

Cairo goals for reproductive health: where do we stand at 10 years?

Ten years ago, 179 countries—including the United States—agreed on a Programme of Action that revolutionized international population policy. In the Programme adopted at the International Conference on Population and Development in Cairo, the notion of “population control” was replaced with a more comprehensive approach to reproductive health, as a means to achieve development and population stabilization by improving the lives of women and men worldwide [1]. The Programme identified policy goals to be reached by 2015, including: increasing the percentage of deliveries attended by skilled caregivers; decreasing infant and child mortality; improving the social, economic, and educational status of women; increasing access to contraceptive care; and increasing life expectancy.

With its broad scope, the Programme engaged forcefully with the intrinsic interconnectedness between reproductive health and other aspects of social and economic development. The ability to delay or space childbearing, for example, can allow women to participate more fully in educational and economic opportunities, and advance women’s roles in society. At the same time, a woman’s status in a relationship may dictate whether she is able to negotiate contraceptive use with her partner in the first place. In addition, delaying or spacing childbearing may be critical to the survival of a family during difficult economic times. Adequate birth spacing also leads to better health outcomes for women and their children, while poor health status due to poverty can increase maternal and child mortality.

The goals established at Cairo encompass a wide range of activities that can advance reproductive health, both in the developed and developing worlds. As advocates for reproductive health, we are naturally concerned with reducing injuries and death from pregnancy and childbirth, increasing the chances that a child will survive infancy, preventing HIV infections and deaths from AIDS, and ensuring access to family planning care. At the same time, improving these outcomes requires not just providing reproductive health services, but also thinking outside of the “reproductive health” box. Programs that enable girls to continue in school, economic support for women (whether it is welfare support in the United States or micro-loans in some developing countries), access to health care, efforts to alleviate poverty and its effects, and legal rights for women are all important goals relevant to reproductive health.

Cairo’s ambitious goals, however, are far from being reached. Lack of resources and lack of political support have both contributed to the slow pace of progress toward these goals. The lack of financial support has particularly been a problem on the part of developed countries. At Cairo, developing countries promised to commit approximately two-thirds of the total resources needed. They have come close to their goal, mobilizing \$11.7 billion last year, with a target of \$12.4 billion for 2005. Developed countries, on the other hand, have contributed only one-half of their funding target, or \$3.1 billion in 2003, compared with a goal of \$6.1 billion for 2005 [2]. This resource shortfall diminishes the range and scope of care that can be provided.

Lack of political support has also been an important obstacle. The United States—a leading donor to reproductive health and family planning programs—has in recent years imposed a series of restrictions and cutbacks to international and domestic reproductive health programs. In 2001, the United States re-imposed the Mexico City Policy (also known as the global gag rule), this policy bans foreign non-governmental organizations from receiving U.S. Agency for International Development (USAID) family planning assistance if they provide abortion, counsel patients about abortion, or advocate for liberalizing abortion laws, with their own funds. Soon thereafter, the U.S. Department of State announced that it would withdraw its \$34 million contribution to the United Nations Population Fund (UNFPA). Going against the recommendations of two fact-finding teams, the State Department withdrew funding because UNFPA works in China, which has a “coercive” one-child program, despite the fact that UNFPA was undertaking a non-coercive demonstration project to convince the Chinese government to move away from birth quotas and targets [3].

In 2003, the Mexico City Policy was extended to cover all family planning assistance provided by the Department of State, retroactively justifying the withdrawal of funds to the Reproductive Health for Refugees Consortium, an organization providing HIV/AIDS prevention services to refugees in Africa [4]. And after promising \$15 billion over 5 years to combat AIDS around the globe, President Bush requested only \$2 billion for the first year. The bill also requires one-third of prevention money to be set aside for

programs teaching abstinence-unless-married as the only means of preventing HIV [5].

In addition to funding cutbacks, the U.S. has also taken a series of diplomatic actions that have called into question its support for reproductive health and family planning programs. In May 2002, at the United Nations Special Session on Children, the United States delegation pushed to remove “reproductive health services” from the final conference declaration [6]. Six months later, at a United Nations population conference in Bangkok, the U.S. delegation threatened to withdraw from the Cairo Programme, unless the terms “reproductive health services” and “reproductive rights” were removed [7]. In March 2004, the U.S. was again the lone dissenter against a resolution reaffirming the Cairo Programme, this time at a regional planning meeting of the Economic Commission for Latin America and the Caribbean [8].

Despite these setbacks, the Cairo Programme of Action remains an inspiring and crucial international public health goal. Many delegates at the conference ten years ago remember it as one of the most powerful and energizing experiences in their lives—with wholehearted commitment and full participation of delegates from almost every country in the world. And very important progress has already been achieved, especially by developing countries themselves. It is time now, however, for renewed support and commitment from reproductive health care leaders and advocates—especially those based in developed countries—to achieve the goals established at Cairo. Support is also needed for the full range of economic and social programs included in the Cairo Programme goals. It is time for the developed countries to honor their financial commitments, and to stop allowing politics to delay and distort basic public health investments. While a bold and challenging agenda, these efforts will help realize the vision glimpsed at

Cairo, of a world in which families are healthy and well, and all children are cared for and wanted.

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