most contentious ones of abortion and sexuality. The prevailing neoliberal approach to international economic policy has thrust the eight Millennium Development Goals (MDGs), launched by the UN in 2000 to first place, subsuming and replacing the range of international development targets and goals set at the various UN conferences, such as ICPD, which took place during the 1990s. In addition, the large-scale and generalized epidemics of HIV have contributed to a waning of interest in the broad, comprehensive approach of ICPD. These developments are salutary reminders that Cairo's much lauded "paradigm shift" might be exaggerated in certain contexts.

These changes in international policy and political environments contribute to the perception by many in development circles that reproductive health and rights are increasingly fragmented and marginalized (El Feki 2004; Sinding 2005a; Gillespie 2004a). In addition, the field of reproductive health and rights faces important questions related to its programmatic agenda, the status of its implementation, and how it connects with other development goals. These questions and concerns are

worthy of more careful examination. Critical reflection on this field is timely and important not only because of upcoming progress reviews of ICPD for 2010 and beyond, but also because of recent changes in the broader policy environment that may have continued impacts on the ability to achieve the goals of ICPD.

It has become apparent that when understood conceptually, ICPD has had much enduring success. Yet when viewed operationally it faces serious challenges. This chapter considers ICPD from the perspectives of its conceptual underpinnings and in terms of operationalizing some of the issues contained in the Programme of Action. We first discuss the conceptual foundations, such as human rights, development, and empowerment that strengthen ICPD. In the next section we lay out the issues and challenges that have tested these foundations and created obstacles to its operationalization. These obstacles include the political environment in which ICPD operates, stronger focus on poverty reduction, and increased importance of global health. Finally, the chapter explores the future of reproductive health and rights and suggests strategies for ensuring that reproductive health and rights remain on the global agenda—both on their own merits and as a means toward other goals related to population and improved health for all.

ICPD and Its Conceptual Foundations

The concept of "reproductive health" was not newly minted at ICPD. The term was first coined by Dr. Mahmoud Fathalla when he was working at the Human Reproduction Programme of the World Health Organization. His initial definition, the basis for the ICPD definition, was based on the WHO Constitution's description of health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Fathalla proposed that "Reproductive health, in the context of this positive definition, would have a number of basic elements. It would mean that people have the ability to reproduce and the ability to regulate their fertility; that women are able to go safely through pregnancy and childbirth; and that reproduction is carried to a successful outcome through infant and child survival and well-being. To this may be added that people are able to enjoy and are safe in having sex. In all of these elements, from a global perspective, health in human reproduction seems to be an impossible goal" (Fathalla 1988: 7).

"Reproductive health" emerged out of the women's health and rights movements that preceded ICPD by at least two decades (Correa and Reichmann 1994). Women's health and rights movements in North America, Europe, Latin America, subcontinental Asia, Africa,

and the Asia/Pacific region had been galvanized to varying degrees by the abuses of population control, discrimination against women, lack of concern for abortion rights and safe motherhood, and women's exclusion from the development agenda (Keck and Sikkink 1998). Forced sterilization to keep poor or otherwise "undesirable" women from having "too many" children has at various times been official policy in countries as varied as India, Peru, Sweden, and the United States. Often governments would set targets (if not quotas) for the identified population. Incentives were paid to women and health workers who "agreed" to permanent forms of contraception; disincentives, such as withholding government benefits or pay, were meted out to those who rejected offers of oral contraception or IUDs (Garcia-Moreno and Claro 1994). Women's health and rights movements analyzed these and other abuses as resulting from society's systematic devaluation and oppression of women. The global women's health and rights movement—complex and at times divided[2]—was and is rightly credited with moving ICPD's agenda forward (Garcia-Moreno and Claro 1994; Dixon-Mueller 1993). Reproductive health focused on power inequalities—the subordination of women—and the ill consequences for their health that ensued.

Because this analysis focused on the injustice and unfairness done principally to women due to their biological and social status as "reproductive," reproductive health as defined in the Programme of Action was to be realized through the promotion and protection of reproductive rights. Prior to ICPD, feminist scholarship influenced national courts and international human rights institutions and helped establish norms around women's human rights that related to their health, particularly their reproductive and sexual health (Cook 1994). Reproductive rights were identified as a set of human rights enumerated in international human rights treaties, including, among others, the right of individuals and couples to decide on the timing and spacing of their children, and the right to have the information and means to do so, free from coercion, discrimination, and violence. Because women's exercise of their autonomy in relation to childbearing in particular so profoundly affects their health, the logical tie between rights and health was easily forged. For example, pregnancies that are not well spaced place a burden on the woman as well as compromising the well-being of her children; lack of control over when and whether a woman will have sex, or whether she or her partner uses effective contraception, directly contributes to poorly spaced pregnancies (Ravindran and Balasubramanian 2004). Similarly, lack of provision of comprehensive information about sex has led to increasing rates of sexually transmitted infections (STIs)

and unintended pregnancies among adolescents in parts of the United States (Human Rights Watch 2002).

The innovation of tying health outcomes to rights promotion and protection was twofold. First, human rights are not abstract aspirational wishes, but concrete obligations governments assume when they ratify international human rights treaties.[3] At a minimum, governments are supposed to ensure that their national laws and policies are in accord with the rights contained in the treaty and to promote and protect the human rights contained therein. Second, human rights directly address power imbalances. Denying or neglecting to provide women access to information and services that contribute to their health, for example, or failing to intervene in a father's decision to marry off his preteen daughter, are understood to be violations of women's human rights (Bunch 1995). The effort to stake out human rights as they directly relate to women's lives led to international human rights norms on government action and inaction around the provision of health information and services, as well as around the conditions under which women can exercise their agency with regard to health care. These rights were then explicitly extended to an analysis of reproduction. ICPD built on this to articulate women's reproductive rights—as already existing human rights applied to women's experiences related to reproduction. Human rights, therefore, provided a tangible, legitimate methodology as well as an agenda for social transformation, through which international and national health policies and programs could be revised in ways that would improve health and its underlying social determinants (see Roseman, this volume).

Another major accomplishment of ICPD has been expanding the concept of reproductive health to mean human rights and empowerment of women as much as it means delivery of health care services or achievement of health outcomes. There is little doubt that ICPD has been a major, if not proximate, factor in promoting the use of law, policy, and international human rights mechanisms in the service of reproductive health. A number of leading scholars have articulated both the novelty and importance of ICPD in its ability to forge a connection between health and human rights:

> Broadly and simply stated, the essence of [ICPD's paradigm change] is this: previous governmental and nongovernmental statements, as well as maternal-child health/family planning programs and policies themselves, regularly conceptualized and treated women . . . as tools through which to implement population control policies, child survival strategies, nationalist or fundamentalist agendas, development schemes, or patriarchal family values and structures. By contrast, the reproductive health and rights approach adopted at ICPD is premised on a

view of women as valuable intrinsically, as well as for the contribution they make to a broader society. (Freedman 2005: 532–33)

Research supports the observation that women's poor reproductive health outcomes are not only correlated with gender discrimination, but they are sometimes caused by such gendered ideologies (Sen, George, and Östlin 2002). Cultures that praise motherhood nonetheless can also propound discriminatory ideologies that consign women to roles of childbearing and rearing; women living in these cultures often have higher rates of maternal mortality and reproductive morbidity (Doyal 1995). Although reproductive rights have been solidified as a core component of the strategy to achieve ICPD's goals, significant gaps exist more than ten years after ICPD to move beyond rhetoric with clear evidence that gender discrimination is a causal factor linked to women's health outcomes, and to show that attention to women's human rights and equality improves health outcomes (see Roseman, this volume).

ICPD also systematized the longstanding idea that reproductive health is instrumental to achieving economic development—either through its role in increasing income growth or in improving social development. The relationship and connections between reproductive health and economic development and poverty reduction have a long history with origins in neo-Malthusian arguments about population growth and its impacts on economic growth. The argument that high fertility rates do impede economic growth was later criticized and questioned (National Research Council 1986) and has since been revitalized by economists examining the impact of the population age structure on a country's economic growth (Bloom, Canning, and Sevilla 2003). Population policy has also historically been tied to policy about environmental degradation and global insecurity (Hartmann 2005):

Degradation narratives link population pressure to poverty and degradation of the environment. . . . In the 1990s this narrative extended to include security concerns: the cycle of poverty leads to conflict and to a rise of migration to urban areas, the creation of slums and the youth bulge—a high proportion of young men in urban populations is blamed for escalating crime, political violence, and terrorism. . . . It is not surprising that some population and environmental organizations feel the need to use national security arguments to win support from legislators . . . for international family planning assistance. (Ashford 2001: 16–17)

Linking reproductive health and rights to development and poverty reduction helped forge an initial consensus on ICPD, and improving understandings about the relationship between reproductive health and poverty reduction has been an important focus of many policymakers since the UN Millennium Summit in 2000, during which participating

nations identified the first of eight major international development goals to be poverty reduction. Since universal access to reproductive health information and services was not included as a separate MDG during that summit, the close relationship between population control/reproductive health and economic development has been stressed even more as advocates scramble to present evidence and arguments for how the provision of reproductive health is critical for the achievement of the MDGs (Freedman et al. 2005a; see Bloom and Canning and Girard, this volume).

Although the impact of dropping reproductive health as a specific goal has yet to be determined, to a certain measure, this argument has been mostly resolved. The five-year review of the MDGs during the 2005 World Summit resulted in new commitments by governments to work toward universal access to reproductive health by 2015 (UN 2005a, para. 57(g)). The UN General Assembly endorsed that target in 2006 (UN 2006a).

Population control has long been the rationale for reproductive health, and ICPD reflected both that ideological tradition and its evolution. The literature on reproductive health as demography and population policy is vast. Demography became the social science and methodology of choice to understand population dynamics and devise interventions and strategies for addressing neo-Malthusian concerns about resource depletion and other presumed effects of overpopulation. Birth control through modern contraceptive technology became the preferred tool to achieve demographic objectives of reducing population and increasing per capita wealth.

From this platform came at least two sets of responses that contributed to the articulation of the ICPD reproductive health and rights approach. On the one hand, researchers questioned the hypothesis that poverty was caused by large family size; rather, evidence emerged that people chose to have large families because they were poor (Mamdani 1972), reflecting the motto "development is the best contraceptive."[4] Over time, U.S. and other support for population programs diminished. On the other hand, recent interest in population control in some local areas has led to a surge in interest in reproductive health programming (Chatterjee 2005), but the tendency is to focus on family planning alone, reflecting a belief that a technical/vertical intervention can achieve what ICPD's horizontal/holistic/rights based approach could not (see Zeidenstein and Bloom and Canning, both in this volume). Like the yearning to reduce provision of reproductive health services to the provision of family planning, there is a desire on the part of some to revive demography and population policy as the principal rationale for reproductive health (Sinding 2006, 2005b).

As a concept that relates human rights, development, and health together through the social (gendered) and biological aspects of reproduction, reproductive health has, as nearly all the chapters in this volume acknowledge, made considerable inroads. The number of UN conferences and international policy documents that contain explicit or implicit reference to ICPD is evidence of this. However, the experiences of implementing and operationalizing the concept of ICPD into policies and programs have brought challenges.

ICPD and Its Operational Issues

The concept of reproductive health was born out of a compromise. Population planners and demographers who previously maintained that targets and quotas had to be met by any means relented when confronted with the harm such coercive policies had for women. This compromise has brought with it both strengths and weaknesses when it comes to operationalizing the ICPD reproductive health agenda. Central to the alliance that helped forge the compromise was the role of family planning and population professionals who were convinced that empowering women and fostering their human rights was a more efficacious strategy for achieving reduced family size and better spaced births (Presser and Sen 2000). Development economists were persuaded that investment in reproductive health and girls' education could lead to economic growth. Joining them were women's health and rights activists, who were content to strike a bargain, even if they might part company with those who viewed women's reproductive capacities in instrumental ways. Women and social activists from the Global South agreed to relax their demands that neoliberal policies be rescinded; feminists accepted that abortion rights were not going to be agreed to at ICPD.

The debate over inclusion of the terms "sexual health" and "sexual rights" illustrates how compromise occurred—and points to both its strengths and weaknesses. The initial draft of ICPD's Programme of Action did not contain any mention of sexuality. For largely tactical reasons, the Norwegian and Swedish delegations added "sexual health" to the text during one of the preparatory meetings, and some feminists lobbied for the inclusion of the term "sexual rights." The idea was advocating for a more radical position would make "reproductive rights" (then, as now, a contentious notion) appear more moderate and become a consensus choice. The ultimate omission of "sexual rights," from the final text of ICPD was therefore "not exactly considered a defeat" (Correa 1997: 110).[5]

ICPD could have been an anomaly—the product of a unique conver-

gence of people and countries with divergent opinions about the meaning of "reproductive health" who united temporarily for short-term gains. That the Programme of Action was to be extended over twenty years suggests, however, that those involved in the Cairo consensus were interested in more than a momentary compromise. Even in debate over particularly sensitive issues such as sexual health and sexual rights, the governments, organizations, and individuals involved in the ICPD process worked together to achieve a common set of agenda points and did not let areas of disagreement derail overall progress. In the end, this process of compromise produced a document far bigger than the sum of its parts, giving strength and purpose to the concept of reproductive health.

Yet only five years after it was created, the ICPD consensus started to show signs of strain, bending under the weight of unanticipated changes in the political, health, and development spheres. By 2000, global health issues such as HIV and AIDS dwarfed other perennial international health concerns (e.g., water-borne diarrheal diseases affecting children). Poverty reduction through meeting the eight MDGs would drive UN, multilateral, and certain bilateral assistance programs. Both shifts would bring to the surface weaknesses in ICPD's conceptualization of reproductive health in regard to its implementation, namely, its holistic focus and lack of agreed upon measures of progress. Furthermore, the 2000 U.S. presidential election heralded a profound and hostile change, creating a uniquely challenging environment for operationalizing ICPD. The overtly conservative politics of the United States, some Islamic states, and the Vatican made abortion and adolescent reproductive and sexual health particularly stubborn areas of ICPD and affected implementation in other areas of reproductive health as well (see Berer, Shepard, and Kissling, all in this volume). The inherent conservatism in part of the reproductive health community itself, among other factors, delayed the implementation of services that integrate HIV prevention and treatment with more general reproductive health care (see Gruskin, this volume).

However, it is not merely a fracturing of the political compromise that has made implementation of reproductive health a challenge. Implementation has been uneven, and this variation can be traced back to underestimation in the Programme of Action about how contentious (or difficult in practice) certain aspects of the ICPD agenda would be to operationalize (UNFPA 2004b). Because there was no agreed upon strategy at Cairo for implementing ICPD, the unforeseen challenges presented by the HIV epidemic and the MDGs in 2000 illustrate how additional pressures on ICPD's already existing compromises further challenge its implementation. ICPD argued for the delivery of reproduc-

tive health services through the primary health care system, but it did not and could not specify the best mechanisms for implementing such a plan. Since ICPD, there have been arguments for different approaches to implementing reproductive health services, although they predate the present concerns of global epidemics and poverty alleviation. Instead the first issue facing ICPD implementers was attracting individuals—usually women—to use available services. Quality of care became an intense area of interest for reproductive health programs; this inquiry grew out of early experiences in the implementation of family planning programs when the programs were under pressure to use any means necessary—including coercion and violence—to achieve their goals. Proposed alternative mechanisms include adopting a human rights approach (Cook and Fathalla 1996), policy and legislative reform, advocacy and community involvement, and restructuring of health services (de Pinho 2005). While there is no single mechanism for implementing reproductive health services, there are examples of successes from each of these approaches. For example, efforts to pass national legislation banning female genital mutilation or increasing the legal age for marriage have been successful in some countries, and a combination of these implementation approaches may be appropriate depending on the setting.

The provision of comprehensive reproductive health services through the integration of previously separate activities was part of the ICPD goals to "encourage greater use of services" and maximize service efficiency. To this end, efforts have generally focused on integrating some combination of family planning, maternal and child health, and HIV/AIDS services in different health care settings (Lush 2002; Mayhew et al. 2000). The reasons for integrating or linking reproductive health services are not only technical (increased coverage and greater efficiency) but may also be strategic in nature. For example, a purported benefit of linking reproductive health and HIV services is to ensure continued funding of reproductive health services when politics mean that HIV services garner greater resources. However, service integration efforts present practical challenges, including determining which services to integrate and at which level of the health system, tracking and reporting donor funding, and measuring results, and also raise the larger question whether the ICPD goal of delivering an expanded set of services can be achieved in the absence of integration. It remains unclear whether current efforts to link rather than integrate services will address some of these concerns (WHO 2006b). Debate about the extent to which implementation and integration of reproductive health services has taken place continues, but the underlying need for increased resources (from both donors and national governments) and ensuring accountability remain areas of concern.

There is also resistance to integration. In a telling contretemps, some policy notables who previously embraced ICPD and reproductive health have called for a return to the good old days of family planning when success meant ensuring that couples had their contraceptive needs met. Health advocates and academics have published articles in leading medical and health policy journals, such as the *Lancet*, advocating a "break from the prevailing international discourse that cloaks family planning in the term reproductive and sexual health," arguing that conflating the two "obfuscates rather than clarifies priorities" (Cleland et al. 2006: 14–15).

Such a repudiation of "reproductive health" in favor of family planning (also known as contraception) speaks volumes in the current context of global health (Brown, Cueto, and Fee 2006).[6] This approach to global health has brought with it a tendency to favor disease-specific or intervention-specific approaches to public health—such as addressing the global HIV epidemics with a dedicated fund and a campaign for vaccine development (or more recently universal access to treatment) (Birn 2005; Katz 2005). Vertical approaches to health are not new (Brown, Cueto, and Fee 2006). However they are antithetical to ICPD's comprehensive, life cycle and public health approach. ICPD considers the range of social, cultural, political, and economic contexts that disempower women and make it difficult for them to exercise meaningful decision making about their reproduction. In many ways, family planning is the technical fix reproductive health has to offer; it is more amenable to the vertical approach and is more easily measured than other reproductive health approaches. Yet a basic critique of vertical approaches remains that while these targeted efforts may be relatively efficient and amenable to measurement, they do not address the underlying factors such as poverty and discrimination that directly affect the health and well-being of women and men in developing countries, and which more basically affect people's decisions about family planning. ICPD, through its explicit incorporation of human rights as an essential component, provides a framework to approach these fundamental causes.

Global health issues have been able to capture funding with remarkable speed and scope, particularly in comparison to resources for ICPD. An analysis of donor funding from 2000 to 2004 found that funding for "global health," as opposed to "international health" or any other collective heading, has been steadily increasing since 2000 and approached $14 billion in 2004 (Kates, Morison, and Lief 2006). This increased funding comes from several sources, and global health is commanding an increasingly large portion of official development assistance as well. The World Bank's spending on health reached a peak of $3.4 billion in

2003 "before falling back to $2.1 billion in 2006, with $87 million of that spent on HIV/AIDS, TB, and malaria programs and $250 million on child and maternal health" (Garrett 2007: 4, online version). Private foundation spending also increased. "Between 1995 and 2005, total giving by all U.S. charitable foundations tripled, and the portion of money dedicated to international projects soared 80 percent, with global health representing more than a third of that sum" (Garrett 2007: 3, online version). ICPD was unique in its preparation of cost estimates for implementation of a package of reproductive health services. These estimates, used to mobilize financial resources for reproductive health from both donor countries and developing countries, have not been met by either donors or national governments. After a peak in funding for reproductive health and population in 1995, resources for reproductive health remained relatively flat until 2002, when there was a jump, mainly due to increased global funding for HIV/AIDS (see Merrick and Reichenbach, both in this volume).

It is our contention that the prevailing enchantment with vertical global campaigns and emphasis on funding only specific health issues considered relevant to "global health" disadvantages ICPD's holistic approach.[7] Concepts of market rationality, benchmarks, and targets imported from business and management do not reflect the complex realities in which we live. For instance, it is a challenge to account both financially and politically for efforts to reform laws and policies; it is relatively simpler to account for how many bed nets have been purchased and distributed. But much of reproductive health is not a single disease or health intervention amenable to this type of vertical approach. Although critical for ensuring accountability and assuring donors that their money is being well spent, measurement of reproductive health indicators are uniquely challenging (see Kaufman, Reichenbach, and Bloom and Canning, all this volume). ICPD emphasized the role that underlying social conditions play in health, especially those that foster women's capacities to make decisions about when and whether to have children, to access qualified medical care when necessary, to live free from coercion and violence, and to control their own sexuality. One cannot develop a vaccine to accomplish this: addressing underlying social conditions is slow, costly, often difficult to achieve, and not solely one sector's responsibility.[8] A broader understanding is required of what the "global health agenda" is. How reproductive health and rights fit both retrospectively and prospectively into this agenda is also necessary, in order to hold onto the conceptual gains of the Cairo paradigm and shore up the weak points (see Reichenbach, this volume).

ICPD: Expanding and Strengthening the Networks

The various conceptual and programmatic approaches used to address reproductive health and rights have not occurred in a static world. Whether in the euphoria following the 1989 fall of the Berlin wall, when human rights expanded around the globe, or during the period of fear and defensiveness kicked off by 9-11, interpretations of ICPD have evolved in a changing world. The prevailing international tendency—what we have called neovertical approaches to global health—presents a potentially competing paradigm of health care delivery and outcomes to the comprehensive and inclusive approach of ICPD. Where and how does reproductive health fit into this new paradigm, particularly when the concepts guiding "global health" challenge or even contradict the rights-and-health approach of ICPD? Are global health and ICPD irreconcilable?

Currently, the major new global health funds (e.g., Global Fund to Fight AIDS, Tuberculosis and Malaria), important bilateral donors such as the U.S. government, and large private foundations such as the Bill and Melinda Gates, John D. and Catherine T. MacArthur, and Rockefeller Foundations fragment ICPD. They tend to fund only specific elements of the ICPD Programme of Action—HIV/AIDS or maternal mortality, for example, rather than the range of underlying conditions that contribute to reproductive health. Although technical approaches have always been an important part of public health solutions (Brown, Cueto, and Fee 2006), the new funding environment challenges the ability to fund intersectoral and integrated sexual and reproductive and rights health interventions as envisioned by ICPD. A good example comes from the United States, where recently social and cultural conservatives have been able to undermine the entire concept of reproductive rights. It is particularly prevalent in the United States, and worrisome, because in absolute terms the U.S. contributes the most toward global reproductive health issues (PAI 2004a).

The rejection of human rights in relation to health can be seen in current U.S. Agency for International Development (USAID) health policies and programs.[9] Now part of the Department of State, USAID's "commitment to improving global health . . . includes child, maternal, and reproductive health, and the reduction of abortion and disease, especially HIV/AIDS, malaria, and tuberculosis" (USAID 2006a). That USAID considers as one joint goal addressing child, maternal, and reproductive health and reducing abortion suggests a distancing of its program from the broader formulation of reproductive health as defined by ICPD. Moreover, the USAID website link from the word "reproductive health" takes readers to the page entitled "Family Planning." Family

planning—and only family planning, states USAID—is reproductive health; family planning provides direct health benefits for women (reduces high risk pregnancies, fights HIV/AIDS, reduces abortion), children (longer spaced intervals), and the environment (USAID 2006b). What is lost when policies transition from a focus on "reproductive rights"—as stated in ICPD—to "family planning"—USAID's wording—is support for women's rights, opportunities for employment, and full participation in society. The entire point of ICPD was that picking and choosing among services and approaches would not achieve the development gains and health improvements that governments so desired for their populations. To leave off the delicate agenda points (for instance, adolescents' access to reproductive health services) because they contradicted deep-seated cultural views was precisely what ICPD counseled against. Setting priorities among areas was anticipated, not wholesale sidestepping.[10]

The gains of ICPD are not all lost, however. There appears to be an increasing recognition that although health improvements may be achieved through technological approaches, they will not be sustainable unless underlying political, social, cultural, and economic determinants are addressed as well (Boseley 2006; Birn 2005; Katz 2005). In addition, reproductive health as defined and conceptualized at ICPD has been adopted as part of the "global health agenda" of international organizations such as WHO, bilateral donors such as DFID (Department for International Development, the UK bilateral overseas development agency) and SIDA (the Swedish International Development Agency), and private foundations such as the Ford Foundation. WHO, for example, places "promoting universal coverage, gender equality, and health-related human rights" as the third agenda item (out of seven) on its general program of work on global health. In its elaboration of this point, WHO states that "Ensuring everyone's right to the enjoyment of the highest attainable standard of health entails expanding access to sexual and reproductive health care for all" (WHO 2006a: 15).

The viability and utility of ICPD, however, has evolved differently in different parts of the world. The perception of ICPD and its place in the global health agenda differs widely whether viewed from Peru, Bangladesh, Uganda, or the United States. The ownership and design of the global health agenda may occur at the level of international institutions, multilaterals, and bilateral agencies, but the implementation of the priorities that emerge from that agenda takes place at regional, national, and community levels. This distinction between the global health agenda and what transpires at the national levels is seen by some as a detriment to furthering the reproductive health agenda. Many advocates are concerned that if reproductive health is not prominently on

the agenda (designated as a separate MDG, for example), then it will be left behind while global health moves forward. In others' eyes, however, the opportunity to operate out of the glare and distraction of international politics allows countries or communities to "just get on with it" and continue to implement reproductive health and rights. How this will turn out will obviously vary from context to context, and the future is far from sure. While there are differences in how ICPD plays out at the international and national levels, the discussion at the international level shapes the language and strategies of women's health advocates and policymakers in implementing reproductive health programs at the national level. A current example is the need to describe the importance of reproductive health in terms of poverty reduction to maintain national funding for reproductive health activities.

Despite these uncertainties in a time of flux, there is no question that the fundamental concepts embodied in ICPD continue to buttress global public health arguments. For scholars and practitioners, women's health and rights activists, and researchers, the theoretical and actual gains of ICPD have been enormous, and ICPD has been the framework that joined together underlying social determinants, health systems, policies, laws, and human rights related to reproductive health. The architecture of global health may have fragmented the ICPD framework. But this fragmentation need not be one of splintering; it may be one of fostering networked nodes—perhaps no longer organized according to the numbered paragraphs of the Programme of Action, but geometrically strengthened and connected in more efficient ways (Valente and Davis 1999). It should be recalled that ICPD is the product of a network of transnational actors. Transnational advocacy groups are networks of people that include both experts and activists with a common value or principle that motivates them to work in a particular issue area. Transnational networks, because they are dispersed locally, nationally, regionally, and internationally, have inherent dynamism and flexibility, even as they are united by common ideas (Keck and Sikkink 1998). They have been able to put issues such as domestic violence on international agendas by appealing to common concerns and taking advantage of political opportunities to generate attention to issues. These transnational networks were critical for ICPD and these networks still have salience today. Whether reproductive health today resembles the way ICPD articulated it may be less important than ensuring that the connections between gender, rights, health, and development are maintained and strengthened. Creating alliances and building coalitions with new actors beyond the field of reproductive health and rights is the way forward for reproductive health and ICPD in the current context framed by "global health." The chapters in this book suggest that reproductive health still

matters but less as a framework and more as a network for exploring complex relationships—institutional, individual, and conceptual—necessary for the achievement of ICPD in the larger context of global health. Reproductive health, viewed as a network of related concerns and bound together by the conviction that human rights, equality, nondiscrimination, participation, and accountability are inseparable elements of health and health systems, can thrive in this new global health framework.

Chapter 2
The Global Reproductive Health and Rights Agenda: Opportunities and Challenges for the Future

Laura Reichenbach

There is mounting suspicion among many in the field of reproductive health that reproductive health and rights have become increasingly marginalized on the global policy agenda since the 1994 ICPD conference (El Feki 2004; Gillespie 2004a,b; Sinding 2005a, 2006). An editorial in a *Lancet* series on sexual and reproductive health claims that reproductive health "has been utterly marginalized from the global conversation about health and wellbeing during the past decade" (Horton 2006: 1549). Another article in the same series refers to the last twelve years of reproductive health as a "sorry tale," in part because "sexual and reproductive health has dropped down the international development agenda" (Glasier and Gulmezoglu 2006: 1550). However, not everyone shares such pessimistic views on the state of the reproductive health agenda. Others in the field, particularly those in the women's health movement who were architects of ICPD, are trying to fuel optimism about the state of reproductive health and rights, referring to ICPD as "vigorously alive" and arguing that, when it comes to reproductive health, the glass is "half-full" rather than "half-empty" (Germain and Kidwell 2005; Germain and Dixon-Mueller 2005).

So which of these perspectives most accurately reflects the reality of the reproductive health agenda today? Is there evidence that reproductive health has "fallen off" the global agenda? And if so, what explains this decline and what are the implications for the future? Most important, what are some strategies for ensuring that sexual and reproductive health maintain or increase its visibility on the global policy agenda? This chapter addresses these questions based on a critical analysis of the recent literature on reproductive health. It examines evidence as to

where reproductive health is or is not on the global policy agenda and how that may have changed over time; it highlights some major influences affecting the global reproductive health agenda since ICPD; and finally, it suggests strategic areas where the field might maintain as well as improve the status of reproductive health on the global policy agenda.

The Global Policy Agenda and Reproductive Health

For the purposes of this chapter the term "global policy agenda"[1] refers to the myriad health and development issues that the international policy community (which includes international institutions, multilateral and bilateral agencies, and funding and donor agencies) are attending to at any one time. This adapts Kingdon's (1984) definition of agenda, "the list of subjects or problems to which governmental officials, and people outside the government closely associated with those officials, are paying some serious attention at any given time" (1984: 3). This definition allows that the global policy agenda is not encapsulated in a single or set of written documents that guide officials and policy makers as to which issues to assign priority and allocate resources. Rather, it considers the agenda to include the range of health and development issues that decision makers and those who influence them consider.

The global policy agenda as conceived of in this chapter is fluid and influenced, at times unpredictably, by politics, economics, and evidence that persuade policy makers an issue is a problem that requires attention. These influences may come indirectly (e.g., media attention associated with a celebrity) or through the mechanism of bureaucratic machineries or institutional politics (e.g., international meetings or the UN conference process).

An effort to examine and better understand the intersections of reproductive health and ICPD with the global policy agenda is worthwhile given the concern expressed by some in the field, especially practitioners and policy makers, that reproductive health has lost its cachet and is no longer part of the lexicon of international policy makers. If this is so, the hard-earned gains of ICPD may be diminished, or even lost. Policy makers must allocate limited money, time, and attention among a host of competing health and development issues. Issues that are firmly situated on the global policy agenda are more likely to garner resources, not just financial, but political and institutional as well.

These concerns are based on a presumption that the global policy agenda affects national and subnational policy agendas. However, this influence is not straightforward (Lee and Walt 1995); several factors in-

fluence the agenda setting process at the national level, including local culture and politics.

Examining the Reproductive Health Agenda

Determining the status of reproductive health on the complex global policy agenda depends on how the reproductive health agenda itself is defined. It is not a single agenda that all stakeholders agree upon. For policy makers and practitioners in the field, the reproductive health and rights (or sexual and reproductive health) agenda is often defined as the individual components outlined in the ICPD Programme of Action (UN 1995). For others, including women's health activists and feminists, the reproductive health agenda is primarily defined by the fundamental concepts and arguments of ICPD—addressing the health and social interventions required to achieve gender equality and equity in the context of human rights and reproductive rights. As the reproductive health agenda is not clear cut, identifying points of intersection with the larger global health agenda is not a straightforward process.

The situation is further complicated because the reproductive health agenda is defined and implemented at several levels—international, national, and subnational. Each country implements ICPD according to its specific political, economic, and social contexts. In many countries, particularly those that have undergone decentralization processes, subnational (provincial or district level) reproductive health agendas may differ from the national one. For the purposes of the arguments here, this chapter focuses on the reproductive health agenda at the global level and defines reproductive health as the underlying cross-sectional components of the ICPD Programme of Action that address gender equality, equity, women's empowerment, and reproductive health and rights. The chapter considers their treatment by the international community, which includes international institutions, multilateral and bilateral agencies, and funding and donor agencies including private foundations.

Is Reproductive Health on the Global Policy Agenda?

Determining whether something is on or off the agenda is not an objective process in which a certain threshold is met. Yet there are several types of evidence that can help to determine an issue's status on the policy agenda. This chapter suggests assessing three areas to determine an issue's agenda status: (1) visibility of the issue on the global political and policy stage; (2) level of resources being spent on the issue; and (3) whether explicit solutions or interventions to address the problem exist and are advocated.

One area of evidence is the level of attention paid by policy makers and other influential people. This can be determined by examining policy documents, conference proceedings, political statements, and media attention. Cumbersome though this may be, it is useful for determining whether an issue is a priority on the agenda (Reichenbach 2002).

Examining the financial resources allocated to a particular issue is a more objective way to assess and compare the level of international attention. Expenditure of funds helps promote accountability and ownership of an issue. Collecting data on resource allocation, while relatively straightforward, is not always easy, particularly for the many interventions of ICPD that are both cross-sectoral (e.g., improving educational opportunities for girls) and highly individualized (e.g., providing maternal health services in a maternal and child health setting) (Ethelston and Leahy 2006; Powell-Jackson et al. 2006).

A final indicator of attention to an issue is whether a specific solution or intervention is associated with it. This affects the status of an issue on the policy agenda by increasing the likelihood that there will be advocacy for an issue by a group or community that takes ownership of an issue and shepherds it onto a policy agenda. Moreover, a clearly stated intervention for a problem increases the likelihood that policy makers will take action on it.[2] The next section briefly reviews the reproductive health agenda from these three perspectives over three time periods: pre-ICPD (1970s and 1980s), during the ICPD preparatory process and at ICPD (early 1990s), and post-ICPD (1995–present).

Reproductive Health and the Global Policy Agenda Prior to ICPD

Reproductive health today, thanks to ICPD, is commonly understood as more than population and family planning or safe motherhood. Prior to ICPD, however, reproductive health was primarily constituted by these individual issues and addressed by separate and mostly technical and scientific communities. Reproductive health at ICPD, in part, grew out of and in response to the issue of rapid population growth and country experience with family planning programs. During the 1970s and 1980s, population and population policy were an integral and highly visible part of the international development agenda. Neo-Malthusian arguments about the impact of overpopulation on efforts to reduce poverty and sustain the environment were compelling for many at the time and evident in the outcomes of two high-level United Nations conferences on population—Bucharest in 1974 and Mexico City in 1984 (Finkle and Crane 1985, 1975). The Bucharest conference became widely associated with the slogan, "development is the best contraceptive," while the

Mexico City conference was well known for the U.S. role in politicizing the issue of abortion. While the processes and outcomes of these conferences were different in their policy implications, they both placed population and family planning squarely on the global agenda.

The resources allocated by the international community to population activities also reflect the importance of population on the global policy agenda. Figure 1 is a reproduction of Schindlmayr's (2004) analysis of donor trends in population assistance and shows an increasing but inconsistent flow of international financial resources allocated to population activities from the 1960s to 1995. As Schindlmayr points out, funding for population assistance increased rapidly by 1970 and continued to increase throughout the 1970s. After falling off in the early 1980s it began to spike prior to both the Mexico City and Cairo conferences and was then followed by a visible decline. This pattern may reflect the increased advocacy leading up to these conferences. Schindlmayr's analysis describes variation in the share of overseas development assistance (ODA) going to population activities over this time period, with a large increase in the 1960s and 1970s when population was roughly 2 percent of ODA. During the 1980s, population as a share of ODA declined to an average of 1.2 percent.

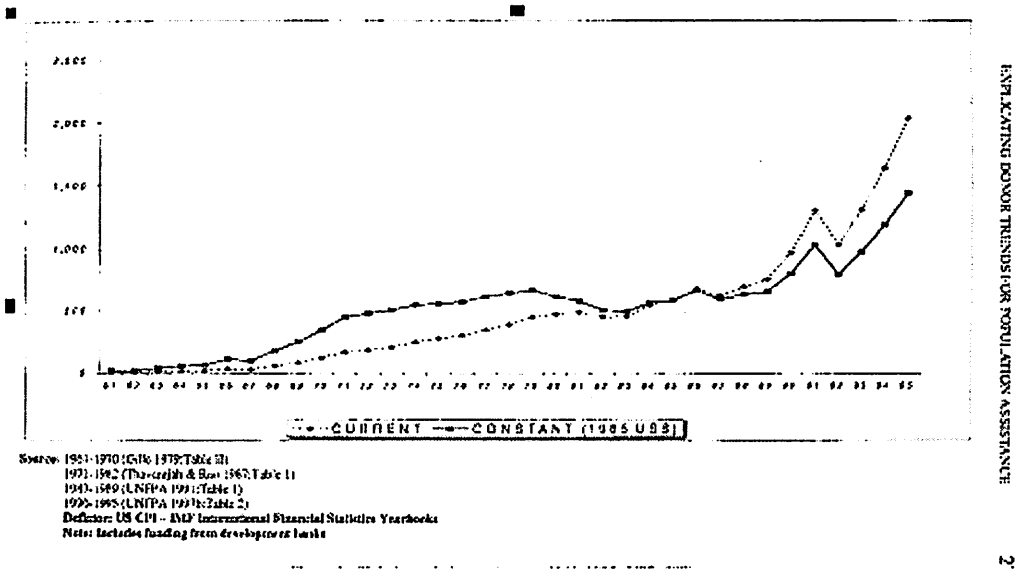

Figure 1. Global population assistance, 1961–1995. Reproduced from Schindlmayr (2004: 27, Fig. 1).

During this period, the issue of population growth became closely linked by demographers, government officials, and policy makers with its solution—the need to decrease fertility and halt rapid population growth in underdeveloped countries perceived as a threat to global en-

vironmental and political stability. The intervention proposed by demographers and population scientists to achieve this was widespread use of family planning. Demographers and population scientists took ownership of the population issue; many of them worked closely with and advised policy makers, ensuring family planning and population's visible status on the development policy agenda.

Reproductive Health and the Global Policy Agenda During the Preparatory Committee Process and at ICPD

During the preparatory committee process, which included several years leading up to and during ICPD itself, reproductive health (defined beyond provision of family planning) actively engaged with a broader set of development issues (e.g., gender equality and equity, women's empowerment, education, environmental sustainability, and improved health outcomes). This is evident in the expanded base of institutions involved in the ICPD preparatory process, which included NGOs and activists working on environmental, poverty, population, and reproductive health and rights issues. Reproductive health was portrayed as integral to realizing a range of development objectives based on arguments beyond fertility reduction and environmental sustainability. The preparatory process was marked by well-organized regional and international meetings of women's health and rights activists. These meetings resulted in a series of dialogues and debates that provided the foundation for the concepts and language that came out of ICPD. A number of articles in the academic and lay press and high profile political speeches related to reproductive health were published during this time. The women's health advocates who spearheaded this work were extremely savvy about ensuring opportunities for media and other coverage of their concerns. As a result, reproductive health became more entrenched and visible on the global policy agenda.

As part of the ICPD preparatory process, economists, demographers, and other experts prepared resource estimates for implementing aspects of the Programme of Action. Referred to as the "costed package," paragraph 13.15 states that these resource estimates are for implementing "programmes in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases, as well as other basic actions for collecting and analyzing population data, [and] will cost: $17 billion in 2000, $18.5 billion in 2005, $20.5 billion in 2010, and $21.7 billion in 2015" (para. 13.15). The Programme of Action designated that donors pay one-third of these estimated costs while national governments cover the remaining two-thirds. ICPD was the first UN conference to prepare such resource esti-

mates and they were intended to serve as an advocacy tool for both donor countries and governments of developing countries. Prior to and just after ICPD there was an increase in funds for population and reproductive health (see Figure 1).

Unlike rapid population growth, reproductive health as defined at Cairo did not have a single solution or technological intervention associated with it. ICPD resulted in a paradigm shift in thinking about how to improve women's lives by proposing a rights-based approach to the provision of reproductive health services, to achieve broader development goals of gender equality, equity, and women's empowerment. While several of the Programme of Action's individual components (e.g., family planning or maternal mortality reduction) continued to be associated with particular solutions, the reproductive health agenda in its holistic form was not characterized by a specific intervention. The lack of specific interventions at the time of ICPD has had implications for its operationalization post-ICPD.

Reproductive Health and the Global Policy Agenda After ICPD

Immediately following ICPD and until the late 1990s, reproductive health continued to be an integral part of the broader development agenda. This is documented in the deliberate adoption of Cairo in a series of high level international conferences. The specific language and/or underlying principles of Cairo were reaffirmed in several global conferences including the Fourth World Conference on Women in Beijing in 1995, the World Summit for Social Development in Copenhagen in 1995, the five-year review of ICPD in New York, and various sessions of the UN Commission on Population and Development (see Girard, this volume). Attention to ICPD was also reinforced in the large number of country case studies and academic articles assessing the implementation (Haberland and Measham 2002; Hardee et al. 1999). Discussions about how to implement ICPD were common among donors, academics, and international and national policy makers during the 1990s.

However, since 2000, many implementers and practitioners have maintained that reproductive health is less visible on the global policy agenda (Langer 2006; Glasier and Gulmezoglu 2006). As evidence, they point to the decision not to hold a high-profile ten-year review of the ICPD conference and, perhaps most glaring, the exclusion of reproductive health as a Millennium Development Goal (Sinding 2005a; Crossette 2005). The implications for reproductive health of its omission as a separate MDG are debated by academics, advocates, and practitioners alike.[3]

Some academics and activists feel exclusion from the MDG list is not necessarily a disaster (Basu 2005), while some policy makers put it bluntly, "If you're not an MDG, you're not on the agenda. If you're not a line item, you're out of the game" (Steve Sinding, in Crossette 2005: 77). Some women's health advocates and practitioners (Langer 2006) have been assuaged by the inclusion of reproductive health as an MDG target at the 2005 World Summit (UN 2005a, para. 57(g)). Regardless of the implications, most agree that reproductive health was not a specific MDG because of its political nature[4] and the hesitancy to put it front and center on the global agenda at a time of conservative politics.

At the risk of unfairly generalizing, women's health advocates, many of whom were pivotal to the Cairo process, tend to project a more positive attitude about the current status of reproductive health. Some, like Adrienne Germain, argue that ICPD is a "living document" with its fundamental principles and intent adapted and reflected in evolving policies and statements (Germain and Kidwell 2005). Sonia Correa cautions that ten years in the ICPD process is not a long time and that a more realistic longer term view must be taken when assessing the fate of reproductive health and rights (Correa et al. 2005).

Other evidence offered for the demise of reproductive health is a decline in resources for reproductive health and rights since ICPD (Merrick 2005; Speidel 2005). The resource targets for the "costed package" in the Programme of Action have not been met. As Table 1 shows, neither donors nor developing countries met their targets for the year 2000. Since then, donor funding has increased, but it is still below what is thought necessary to implement the costed package. In 2002 and 2003, donors met only 40 percent of their ICPD commitments (in real terms) (Ethelston and Leahy 2006). (See Merrick, this volume for analysis and explanation of donor assistance trends post-Cairo.)

There are several explanations why the resource targets set at Cairo have not been met. These include a sense that population and reproductive health are no longer salient as a development issue because of the fertility decline that has occurred in many parts of the world (Gillespie 2004; Blanc and Tsui 2005); that donor priorities have shifted to other issues; and that the resource estimates no longer reflect the reality of programming reproductive health. For example, the original ICPD cost estimates significantly underestimated the HIV/AIDS epidemic. In the Programme of Action the $18.5 billion estimated for reproductive health in 2005 included $1.4 billion for "sexually transmitted infections, including HIV/AIDS. Ten years later, HIV/AIDS alone needs more than $10 billion for 2005" (Ethelston and Leahy 2006: 39).

Although the Programme of Action cost estimates have not been met, the trend in donor resources for population and reproductive health

TABLE 1. Programme of Action Resources for Costed Package: Estimated and Actual

	2000	2001	2002	2003	2004	2005	2010	2015
Targets for costed package	$17 billion $5.7 billion (donors) $11.3 billion (domestic)	n.a.	n.a.	n.a.	n.a.	$18.5 billion $6.1 billion (donors) $12.4 billion (domestic)	$20.5 billion $6.8 billion (donors) $13.5 billion (domestic)	$21.7 billion $7.2 billion (donors) $14.3 billion (domestic)
Actual resources by source	Donors $1.975 billion Domestic $3.5 billion	Donors $2.06 billion Domestic $1.5 billion	Donors $2.878 billion Domestic (data not collected)	Donors $4.189 billion Domestic $11.7 billion	Donors $5.2 billion Domestic $14.5 billion	Donors $5.8 billion Domestic $14.9 billion	n.a.	n.a.

Sources: UNFPA, NIDI (various years).

has increased since 2000. Estimates of donor spending on population, reproductive health, and HIV/AIDS show an increase from $4.7 billion in 2003 to $5.3 billion in 2004. "Estimates for 2005 show that donor funding increased to $6.1 billion" (statement by A. Pawliczko, New York, 3 April 2006). Population as a percentage of ODA reached a high of 5.12 percent, up from 3.65 percent in 2002 (UNFPA 2005a). In 2003, population assistance was 11.45 percent of U.S. total overseas development assistance (UNFPA 2005b). Figure 2 shows primary population assistance funds from the decade beginning in 2003.

While overall amounts of international assistance for population and reproductive health have increased, the reproductive health community has expressed concern that the distribution of those resources has been shifted from family planning and reproductive health to HIV/AIDS. Figure 3 shows quite clearly that during the period 1995-2003 resources for family planning declined while resources for HIV/AIDS increased sharply. Donor spending on reproductive health in 2002 and 2003 was close to $3 billion. Shiffman's (2008) analysis of donor spending shows that donor spending on HIV/AIDS in 1992 was 7.7 percent of health and population assistance and this figure had risen to 23.5 percent of donor health and population assistance by 2005. During the same time period, aid for population decreased from 32.1 percent to 8.0 percent of health and population aid. A recent meeting of the UN Commission on

FIGURE 2. PRIMARY FUNDS FOR POPULATION ASSISTANCE, IN CURRENT AND CONSTANT DOLLARS, WITH PERCENTAGE CHANGE, 1993-2003

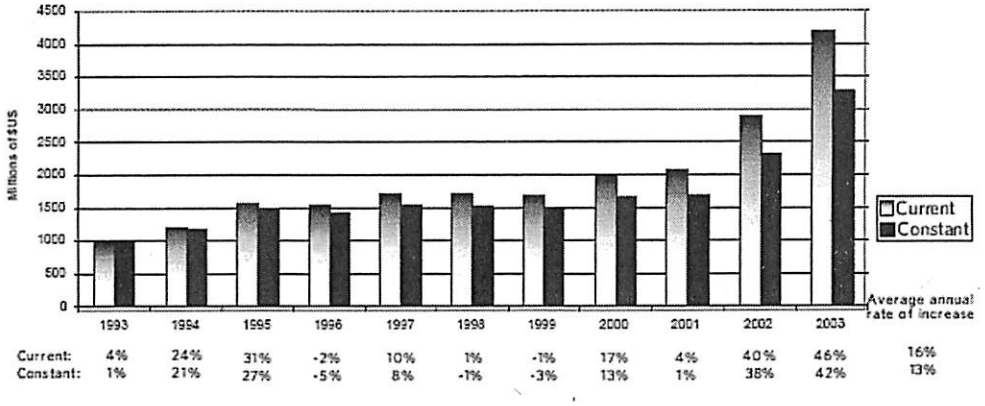

Figure 2. Primary funds for population assistance, current and constant dollars, with percentage change, 1993–2003. UNFPA 2005a.

Population and Development reported that ICPD estimates are not being met. While ICPD estimated 8 percent of total population assistance for STDs/HIV/AIDS, actual spending in 2005 was 72 percent. Absolute dollar amounts for family planning "are lower than they were in 1995" with family planning as a percentage of all population assistance decreasing from 55 percent in 1995 to 7 percent in 2005; funding for reproductive health services declined to 17 percent (Deen 2008: np).

There is evidence that funding for HIV/AIDS has increased dramatically, and possibly at a cost to family planning and reproductive health (Shiffman 2008). "During the last 10 years, spending on HIV/AIDS has increased by 300 percent" (Sinding 2005b: 5). Of the $6 billion in population assistance projected for 2005, "donors are deploying close to 60 percent to address the HIV/AIDS pandemic, while reproductive health and family planning activities are benefiting from less than 25 percent and 10 percent of total funds, respectively" (Ethelston and Leahy 2006: 1). During this period there was also the creation of funding mechanisms that specifically targeted HIV/AIDS. For example, the creation in 2003 in the United States of the President's Emergency Plan for AIDS Relief (PEPFAR) called for $15 billion to be spent in 16 countries over five years. Reproductive health areas beyond HIV/AIDS also show a dilution of funds. A recent estimate of donor spending on maternal, newborn, and child health found that $2.935 and $3.481 billion of ODA went to maternal, neonatal, and child health activities in 2005 and 2006; however, child health accounted for more than two-thirds of ODA in these areas (Powell-Jackson et al. 2006; Greco et al. 2008).

The interventions for achieving the Programme of Action after ICPD were not clear-cut, and evidence did not point to a clear or easily imple-

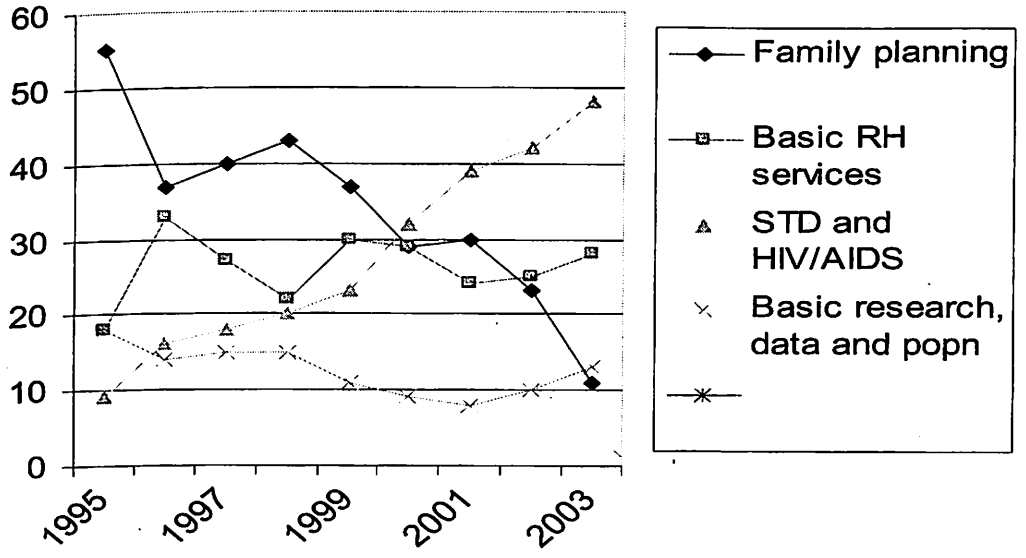

Figure 3. Donor expenditure for population assistance by category. UNFPA 2005b.

mented solution. Different approaches to operationalizing reproductive health were offered; calls for rights-based approaches (Jacobson 2000) and interventions that addressed health sector reforms were made (Ravindran and de Pinho 2005). These different approaches were not always clearly articulated among all stakeholders and resulted in discussion and debate as to how to address reproductive health. This made it difficult to advocate a solution for reproductive health on the agenda. Furthermore, national examples and case studies produced during this time showed variation in models and approaches to implementing reproductive health thus moving the evidence base away from a single easily replicable approach.[5]

Based on this brief analysis of measures of policy attention, financial resources, and advocacy of solutions or interventions, there does appear to have been a decline in the status of reproductive health on the global policy agenda since 2000. What explains this decline, and what are its implications for the future of reproductive health?

Explaining the Decline in Reproductive Health on the Global Policy Agenda

Several explanations have been offered for the decline in attention to reproductive health, including lack of financial resources to effectively implement the ICPD agenda (Speidel 2005; UNFPA 2005b); insufficient political will to address reproductive health and rights (Jahan and Germain 2004); the effect of successful fertility decline in much of the

developing world (Gillespie 2004a; Blanc and Tsui 2005); and an agenda thought to be too diffuse to be easily implemented (Sinding 2006). Three reasons for the decline in attention will be examined below: the current political and policy environment in which reproductive health operates; the changing development policy agenda; and the increased focus on global health.

The Global Political and Policy Environment and the Reproductive Health Agenda

An important factor in the declining status of reproductive health on the global agenda is the political context in which reproductive health and rights must operate. The current conservative political environment in the United States has had a particularly significant impact. The U.S. influence is evident in the highly visible role the U.S. played at earlier UN conferences on population (see Finkle and MacIntosh 2002; Finkle and Crane 1985). It is also apparent in its long history of financial support for global population and reproductive health activities: "Since 1965, USAID has obligated over $6.6 billion in assistance for international population planning" (Nowels 2003: CRS-11). The United States remains the leading donor in terms of global share of development assistance for HIV/AIDS and population; it provided 11 percent of donor assistance in 2003 (Speidel 2005). A recent study comparing the average share of funding for population activities for the 21 OECD donor countries found the United States to be the major donor over the period 1996-2002, providing more than 75 percent of donor support for family planning activities and 60 percent for HIV/AIDS (Van Dalen and Reuser 2006).

While not the only donor—continued financial support for reproductive health and rights by European and especially Scandinavian countries is considerable—the United States remains an important influence on the reproductive health agenda at both global and national levels. U.S. influence at the national level is manifest in its provision of technical assistance to countries around the world as well. In 2003 67 percent of U.S. funding for population and reproductive health was provided through cooperating agencies that provide funds and technical assistance at the country level (Speidel 2005). The U.S. can put political pressure on recipients of U.S. foreign assistance for population and reproductive health. The threat of withholding assistance when the recipient organization or government does not abide by certain expectations (such as adhering to the Global Gag Rule[6]) is a powerful influence on the content of the reproductive health agenda at the national level.

The conservative politics and policy decisions of the George W. Bush

administration have also imposed significant political barriers to reproductive health. A detailed recounting of this has been done elsewhere in this book (Girard and Kissling, both in this volume). Bush's reinstatement of the Mexico City Policy, the increasing role of the religious right in public health policies, and the lack of political support for reproductive health from the U.S. delegation at regional conferences in preparation for ICPD+10 represent attempts to "turn back the clock" in the language and scope of reproductive health and rights. A change in U.S. administration might alter this conservative agenda, depending on the composition of the government. However, in the current political climate, the reach of U.S. influence on reproductive health and rights has broadened beyond the issue of abortion to include issues related to sexuality, contraception, and women's rights. It may take sustained effort to redirect the effects of eight years of Bush administration policies, especially since they are but one of the factors which have constrained ICPD.

The Influence of Broader Development Policy

The status of reproductive health has also been affected by changes in the broader health and development policy environment since ICPD. The growing HIV/AIDS epidemics, increased attention to poverty reduction, and new funding mechanisms have had important effects.

The increasing HIV/AIDS epidemic has affected funding, political attention, and human resources for reproductive health (see Gruskin, this volume). As already discussed, spending for HIV/AIDS has increased at the expense of reproductive health and family planning, and further increases in HIV/AIDS spending are expected, based on revised estimates of the costs of addressing the epidemic. "The 2006 UN General Assembly high level meeting on AIDS called for annual HIV expenditure in low and middle income countries to rise from $8.3 billion in 2005 to around $23 billion by 2010" (England 2007: 344). There is debate as to whether current spending on HIV/AIDS is justified given the burden of HIV in the context of other diseases (see DeLay, Greener, and Izazola 2007; England 2007).

The rapid growth and sheer size of funding for HIV/AIDS has affected the structure of health spending and systems. Some argue that HIV "has produced the biggest vertical programme in history, with its own staff, systems, and structure" (England 2007: 344). The impact is the potential underfunding of other diseases and the creation of separate health structures and delivery systems that hinder other health services. Others see HIV funding as an opportunity to strengthen the health system: HIV "should provide an opportunity and entry point for strengthening health and social service systems if it is used appropri-

ately" (DeLay, Greener, and Izazola 2007: 345). While potential exists for reproductive health to be integrated into HIV service provision, some may view the proposition in zero-sum terms (see Gruskin, this volume).

Poverty Reduction and the MDGs

Poverty reduction has become the focus of the larger development agenda as witness the huge focus on achieving the MDGs. Reproductive health is overshadowed by the MDGs not just by exclusion (as discussed earlier) but because of the need to justify reproductive health interventions and ICPD in terms of achievement of the MDG goals, particularly the first MDG on poverty reduction. The reproductive health field is under pressure to document the relationship between reproductive health and poverty. As Greene and Merrick (2005) find in their review of the literature on reproductive health and poverty, there is a dearth of evidence on this relationship; what does exist has not been used in a compelling way, and the pathways are not clear. There is a need for more research and evidence collection to convince Ministries of Finance and Planning that investments in reproductive health contribute to poverty reduction.

New Funding Mechanisms

The increased attention to poverty reduction has created new funding strategies in development assistance that present challenges for reproductive health. Donors have moved to broader mechanisms such as general budget support or the Poverty Reduction Strategy (PRS) process, which devolves allocation of specific funds to the country level. The number of countries participating in the PRSP approach has more than doubled since 2002 to over 50 (Vogel 2006). The PRSP process makes it easier for specific health issues to become lost and more difficult to track funds allocated to a particular issue (Merrick, this volume).

At the other end of the funding spectrum are highly visible disease-specific funding campaigns. One high profile example is the Global Fund to Fight AIDS, Tuberculosis, and Malaria created in 2002. "Since its birth, it has approved $6.6 billion in proposals and dispersed $2.9 billion toward them. . . . The fund estimates that it now provides 20 percent of all global support for HIV/AIDS programs and 66 percent of the funding for efforts to combat TB and malaria" (Garrett 2007: 4, online version). Countries spend time and resources submitting proposals to the Global Fund through a unique process involving country coordinating mechanisms. Beyond the obvious attention to HIV/AIDS, reproductive health writ large is usually not part of these proposals. Perhaps in

response to this exclusion, a global fund for maternal and child health has been suggested as a mechanism to ensure that funds are made available and donors are held accountable for the achievement of MDG-4 (Reduction of child mortality) and MDG-5 (Improve maternal health) (Costello and Osrin 2005).

Because of their predominance on the global health agenda, HIV/AIDS and the MDGs are seen by some as carts that reproductive health should hitch itself to in order to remain on the policy agenda and ensure continued funding. The reproductive health community has been left scrambling to respond to calls for how reproductive health relates both to HIV/AIDS and poverty reduction. ICPD could not have predicted these new forces on the global agenda. As a result, the groundwork in terms of evidence collection was not laid at ICPD and is now being done so hurriedly, perhaps adding to the sense by practitioners of reproductive health being left behind.

The Increased Importance of Global Health

As mentioned in the introduction to this volume, the increased importance of global health, which adopts a particular approach to funding, accountability, and measurement, has troubled the status of reproductive health on the policy agenda.[7] Global health is driving the increase in U.S. and European overseas development assistance, as well as that of the World Bank and private foundations (Garrett 2007; Ethelston 2004a). Despite this increase in funds for global health, recent estimates suggest that more money is needed. Jeffrey Sachs in 2001 argued that $20 billion a year was needed to address global health (Sachs 2001). "Estimates of the additional donor assistance required every year to achieve the MDGs by 2015 range from U.S.$50 billion to $100 billion" (Ethelston 2004a: 39). Whether accurate or not, these global estimates have been useful for advocacy for global health issues. While more money is available for global health, reproductive health still must compete for financial and other resources among an agenda of a larger set of issues.

The way these funds are programmed also impacts reproductive health. Popular interpretations of global health are marked by a vertical approach to programming with a preference for disease-specific large-scale interventions that often take the form of high profile global initiatives (e.g., WHO 3 x 5 Initiative). Reproductive health is unique in the breadth of issues that define it; it encompasses an array of health issues and interventions—some, such as improving women's empowerment, which requires multisectoral approaches. Reproductive health is a complex concept as opposed to a specific health strategy to be addressed

through a well-financed and highly publicized international initiatives such as Roll Back Malaria or Stop TB Initiative (Shiffman et al. 2002). There is no "magic bullet" approach for reproductive health that easily fits the focus on vertical programs so popular in global health today.

The increasingly dominant funding and agenda setting role of a few large U.S.-based private foundations in today's global health environment cannot be overlooked. "As of August 2006, in its six years of existence, the Bill and Melinda Gates Foundation had given away $6.6 billion for global health programs. Of that total, nearly $2 billion had been spent on programs aimed at TB and HIV/AIDS and other sexually transmitted diseases" (Garrett 2007: 3, online version). While this increase in funding for global health is laudable, the grant making of large private foundations may "influence the decisions of other funding agencies" and not necessarily be reflective of needs at the national level (Okie 2006: 1087).

The Programme of Action stated that the original resource estimates for ICPD were to be revised and officially reviewed. Official revisions have not been done, however one well accepted estimate suggests that $35 billion to $45 billion annually is required over the next few years (Ethelston and Leahy 2006). The UN Millennium Project estimated total costs for family planning, maternal and newborn health, treatment of selected sexually transmitted infections, and prevention of HIV/AIDS in 2005 at $18.2 billion, in 2010 $29.8 billion, and in 2015 $35.8 billion.[8] Estimates for the resources to achieve MDG-4 and MDG-5 are a minimum of $7 billion per year (Powell-Jackson et al. 2006).

Measurement and Priority Setting in Global Health

Another impact of global health on reproductive health is the increasing reliance on evidence-based priority setting and application of summary measures of population health to set health priorities (Van Der Maas 2003; Murray et al. 2002; Murray and Lopez 1996a; World Bank 1993). One widespread measure is burden of disease (BOD) analysis.[9] Its appeal to policy makers and donors is understandable. It calculates the burden of ill health for a wide range of conditions using the same measure, the disability-adjusted life year (DALY), purportedly allowing for comparison among a range of health issues. It also ranks a set of health interventions based on their cost-effectiveness measured in DALYs, giving policy makers the sense that they are prioritizing the health intervention that provides the biggest return for each dollar spent.

Efforts to measure the burden of disease due to reproductive health conditions have been useful yet flawed. The first global burden of dis-

ease (GBD) exercise in 1990 estimated that reproductive ill health contributed 5-15 percent of the burden, with the main contributing factors being death and disability due to pregnancy and childbirth, sexually transmitted infection (including HIV/AIDS), and reproductive tract cancer (Murray and Lopez 1996b). Furthermore, the 1990 GBD analyses found that reproductive ill health accounted for a greater global burden of disease for women than men (22 versus 3 percent). These early calculations of the DALYs associated with reproductive ill health served a constructive role in getting reproductive health on the global health policy agenda (Petchesky 2003; Allotey and Reidpath 2002; AbouZahr 1999; Murray and Lopez 1998). The quantification of disability associated with reproductive health conditions complemented the efforts at ICPD to generate policy attention to reproductive health. An update in 2001 reported that the burden of disease related to sex and reproductive health accounted for 18 percent of GBD among women aged 15–44 and 32 percent among women aged 15–44 (Lopez et al. 2002).

While DALYs represent an important technical advance in the field of global health, there are technical limitations in the assessment of the burden of sexual and reproductive ill health (AbouZahr and Vaughn 2000) that affect where reproductive health fits on the global agenda.[10] One critique is that the basis for calculating DALYs, the International Classification of Diseases (ICD), which allows for DALYs to be classified as diseases, injuries, and their sequelae, is problematic when measuring reproductive morbidities that go beyond anatomical diagnoses (see AbouZahr and Vaughn 2000). A second critique considers the valuation of health states. Reproductive ill health is underreported because symptoms are often unrecognized, undiagnosed, or asymptomatic; shame and stigma associated with sexually transmitted infections or infertility create strong social and cultural reasons for under reporting them (AbouZahr 1999). The valuation of health states, a critical component in BOD calculations, is therefore especially challenging for reproductive health issues. Finally, a lack of reproductive health data creates a tendency to underreport some reproductive health conditions, thus skewing incidence estimates essential to the DALY calculation. This is exacerbated by the fact that the reproductive health field has struggled to agree on indicators to measure progress, show results, and make linkages and associations with other development issues. The challenge of finding indicators for reproductive health that are both measurable and manageable remains (Kaufman, this volume).

The limitations of summary measures such as DALYs for reproductive health are significant. They shape policy makers' perceptions of the relative importance of reproductive health in the overall global health agenda. This translates into a large portion of the reproductive health

agenda, as defined by ICPD, being left out. These measurement limitations directly affect the resources allocated for reproductive health. As described earlier in this chapter, resources for reproductive health have been declining over the past decade. While the mismeasurement of reproductive health issues is not the only explanation for diminishing resources, it could be argued that more accurate measurement of the burden of reproductive health may lead to increased attention and allocation of resources.

Conclusion: Moving the Reproductive Health Agenda Forward

The analysis in this chapter suggests that reproductive health has slipped in its status on the global policy agenda since ICPD. This conclusion, based on evidence of declining policy attention, diminishing resources, and lack of a clear intervention that all stakeholders agree on, is made with several caveats. First, this judgment is based on interpretation of an incomplete set of evidence. Second, the analysis focused only on the global reproductive health agenda; the results may be more encouraging at the national level, depending on the country context. While beyond the scope of the analysis here, evidence at the national level seems less pessimistic, and it is important for the field to continue to document success at the national level. Bangladesh is one such example (Jahan and Germain 2004). This ownership at the national level was an overall goal of ICPD and should therefore be considered as successful implementation of ICPD.

Third, the conclusion depends on the definition of reproductive health one adopts. A more holistic definition of reproductive health views ICPD as a "living document" with the major principles and underlying concepts of its agenda being adopted and adapted into other documents and settings since ICPD. Some women's health advocates have argued that "Cairo provided the foundation for the MDGs" (Germain and Kidwell 2005) and that the UN Millennium Project moves the ICPD agenda forward (Glasier and Gulmezoglu 2006). If reproductive health is defined as the set of individual components, one may be less optimistic. As for funding, the evidence is pretty clear that there is diminishing attention to reproductive health in the global donor community, particularly when HIV/AIDS is separated from reproductive health activities.

How then do we think about the reproductive health and rights agenda in the future? What are some strategies for maintaining and increasing its status on the global agenda? It is important to consider the reproductive health and rights agenda in the current policy context it

operates in, and in particular, the unique factors that the current interest in global health bring to bear. The impact of global health should not be considered just in how reproductive health relates to other health and development issues (e.g., HIV/AIDS or MDGs) but in how it interacts with and responds to the changing global health and development environment itself. Such a view suggests that maintaining and increasing reproductive health's visibility on the global agenda will require a multipronged approach that addresses new funding mechanisms, improvements in measurement of progress, and expanding advocacy. On today's global policy agenda, reproductive health is more recognizable in terms of the underlying concepts of ICPD that have been explicitly or implicitly adopted in a range of new policy agendas. This provides the opportunity for the ICPD agenda to be adopted and adapted into a larger network comprised of new relationships. This should be seen not as a weakening of reproductive health but as a testament to the inherent and enduring strengths of ICPD and its Programme of Action.