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Reproductive Health in Developing Countries: Challenges and Policy Issues: Moving from Statistics to Solutions

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Abstract

In 1994, the International Conference on Population and Development issued a 20-year Programme of Action that reflects the international consensus on a comprehensive set of recommendations aimed at fostering sustainable development, poverty reduction and women's empowerment. It also aimed at improving health - including reproductive health - and the quality of the people, and creating a better balance between population dynamics and social and economic development. The paper identifies some of the challenges the developing countries are facing to implement the Programme of Action, particularly in terms of resources. Lack of donor support including opposition from powerful section of the world, is hindering the success of the program. The paper also proposes a policy alternative to donor dependence in terms of diverting a major part of the military expenditure - if not all - to the broader issues of population and development. It is argued that without such a firm commitment from the developing countries themselves, the goals of the conference will not be met effectively.

Keywords and Phrases: Reproductive health, ICPD, Maternal mortality, Sexual health, Contraception, Empowerment, Equity, Sustainable development, Debt burden, Defence spending, HIV/AIDS, Policy.

AMS Classification: None.

"Every dollar that is spent on unnecessary weapons represent a missed opportunity to improve the life of a person in need of food, shelter, education or health care. .... and yet, poor countries continue to buy weapons and rich countries continue to supply them." Oscar Arias Sanchez. Keynote Address at DSE 2000 www.dse.de/sancche-e-htm"

"War and the preparations for war, is one of the greatest obstacles of human progress, fostering a vicious cycle of arms buildups, violence and poverty." Oscar Arias Sanchez. Globalization and the challenges of Human security, University of San Diego, Joan B. Kroc Institute for Peace & Justice, September 25, 1998.
"There are no magic answers, no miraculous methods to overcome the problems we face, just the familiar ones: honest search for understanding, education, organizations, – inspired by the hope of a bright future." Noam Chomsky. www.globalissues.org/Other.asp

1 Introduction

Poverty is the root cause of the double tragedy of high maternal mortality rates and excessive fertility in developing countries. It exerts its influence through illiteracy, malnutrition and the low status of women. Thus, reproductive health in developing countries is a complex issue, involving an interaction between demographic, sociocultural and medical factors, all in turn determined by poverty. It is important to bear in mind this background as we study in depth the application of current interventions to improve reproductive health. The current emphasis on reproductive health (RH) in population programs began in the 1970s when human rights and women's health advocates began to ask questions about the rationale of traditional policies that mainly focussed on reducing population growth through family planning services (Dixon-Muller 1993a ; Sinding and Ross 1994). Since the 1970s a growing international women's movement has been arguing that women in the developing world often do not have reproductive autonomy in that their male partners and other household members and community leaders (mainly through religious dogma) influence their decisions, particularly where social and cultural norms value women primarily for their childbearing role (G.Sen, Germain and Chan 1994). They pointed out that women's lack of control over reproductive decisions limits their quality of life, poses a heavy health burden on them and ultimately prevents their participation in the development process (G.Sen 1994). They pushed for policy changes to make health services more responsive to women's needs and address the health consequences of reproduction, rather than being exclusively focussed on lowering fertility, and they even criticised the often coercive nature of family planning programs. Amartya Sen was also in the forefront of those debating the relationship between population and development in the 1960s and 1970s (Sen 1994a, 1999). He argued that directing resource flows exclusively towards family planning detracts from encouraging broader social development which is the most effective and ethical way of reducing population growth (Sen 1994a).Thus the ground work was laid for the shift that was observed in Cairo 1994 from an emphasis in population policy on aggregate population growth to individual welfare and rights.

In this report I have tried to identify some of the challenges that developing countries are facing to implement the Programme of Action (POA) agreed upon at the International Conference on Population and Development (ICPD) in Cairo, 1994, par-

ticularly in terms of resources. At ICPD all the participating countries agreed on a comprehensive 20-year plan to stabilize the world's population by investing in people and better meeting their health and development needs. The POA articulated a new vision, asserting the interdependence of population and development and calling for the empowerment of women not just for the matter of justice for women but as the key to improving the quality of life for all. Participants of the conference stated very clearly in the POA that by meeting people's needs for family planning and other sexual and reproductive health services, population goals will be met - by choice and opportunity, not coercion and control. In this paper I briefly outline the ICPD's achievements, including a description of its implementation and funding mechanism, and the progress made in implementing the ICPD POA thus far.

I also suggest a policy alternative of redirecting national resources rather than depending on donors for financing the RH initiatives suggested in Cairo. On average, developing countries spend US$22 billion on arms, a sum that otherwise spent would enable those countries to achieve universal primary education and also reduce infant and maternal mortality to the levels stated in the POA (Oxfam and Amnesty International, 2003). In developing countries, defence spending has a negative impact on the rate of economic growth (Hannah 2003). This expenditure is mortgaging a country's development initiatives. Research shows that this money could otherwise be spent on health care and education leading to the overall economic development of the countries (Economist 2003). The lethal combination of 'over-armament and under-development' is the real problem facing the people of the developing countries today.

Since 1994 many studies have been undertaken by international agencies, NGOs and academics, and generated dismal statistics which are not very encouraging but widely quoted in various publications. Some of the basic facts that I refer from time to time in this paper may be found in the two tables and also in the appendix at the end of the report. The policy alternative that I am suggesting here is also not new, and references to redirecting miliary spending are scattered throughout the literature in the areas of health, education, trade and others. I have tried to organize these references in a systematic policy perspective that makes sense to the financing needs of the reproductive health initiatives proposed at ICPD.

Cairo 1994 and Reproductive Health

Lack of reproductive health (RH) constitutes a significant deprivation of well-being in developing countries and yet the field is not central to mainstream development policy. So the RH approach included in the ICPD POA, approved by all of the 180 states present, represented a major shift from previous thinking on population and development. The POA reaffirmed the importance of slowing population growth as an important goal for social and economic development, but it also emphasized the need for a significant departure in strategies to achieve this goal - an emphasis on meeting the needs of individual women and men rather than on achieving demographic targets through family planning alone. In one sentence, ICPD's Vision for RH can

be summarized like this: **A world where all individuals would have access to comprehensive reproductive health information and services throughout their life cycle by 2015.** (Vide Appendix for detailed list).

Building on the outcomes of the World Population Conference in Bucharest (1974), the International Conference on Population in Mexico City (1984), the Earth Summit in Rio de Janeiro (1992), the Vienna World Conference on Human Rights (1993), and decades of experience and research, the ICPD POA calls for an approach to RH that is comprehensive and client-oriented, based on the interrelationship between population, human rights and sustainable social and economic development, and the principles of choice, gender equality, equity and the empowerment of women. To satisfy the RH needs of all during all the stages of life cycle, it recommended that all countries provide, through the **Primary Health care system**, a range of services and information, including but not limited to Family Planning. **Conceptually, the term has come to describe an approach which sees women's health and well-being as important in its own right, not as a means towards the ends of fertility reduction or child health**, (J.DeJong, 2003). As a panel of the American Academy of Sciences concluded robust reproductive health implies that:

1) every sex act should be free of coercion and infection;

2) every pregnancy should be intended; and

3) every birth should be healthy. (Tsui et al, 1997).

The reality, of course, is far from these goals, as is most visibly illustrated by the HIV/AIDS pandemic, particularly in the sub-Saharan region. No population in the world has yet met these goals. Problems are particularly acute in the developing countries. Almost 600,000 women die due to pregnancy related causes, 99% of them in developing countries, and about 7.6 million infants die in the perinatal period each year (WHO 1998). What sobering statistics!

Rejecting the concept of 'population control', the Cairo conference recognized that smaller families and slower growth depend on free choice and conditions that encourage such choice. So the ICPD POA seeks to ensure that " All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so." So defined, the RH approach:

- provides the rationale for design and implementation of client-focused programs based on the principles of choice, equality and quality of care,

- promotes the comprehensive RH care of women, through open access to information and a combination of services,

- legitimizes client demand as a right as well as the basis for provision of goods and services, and

· encourages international cooperation and public/private partnerships to improve the quality of life of present and future generations.

This vision of RH received the support of more than 1500 non-governmental organizations and the unanimous endorsement of 180 government delegations. Although it was hailed as the breakthrough for such an agreement of NGOs and government delegations, it will be shown later that the seeds of failure were built into the non-binding nature of the POA for individual country and the lack of definite commitments on the specific shares of respective donors and developing country financing arrangements for the implementation of the POA. "Eliminating coercion while promoting women's health and rights will simultaneously require a dramatic increase in funds to expand and improve RH programs worldwide and an unfailing commitment to providing a wider range of needed services."(Jacobson and Malik 2002). This ambitious agenda requires an acknowledgement that having help create the situation in the first place, those countries and NGOs (signatories of the POA in Cairo) have a moral and ethical obligation to help change it. In the annual battle to cripple the UNFPA, the conservative right in the world has shown no inclination for such an agenda.

Implementation and Progress

2004 marks the tenth anniversary of the ICPD (1994) in Cairo. The POA marks a paradigm shift in international agreements on population. One must remember that , before 1994, issues such as sexuality, abortion, female genital mutilation, violence against women and reproductive health were far from commonplace. This neglect of women's health changed dramatically since ICPD in 1994, and the issues were taken up and extended in Beijing a year later. The move away from the demographic paradigm towards a RH approach makes the POA relevant for all countries, and not only for those facing rapid population growth. The goals established in 1994 were set for a 20 year framework. As a result of the first 5 yearly review, the ICPD goals were updated in 1999 (Cairo+5, ICPD+5) in order to take account of the growing HIV/AIDS pandemic, (UNFPA, IWHC). Ten years later, the RH agenda and agreed principles have come under threat by the anti-abortion lobby and fundamentalist groups. The Global Gag Rule (also known as Mexico city policy) led to massive funding cuts to RH and HIV/AIDS preventions programs in the poorest countries with devastating impact. While there is no comprehensive survey of all countries' compliance with ICPD commitments, many regional and national assessments have been conducted.

Population and RH are central to development and must be included in development programs and poverty reduction strategies. Without a firm commitment from government of the developing nations, NGOs and donor countries, to population and RH including gender issues, and the necessary allocation of resources, it is unlikely that any of the goals and targets of Cairo 1994 or the Millennium Development Goals and targets will be met effectively. The messages ten years after Cairo 1994 are very clear: current levels of resource mobilization are inadequate to fully implement the

Cairo agenda, the resource gaps are especially large in poorer countries. (Population and reproductive health, www.developmentgateway.org).

"The lack of donor support for RH services is jeopardizing progress towards meeting anti-poverty goals", the Executive Director of the UNFPA warned on March 22, 2004. Ms. Obaid warned that if the funding gap is not closed, "it is unlikely that any of the world's Millennium Development Goals will be met." Ms. Obaid's comments came as the UN Commission on Population and Development opened the session in New York to assess progress made during the decade since Cairo 1994. (UN News Service, March 22, 2004, www.un.org). Addressing the commission, the UN Under-Secretary-General for Economic Affairs, cited studies showing some progress, but "yet many women still lack access to care and the risk of maternal mortality remains unacceptably high." "Without a solidly built and actively maintained foundation of political will and resources, both human and financial, the goals of the (Cairo) Programme of Action will not be fully achieved," he said. Maternal Mortality Ratio (MMR) is the one public health indicator showing the maximum variation between developed and developing countries. In developed countries MMR is only 27 per 100,000 population compared to 480 in developing countries. POA goal was set at 120 by 2005 and 75 by 2015. The goal is not to be met (WHO 1998).

One of the most positive developments to come out of the ICPD process has been a new relationship between government and non-government sectors, based on growing awareness of the need to work together for successful implementation of POA. Cairo+5 review helped re-establish links within NGO community, reminding organizations of their common purpose. It is hoped that it will strengthen that relationship forged during ICPD and later.

When looking at the achievements in the area of RH, the following could be considered as the highlights for the decade (1994-2004):

- most developing countries have adopted the ICPD definition of RH and either already adopted policy reforms or initiated policy reforms to reflect the new focus,
- about 50% of the countries have made changes in programs and most of them have modified legislation to bring their laws into compliance with ICPD,
- some countries like China, India, Indonesia, Brazil, Mexico, Kenya, Iran, Bangladesh have made some progress in meeting the RH needs of their populations,
- birth rates have declined significantly all over the world, mainly due to increase in use of modern contraceptives,
- the commitments contained in the POA have been taken up by countries to varying degrees since 1994,
- adolescent sexual and RH is being increasingly recognized as an important concern,

- only Netherlands, Norway and Denmark have nearly met their funding targets,
- USA, Japan, UK, and most other rich developed countries have drastically reduced their share of the funding commitments made in 1994.

The ICPD+5 review held in New York in 1999 highlighted these and other examples of progress at the national level. It also presented alarming facts to the attention of the world's population. Worldwide, maternal mortality remains very high, especially in Sub-Saharan Africa and Asia: 600,000 women die every year and some 18 million are left disabled or chronically ill, due to "preventable complications of pregnancy and childbirth." Sexual violence is endemic and lethal, both within and outside marriage. At least 150 million women who want to prolong child bearing or birth-spacing cannot do it due to the " gap between contraceptive use and the percent of individuals want to use" to space or limit their families (Girard 1999; Bodiang 2003; Hardee, et al. 1999).

Funding the ICPD Initiative: Policy Makers' Nightmare

The ICPD POA is one of the few international agreements to have developed detailed estimates of financial resources needed for its implementation. ICPD estimated (in 1993 dollars) that combined domestic and international resources of US$17 billion would be required to fully implement the RH programs, including family planning, by 2000, $18.5 billion by 2005, $20.5 billion by 2010, and $21.7 billion by 2015, the last year of the program. No definite commitments were made on the specific shares of funding of respective donor and developing countries for any of the years. According to the informal sharing formula, developing countries would be responsible for two-thirds of these costs with donor countries contributing the remaining one-third. In 2002, the developing countries were two-thirds of the way towards meeting their target of $11.3 billion, while donor nations are providing only $2.1 billion of their target of $5.7 billion, less than half of what they pledged for the year 2002. (Anan 2001 and Forman, et al. 1999). The unanimity in the language in the POA agreement was achieved at the cost of this informal funding agreement which is eventually going to cost the success of ICPD - the most successful of all international conferences on population and development. This kind of major funding gaps from the donor nations and the trend that it established, do not hold much promise for meeting the financial goals of the ICPD POA. Unless there is a major re-commitment of funds from current donors or an increase of donor countries, it is highly unlikely that global funding of the magnitude projected by the POA will be available over the next ten years. Unfortunately, the current funding pattern suggests that there is most likely to be serious uncertainty about the levels of financing even in the short term. The developing countries may be doing what they can to protect RH agenda, but they need help. It is the richer countries, whatever they said at Cairo, are not responding.

"It is very tempting to blame the rich countries for lack of support and awareness but the depressing truth is that the major reason is improper and inefficient utilization

of available resources and misplaced priorities by the developing countries," (Singh, 2003). Although their resources are scarce, military spending by developing countries is increasing since 1993 at a dangerous space, mostly in East & South Asia, South America and Central Africa, (Ali and Galbraith, 2003). In 1997 developing nations spent over US$232 billions on military while the developed nations including US spent US$610 billion. This represents approximately 25% of the total global military expenditure - more than 15% of the total spending by developing countries. Tables 1 and 2 show the countries with the highest maternal mortality ratio spent less than 2% of its GDP on health. Eritrea spends 27.5% of its GDP on military, Ethiopia 6.2-8.5%, Angola 3.1-5.8%, India 2.5-2.7%, Pakistan 4.5-5.8% of the respective GDP on military. Ethiopia's arms expenditure is more than twice that of education and 8 times that of health care. Other war-torn African nations such as Angola and Mozambique spend up to half of the public budget on war efforts, (Adams,1991). Although in most countries the military lost some ground due to debt crisis, it has gained strength in Gabon, Guyana, India, Malaysia, Pakistan, Sri Lanka, Sudan, Uganda and Zaire where health clinics and school budgets were cut to spare the military, (Adams, 1991). By the mid-1980s, the developing world governments were spending up to 85% of their revenues for military expenses and debt payments combined. It could not continue for long. The Third World countries still have 8 soldiers for every physician, two and half times that of the developed countries. And the rich countries still have arms promotion packages in place, (Adams, 1991).

RH Policy in the Developing Countries: Moving from Statistics to Solution

The role of external aid and charities is limited and is unlikely to bring sustained and significant improvement in health, let alone the more comprehensive Cairo RH goals. The estimated total external aid will not make any dent in the world of massive inequality in health, (Poullier, et al, 2002). Health problems in the developing countries in Asia and Africa are exacerbated by arms sales, (Southall and O'Hare, 2002). They noted correctly that even if the arms trade were curbed, the health problems in these countries would persist because many of these nations are also burdened with massive debt burden and corrupt bureaucracies. But there is no doubt that exporting arms, particularly small arms, into these countries has fuelled the conflicts and that these countries have massive health problems, including RH. In the vast majority of these countries the net effect of military spending has been to retard development. This is because importing arms manufactured in wealthier countries create a negative burden on their economies, especially because debt is incurred to purchase arms. Thus, instead of facilitating national development, military spending would have exactly the opposite effect, diverting resources away from productive sector of the economy. Most economists agree that military spending generally has negative effect in developing countries.

Let us see what the UN Development Programme's 1998 Human Development

Report told us. It estimated that the annual cost of achieving universal access to the following basic social services in all developing countries:

- $9 billion would provide water and sanitation for all;
- $12 billion would cover RH for all women;
- $13 billion would give every person on earth basic health and nutrition; and
- $6 billion would provide basic education for all.

That means only $40 billion per year will solve most basic health and development related problems in the developing nations. And these social and health expenditures pale in comparison with what the world spend on military - some 1 trillion dollars. Even 20% reduction in military expenditure by developing countries will save more than $40 billion which can be utilized on all of the programs listed above, with some spare changes remaining for the corrupt politicians and the bureaucrats of those countries, without a dime from the donor nations.

So, I propose that the developing countries in the world stop spending on military completely for the next 10 years and utilize all those $200 + billions of dollars on the social and economic developments of the people of those countries and then take it from there. Military is the biggest bureaucracy in most developing countries. Sustainable development is undermined as high costs of weapon systems add to the debt load of those countries or displace funding for health, education or other social programs. The POA mandates all UN member states to work at dealing with problems caused by the proliferation and misuse of arms at the national, regional and international levels and in cooperation with civil societies. It also affirms that arms export criteria should be subject to existing human tights and humanitarian law, (POA Para 2.11). This way, both the human resources and money can be directed solely for the sustainable development purpose of those countries, including RH. Expenditure on arms will never create a world in which nations and people will feel secure. The arms trade makes worse the causes of the conflicts in the first place - poverty, economic insecurity, civil disorder and regional tension.

Is it going to solve all the problems of the developing countries? I think so. If Cairo means anything, the developing countries must put their money where their needs are. Let us see what Dr. Oscar Sanchez, former President of Costa Rica has to say. Costa Rica does not have any standing army, the provision was written in the constitution in 1949. Since then, Costa Rica has consistently been characterized as the most stable democracy in Latin America. She was able to dedicate almost 25% of its budget to education, and adult literacy rate exceeds 95%. Her health care is very high, life expectancies are comparable to Europe and US. Virtual elimination of military expenditure made this possible. "By abolishing our armed forces, we gained a moral force which has become our best defence," said Dr. Sanchez in the Keynote Address mentioned before. "The idea of human security recognizes that poverty, hunger, and

disease are forms of violence that have no justification," says Dr. Sanchez. "It demands that we devote energy and resources to meeting the real needs of people rather than the imagined needs of the military establishments," he continued. Time has come to put an end of the demand of the dictators and death squads, time has come to invest in people rather than in weapons. "Let us be a part of the force for light and transparency. Let us be a voice for the unheard, and harbingers of change," said Dr. Sanchez.

"In the ultimate mockery of 'defense'," says World Military and Social Expenditures, "military power wedded to political control turns inward to terrorize the people it is intended to protect." By choosing to mobilize adequate resources to address human suffering around the world, the rich and powerful nations have a unique opportunity to set examples and earn a truly dignified place in human history. They decided not to, it is their money and ultimately, their prerogative. This is where the governments of the developing countries come in. They must take the necessary leadership now and do what Dr Sanchez suggested. A far better way to alleviate poverty and enhance quality of life including RH for hundreds of millions of people is through sustainable growth, where a nation's resources are used productively to satisfy the needs of its people. This solution offers a much better prospect for a secure and peaceful world.

Concluding Remarks

To achieve the goals and objectives of the POA, continued efforts and commitments are needed to mobilize sufficient human and financial resources, to strengthen institutional capacity and to foster partnerships among governments, the international community, NGOs and civil society. With such efforts and commitments, the next review and appraisal may be expected to show broader progress in achieving the goals and objectives of POA. Community based local facilities for procurement and/or production of contraception and essential products including condoms for RH programs must be established to eliminate or minimize the contraceptive gaps. The question is: Will the governments of the developing countries take the initiative now? More relevant question may be: will the people of those countries force their governments to change the suicidal course of arming and re-arming them at the cost of their health, education and welfare? The answer seems to be a resounding 'NO' for both the questions. But history has shown that cost of not dealing with major issues now, will, in the long run, be substantially higher.(BMJ Editorials, and Korb, 2003). " **We must understand that in the end, weapons alone cannot buy us a lasting peace in a world of extreme inequality, injustice, and deprivation for billions of our fellow human beings**," (Renner and Bell). The issue is how to break the vicious cycle of arms trade and poverty and liberate the people from poverty and ill health (Gunatilake 1995).

Table 1: Maternal Mortality in selected countries.(WHO, UNICEF, UNFPA 1995 data)

Countries	Maternal Deaths	MMR	Lifetime Risks: 1 in
Afghanistan	7,900	820	15
Angola	7,100	1,300	9
Ethiopia	46,000	1,800	7
Eritrea	1,600	1,100	12
Nigeria	45,000	1,100	14
Somalia	7,100	1,600	7
Bangladesh	20,000	400	42
China	13,000	60	710
India	110,000	540	55
Pakistan	10,000	460	80
Indonesia	22,000	470	65
Sri Lanka	210	60	610
S. Korea	140	20	2,500
Malaysia	210	39	630
Singapore	5	9	5,400
Thailand	450	44	1,100
Costa Rica	30	35	820
Iceland	5	16	2,400

Appendix

Millennium Development Goals (MDG) that compliment ICDP Programme of Action (MDG indicators, UNDP Human Development Indicators 2003) Goals and Indicators for monitoring progress:

Goal 4: Reduce Child Mortality. Under five mortality rate. Infant mortality rate. Proportion of one-year-old children immunised against measles.

Goal 5: Improve Maternal Health. Maternal mortality ratio (MMR per 1000,000 live births) Proportion of births attended by skilled health workers

Goal 6: Combat HIV/AIDS, Malaria and Other Diseases HIV prevalence among 15/24 year-old pregnant women Condom use rate among contraceptive users Number of children orphaned by HIV/AIDS Prevalence and death rates associated with Malaria, TB and under DOTS program

Goal 8: Develop a Global Partnership for Development. Proportion of population with access to affordable, essential drugs on a sustainable basis.

Table 2: Public Expenditures in Selected Countries. UNDP Human Development Indicators, 2003

Countries	HDI	Education % of GDP	Public Health % of GDP	Defence % of GDP	Still Births Attendants %
Afghanistan	-	-	-	-	-
Angola	164	2.7 - 3.9	2.0	5.8	23
Ethiopia	169	3.4 - 4.8	1.1	6.2 - 8.5	6
Eritrea	155	4.8	2.9	27.5	21
Nigeria	152	0.9	0.5	0.9 - 1.1	42
Somalia	-	-	-	-	-
Bangladesh	139	1.5 - 2.5	1.5	1.1 - 1.3	12
China	104	2.1 - 2.3	2.0	2.3 -2.7	89
India	127	3.9 - 4.1	0.9	2.5 - 2.7	43
Pakistan	144	1.8 - 2.6	0.9	4.5 - 5.8	20
Indonesia	112	-	0.6	1.1 - 1.8	56
Sri Lanka	99	2.8 - 3.1	1.8	2.1 - 3.9	97
S. Korea	30	3.5 - 3.8	2.6	2.8 - 3.7	100
Malaysia	58	5.2 - 6.2	1.8	2.2 - 2.6	96
Singapore	28	3.7	1.3	4.8 - 5.0	100
Thailand	74	3.5 - 5.4	2.1	1.4 - 2.3	85
Costa Rica	42	4.4	4.7	0 *	98
Iceland	2	5.4	7.6	0 *	100

* No army

The ICPD Vision The RH portion of the ICPD POA calls for all States

1. To ensure that comprehensive and factual information and a full range of reproductive health care services , including family planning, are accessible, affordable, acceptable and convenient to all users (through the primary health care system by 2015).

2. To enable and support responsible voluntary decisions about child-bearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so; [and]

3. To meet changing reproductive health needs over the life cycle and to do so in ways sensible to the diversity of circumstances of local communities.(UN Pop. Fund, Issue 22, July 99)

Role of Public Sector: The approaches that can influence Reproductive Health.

· Inform people and health service providers about health risks.

· Finance Health care (create affordable public health infrastructures)

· Directly provide health care (social marketing)

· Mandate that certain socially sensitive activities be carried out, and

· Regulate how health care activities are carried out.

Some essential initiatives related to Sexual and Reproductive Health:

1. Reduce unwanted pregnancy.
2. Improve access to contraceptive information and products (preferably free of charge for those who cannot afford.
3. Delay onset of sexual activity.
4. Introduce sexual and reproductive health education in schools (3 above can be covered in the curriculum).
5. Interrelationships between sexual and reproductive health, education and female employment for ongoing evidence-based policy development.

Key (blunt) safer sex messages to promote responsible sexual behavior:

1. It is ok to say 'No' even inside marriages.
2. Always use condom if you do not want to be pregnant (and you are not on IUD or Pills).
3. Avoid multiple sex partners.
4. Ask questions about your partner's HIV/AIDS status and refuge sex if you are not satisfied.

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