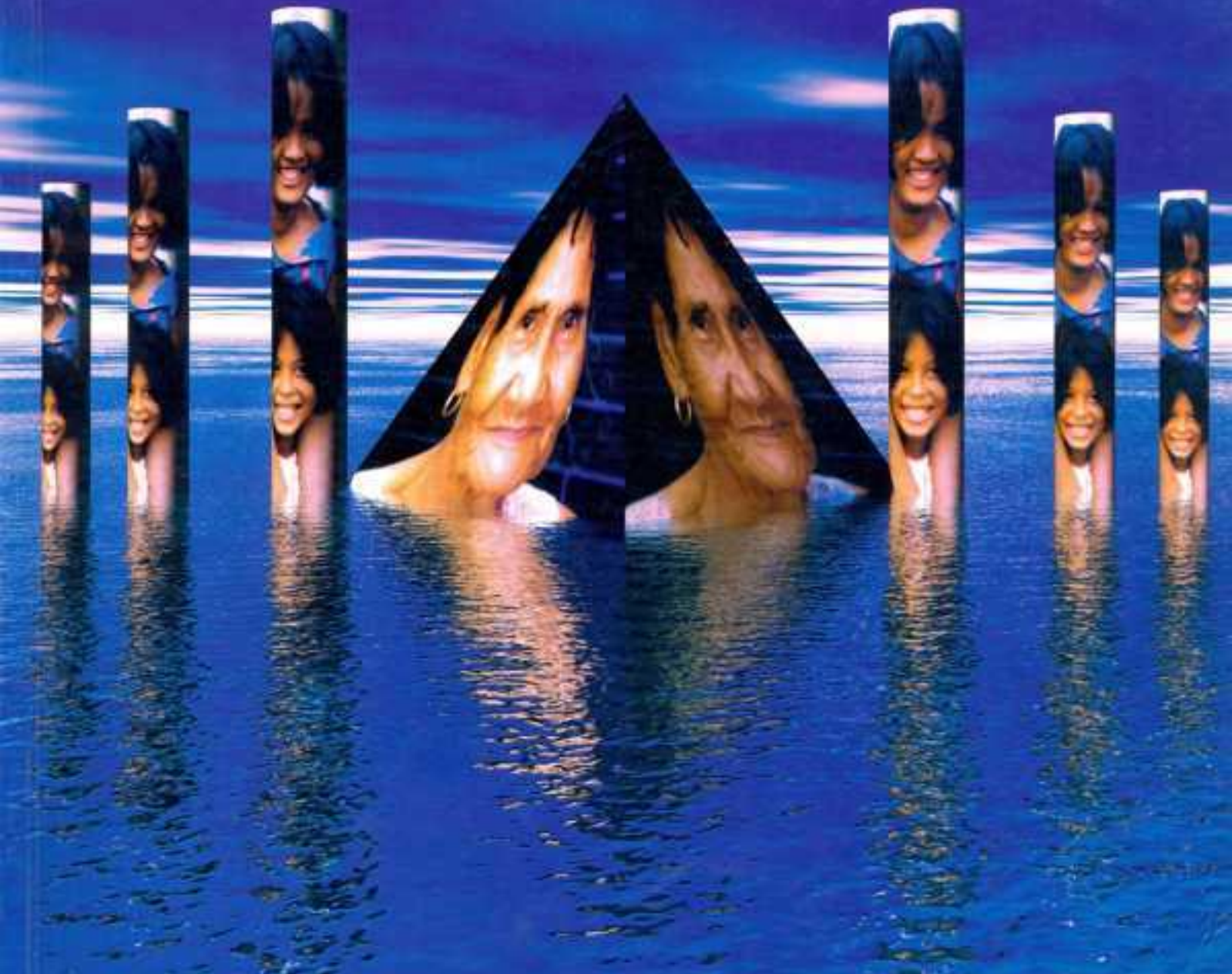
TAKING UP THE CAIRO CHALLENGE

Country Studies in Asia-Pacific



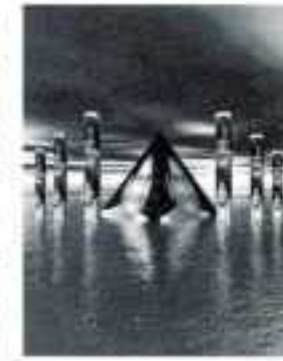
Asian-Pacific Resource & Research Centre for Women

TAKING UP THE CAIRO CHALLENGE

The Asian-Pacific Resource & Research Centre for Women (ARROW) was established in January 1993 as a regional non-governmental non-profit women's organisation based in Kuala Lumpur, Malaysia. ARROW's goal is for women in Asia and the Pacific to be better able to define and control their lives, particularly in the area of women's health and women's rights. Since 1993, ARROW has been able to make significant progress towards this goal through the provision of practical information, resources and research findings on women and development in the Asian-Pacific region. ARROW remains committed to its Women and Health Programme focus of strengthening initiatives to re-orient health, population and reproductive health policies and programmes with women's and gender perspectives and, at the same time, strengthening women NGOs' capacity to influence relevant organisations, both governmental and non-governmental. This programme focus has been further tailored to strategically cover four key areas of the recommendations from both the Cairo and Beijing Conferences. The four key areas are:

- Women's right to comprehensive, accessible, affordable and quality health services throughout their lives recognised and implemented in the health care system.
- Sexual and reproductive health and rights approach included in health policies and programmes rather than a narrow maternal health and family planning focus with demographic objectives.
- Women-centred and gender-sensitive approach addressing the effects of gender inequality on women's health status and the need for women's perspectives and experiences to be included in health policies and programmes.
- Violence against women recognised as an important women's health concern.

Concept of Cover Design



The design on the cover page depicts a myriad of issues that remain in terms of women's reproductive health needs and rights. The older woman's face is repeated on all sides of a pyramid that is placed at the centre of this design, emphasising that all policies , programmes and services which have an impact on women's lives, should place the individual woman's rights and needs as the central consideration. The three pillars depict the three main stakeholders—governments, NGOs and international organisations—who are responsible for ensuring the smooth and effective implementation of the Cairo Programme of Action at national level. Special attention needs to be given to the health needs of groups who are conventionally overlooked (depicted by the faces of the sisters on the pillars)—adolescents/young women, older women, unmarried women and lesbians. The design emphasises that challenges remain and that obstacles can be overcome if governments, NGOs and other stakeholders make a strong commitment and work in "true" partnership with each other. The pyramid and pillars are placed in water to show that with such "true" co-operation between the various stakeholders, achievement of what may be considered too difficult, is possible.

Cover design and layout by Angela M. Kuga Thas

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Asian-Pacific Resource & Research Centre for Women (ARROW)
2nd Floor, Block F, Anjung FELDA, Jalan Maktab
54000 Kuala Lumpur, MALAYSIA.
Tel: 60-3-2929913; Fax: 60-3-2929958; E-mail: arrow@pojaring.my
Homepage: http://www.asiaconnect.com.my/arrow/

TAKING UP THE CAIRO CHALLENGE

Country Studies in Asia-Pacific

Asian-Pacific Resource & Research Centre for Women

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PREFACE

At the end of the Cairo International Conference on Population and Development (ICPD), there was much hope that commitments by governments to the Programme of Action would be swiftly transformed into action. The Cairo Agenda was heralded by women NGOs as the most important and progressive international agenda to secure women's health and rights, and to promote gender equality.

The challenges of implementing the ICPD Programme of Action have been greater than anticipated. Although there have been significant achievements, there is still a long way to go. *Taking Up the Cairo Challenge* presents some of the first national and regional efforts, globally, to monitor achievements and obstacles to ICPD implementation at country levels, two years after Cairo. The specific focus is on the area of reproductive health and reproductive rights, with the aim of assessing to what extent these concepts have been understood, accepted and concretely addressed in health, population and family planning policies and programmes. *Taking Up the Cairo Challenge* represents the commitment and competency of women NGOs and women researchers in Asia and the Pacific in ensuring the ICPD implementation.

In mid-1995, ARROW carried out a preliminary survey on post-Cairo changes in Thailand and Indonesia, interviewing 12 to 15 people in each country. This survey was aimed at highlighting areas and issues to be addressed in the research project and thus, provided a conceptual framework for implementation of the wider research. As a result of this preparatory work and due to enthusiastic responses from countries around the region, an eight country research project on *Changes in Population Policies and Programmes Post-Cairo* was initiated in 1996. The countries covered included Fiji, China, Indonesia, Malaysia, Pakistan, Singapore, Thailand and Vietnam. In the implementation of the project, ARROW had collaborated with women's health NGOs, development NGOs and women's health and population researchers. A consultation to discuss the findings of this research project and follow-up activities at national level was organised by ARROW in December 1996. Although country studies were completed in 1996, many of the country scenarios and underlying barriers to more effective implementation of the Cairo Programme of Action, remain the same. The eight country studies, overview and report of the *Regional Consultation on Strategies for Change* contained in this publication are, thus, still highly relevant

THE RESEARCH

Eight country studies covering Fiji, China, Indonesia, Malaysia, Pakistan, Singapore, Thailand and Vietnam, assess the extent of governments' action and commitment towards the full implementation of the ICPD Programme of Action in the areas of women's reproductive health and reproductive rights.

in assessing government action and commitment towards the implementation of the ICPD Programme of Action. It is hoped that *Taking Up the Cairo Challenge* will continue to be a useful contribution to the ICPD+5 evaluation processes in 1999 at all levels and beyond this, to ensure effective implementation of the Cairo recommendations. The draft publication was used as an input into the Asia-Pacific NGO Consultation on ICPD +5, the HERA (Health, Empowerment, Rights and Accountability) International Conference on Partnership and the DAWN (Development Alternatives with Women for a New Era) ICPD +5 project in 1998. The findings and recommendations were also put forward at the NGO Forum and the Hague International Forum on ICPD +5 in February 1999.

ARROW is very appreciative to the individual researchers and to the country research co-ordinators, as well as their respective organisations, for engaging in this project. A special thank you goes to government agency representatives and officials, and representatives of NGOs and international organisations, for their co-operation during the research project . ARROW also acknowledges the significant contributions of interns to ARROW—Bharati Sadasivam, Mary Noonan and Geeta Nanda—who helped ensure the smooth implementation of the project. Bharati Sadasivam, a summer intern with ARROW from the Graduate School of International and Public Affairs, Columbia University, New York, carried out the preliminary survey in Thailand and Indonesia. Mary Noonan, a graduate intern with ARROW for the summer of 1996, from the University of Michigan, School of Public Policy Studies, prepared a draft summary analysis based on the country studies. Geeta Nanda, also a graduate intern and from The John Hopkins University School of Hygiene and Public Health, Baltimore, assisted in the editing and finalisation of the overview chapter. For editing of the country reports and preparation of the final report of the *Regional Consultation on Strategies for Change*, the assistance of Zainah Anwar, researcher and writer, is much appreciated. The ARROW staff too are acknowledged for their full support to the research and dissemination of the findings, especially Angela M. Kuga Thas and Sharon A. Bong for the final editing and production of this publication.

Finally, ARROW would like to express a deep gratitude to the funders—the Swedish International Development Cooperation Agency (Sida) for funding this research and the regional consultation, and for contributing to ARROW's institutional funding during 1996–1998; and the United Nations Population Fund, for funding the production and dissemination of this publication in 1999.

Rashidah Abdullah
February 1999

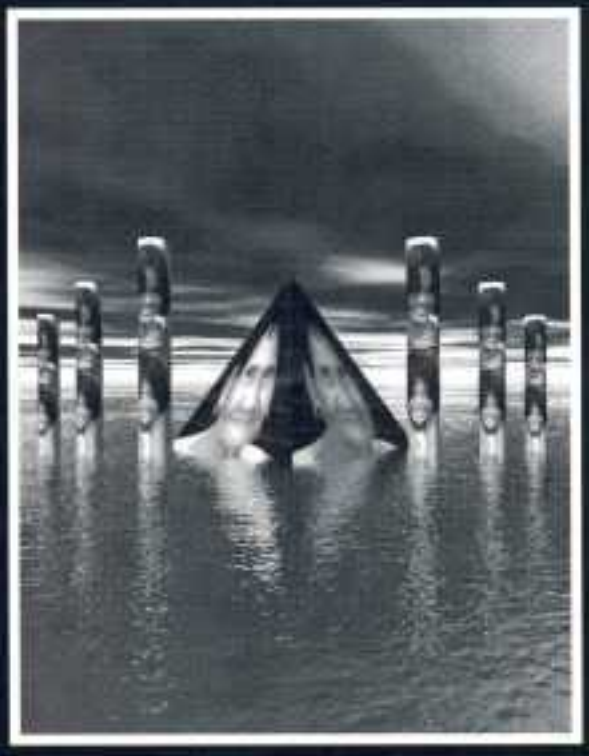
ARROW Staff

Rashidah Abdullah
Director
Angela M. Kuga Thas
Programme Associate
Vanitha Subramaniam
Programme Officer (Research)
Sharon A. Bong
Programme Officer (Publications)
Zailan Rose Kamaruddin
Programme Officer (Information & Documentation)
Uma Thiruvengadam
Documentation & Information Centre Assistant
Khatijah Mohd. Baki
Administrative Assistant
N. Manimekaladevy
Secretary/Administrative Assistant

Other ARROW Staff during the research project:

Kristinawati Ramlan
Zuhanariah Mohd. Nordin
Aliza Mohd. Aris
Wan Hartini Wan Mohd.
Thilaha Nalliah

SECTION 1
OVERVIEW OF FINDINGS AND COUNTRY STUDIES



1 Changes in Population Policies and Programmes: Overview of Findings

RASHIDAH ABDULLAH

the Author
Rashidah Abdullah is the Director of the Asian-Pacific Resource & Research Centre for Women (ARROW)

Introduction and Background

There is still a long way to go before the recommendations of the International Conference on Population and Development (ICPD) in Cairo 1994 are known, understood and acted upon primarily by government, international agencies and donor organisations in Asia and the Pacific. This was one of the main conclusions of a regional research project *Changes in Population Policies and Programmes Post-Cairo,* co-ordinated by the Asian-Pacific Resource and Research Centre for Women (ARROW) in 1996, covering China, Fiji, Indonesia, Malaysia, Pakistan, Thailand, Singapore and Vietnam. ARROW is a regional, non-profit, women's NGO focussing on women's health. The project was initiated in an effort to understand more deeply the extent to which the principles and specific recommendations of the ICPD Programme of Action, particularly in terms of reproductive rights and reproductive health, were understood, accepted and concretely addressed in population, family planning and health policies and programme implementation. Country research co-ordinators and their teams carried out in-depth interviews with key government, NGO and donor agency personnel in positions ranging from policy to field-level. Research co-ordinators were demographers (Thailand and Fiji), public health specialists (China and Malaysia), women's studies academics (Indonesia) and social scientists (Vietnam, Singapore and Pakistan), most of whom were also affiliated to NGOs concerned with Cairo implementation.

This chapter presents an overview of the research process and methodology and a synthesis of the main findings, the immediate recommendations of the country researchers and some overall conclusions. It is based on the eight country studies which are presented in this publication.

The rationale given for the research was as follows:
It is now known that the existence of well articulated, internationally endorsed

documents outlining actions that need to be taken by governments, international agencies and NGOs to advance women's position, are slow to be ratified and implemented. Such documents include the Nairobi Forward Looking Strategies (1979), the Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention), and the Platforms and Programmes of Action of the 1992 Rio Earth Summit, the 1993 World Conference on Human Rights and the ICPD 1994. Women NGOs have recognised that it is critical that governments, donor agencies and other international organisations be monitored and made to account for their actions to comply with these documents.

At the end of 1996, progress appears minimal in most countries of the Asia-Pacific and the world. This was also the assessment at the Post-Cairo Workshop at the NGO Forum in Huairou, from both plenary presentations and discussions. Among the factors involved are:

- The lack of an effective women's movement, including a women's health movement, nationally and regionally to act as a watchdog, to lobby and advocate.
- Absence of concrete accountability mechanisms, and the tendency of population, health and family planning organisations to claim that they have implemented recommendations and have "changed" substantially whereas change appears to have been minimal. The assertion that policies and programmes are already sensitive to women and thus, there is no need to change. There is therefore a need to systematically assess country situations and the regional scenario as part of the monitoring and accountability process post-Cairo and to determine effective strategies to strengthen this process.

Design and Methodology

Preliminary Survey—Preparatory Work

ARROW planned to conduct the research using interviews with key people from the various sectors involved with ICPD implementation—government, NGOs and donors. The use of interviews was believed to be more effective than questionnaires as points of view could be explored more easily and related more holistically to one another.

In June–July 1995, a preliminary survey was carried out in Thailand and Indonesia, in order to identify more clearly the areas and concerns which needed to be addressed in the research and the people who should be interviewed. The survey was carried out by Bharati Sadasivam, a summer intern with ARROW from the Graduate School of

International and Public Affairs, Columbia University, New York.

Prior to the survey, the framework of issues and questions drawn up was sent to women's health activists in five countries for their input. These were Indonesia (Ninuk Widyantoro and Adrina), Thailand (Dr. Kritaya Archavanitkul), India (Sundari Ravindran and Indu Capoor), the Philippines (Marilen J. Dañguilan) and Bangladesh (Nasreen Huq). Based on these inputs and also in reference to a "Post-ICPD Survey on Government Accountability" initiated in July 1995 by the Health and Development Policy Project in the United States, a draft framework of questions was developed. Using this framework, Bharati conducted twelve interviews in Indonesia (Jakarta and Yogyakarta) and ten in Thailand; collected and assessed other relevant documents and materials; and produced the very useful report "Preliminary Survey and Conceptual Framework" (Sadasivam 1995). Following the preliminary survey process, the framework questions were then modified to include some additional concerns that had surfaced.

Research Objectives

The set of objectives for the regional research were defined as:

- To assess to what extent the principles and specific recommendations of the ICPD Programme of Action, particularly in terms of reproductive rights and reproductive health, have been:
  - understood, "accepted", discussed and commitments made;
  - concretely addressed in population, health and family planning policy review and reformulation;
  - concretely addressed in programme implementation, in terms of change in objectives, service range, service delivery processes, training and budgets.

- To determine the opportunities and barriers to facilitating such changes in various country contexts such as the:
  - roles and effectiveness of women NGOs; the roles of donors and international agencies.
  - political will and interest in women's issues in general; the demographic country scenario.
  - status of health needs and quality of the health care system in general/the accepted indicators of successful population, health and family planning programmes.

- To recommend strategies and activities at all levels in order to overcome barriers and maximise opportunities.

Areas Covered

In addition to areas specified in the objectives, the following guides were provided:

- Bharati Sadasivam's "Framework Questions" (see Appendix 1.2)

- A "Women-Centred Reproductive Health Framework" for programme implementation areas (see Appendix 1.3)

Additional questions/areas given were:

- Has the ICPD Programme of Action or sections been translated into local languages and disseminated? If so, who initiated and implemented this?
- Have new mechanisms/linkages between women NGOs and government bodies or other NGOs been firmly established?
- How have key concepts in the Programme of Action (e.g. reproductive health, reproductive rights, gender equality, male responsibility, quality of care, etc.) been understood, accepted and operationalised in programmes?
- What commitments have been shown by the government to women's advancement in general (e.g. ratifying the Women's Convention, monitoring the ICPD Programme of Action, the Beijing Conference)?
- Has a gender analysis of women's health needs, including population and family planning, been done by either government or NGO women's groups? Is there a need for this?
- Has a gender analysis of the population policy and family planning programmes been done?
- What was the extent of national media coverage on ICPD and Beijing, especially on reproductive health and reproductive rights?

Agencies and People Interviewed

The guidelines suggested in-depth interviews with 15–20 key people in the main health, population, family planning and women's development agencies such as: Ministry and Department of Health; Population Ministry or agency responsible for policy formulation, research and/or service delivery; population research bodies—University departments, research institutes, etc.; health NGOs with a component on women's health, family planning etc. (education or service delivery); family planning NGOs, for example, the Family Planning Associations and others; women's NGOs with an interest in women's health and/or a service delivery programme; the Ministry of Women's Affairs or Women's Development Department; donor and International agencies such as UNFPA, IPPF, USAID and Ford Foundation. It was also suggested that interviews needed to be conducted with: (i) both top policy makers and programme managers in order to obtain the "official" view as well as with middle level officials involved closer to delivery of services; (ii) people outside of the capital city and if possible, in several locations; (iii) some

of the main country delegates to the Cairo ICPD.

Discussion of Draft Paper in a Country Consultation

After preparation of a first draft, countries were asked to discuss the draft with "women NGOs and other relevant and sympathetic agencies (about 10–15 people)", in order to gain input before preparing a final draft.

Identification of Country Researchers

Through friendship and contacts with ARROW's informal network of women NGOs and other organisations, and through recommendations from this network, ten people and/or organisations were identified as being potential country co-ordinators. Generally, the people needed to have research and analytical skills; be familiar with population, demography, family planning and women's health; and be sympathetic to women's health needs and rights. In the selection of countries, the geographical diversity and needs of the region were kept in mind.

The invitation to participate in the research was responded to enthusiastically by all those approached (except Bangladesh). Unfortunately, however, India and the Philippines dropped out due to unknown reasons soon after the beginning, and the lack of time did not allow for a replacement (see Table 1.1 for the final list of countries and people involved).

Implementation of the Research

Eight country reports have been completed. Most followed the framework in terms of objectives, questions and methodology, producing reports of country scenarios which have common qualities with one another while also projecting individual needs and circumstances. All used the interview methodology and some also sent out questionnaires. Only a few countries were able to hold country consultations due to funds and time, but those who did not, were able to circulate their draft reports for comments by key people.

Consultation to Strategise based on the Findings

All the reports are rich in information analyses and insights. In terms of identifying strategies for action, however, there are fewer ideas. It was thus decided that a consultation be held to specifically discuss the implications of the research and what should and could strategically be done at national regional and international levels. The *Regional Consultation on Strategies for Change: Implications of ARROW's Post-Cairo Research Project*, held at the end of November 1996, involved the researchers, national women NGOs from the

Table 1.1: Final List of Countries and Researchers Involved

Country	Researcher/Organisation	Other Researchers
China	Dr. Zheng Xiaoying Director Institute of Population Research Peking University, Beijing	
Fiji	Dr. Margaret E. Chung United Nations Freelance consultant Suva	
Indonesia	Dr. Saparinah Sadli Director Women's Studies Program Universitas Indonesia, Jakarta	Ms. Kristi Poerwandari Ms. Anita Rahman
Malaysia	Dr. Wong Yut Lin Lecturer Health Research Development Unit Faculty of Medicine, University of Malaya Kuala Lumpur	Ms. Carol Yong
Pakistan	Ms. Hilda Saeed Co-ordinator, Shirkat Gah Women's Resource Centre, Karachi	Ms. Khawar Mumtaz Ms. Fauzia Rauf
Singapore	Dr. Vivienne Wee Director Centre for Environment, Gender and Development (ENGENDER)	Ms. Tan Kay Hoon Ms. Charulata Prasada
Thailand	Women's Health Advocacy Network Institute for Population and Social Research, Mahidol University Buddhamonthan, Salaya	Ms. Varaporn Chamsanit
Vietnam	Prof. Le Thi Nham Tuyet Director Research Centre for Gender, Family & Environment in Development (CGFED), Hanoi	Dr. Pham Xuan Tieu Mr. Hoang Ba Thinh

same countries and other women NGO resource persons from ARROW's Programme Advisory Committee (see Chapter 10 for the report).

Understanding and Acceptance of the ICPD Programme of Action

Not all researchers directly reported on the level of understanding of the various agencies and levels of personnel on key concepts of the Programme of Action, such as reproductive rights, reproductive health, sexual health, gender equality and the empowerment of women. Some commented informally that it was difficult to find out through interviews what people understood by these terms.

Awareness of the ICPD and Programme of Action

The general finding was that there was low awareness among both the agencies concerned and the general public regarding the existence, contents and significance of the ICPD Programme of Action. Singapore reports: "There has been little, if any, information dissemination about the content of the ICPD and other international conventions/ agreements to the general public. Most NGOs approached for this (research) were not aware of the ICPD". Similarly in Thailand, understanding appears low as explained by an official from the Ministry of Health: "I would say that the Cairo conference does not have much influence on the population situation in Thailand. Meetings were called after the conference so that health officials would acknowledge the conference resolutions. In spite of this, I'd rather say that the recognition of the conference among health officials is limited. It's true that summarised copies of the conference resolutions were distributed. But it depends on each official whether he/she will read the document. I don't think our local service providers know much about the conference". In Pakistan, a top gynaecologist said: "There's a lot of talk about the ICPD and reproductive health, but people are not familiar with its overall concept".

National Influence / Importance of the ICPD

In some countries, researchers found that the lack of awareness and in-depth understanding of the ICPD is due to the fact that the Programme of Action is not regarded as a significant document by these governments. Moreover, it is considered not relevant as it promotes Western values or it does not relate to current realities of developing countries.

For Singapore, the Population Planning Unit of the Ministry of Health stated in a letter to the researcher:

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"Singapore generally adopted a low profile at the ICPD" explaining that "no signatory was required for the ICPD Programme of Action as the document was only meant to serve as a guide [his emphasis] for countries to draw up their own population programmes". The Singapore researcher suggested that one of the weaknesses of the ICPD is that: "it may lead to the perception that a country which has already met its people's primary health care needs has already surpassed the initiatives outlined in the ICPD Programme of Action. Also, the Programme of Action does not deal substantially with the issue of eugenics which is a key population thrust in Singapore".

In Malaysia, some misconceptions about the Programme of Action were noted. The researcher reported that "… one middle management staff mistakenly referred to 'free sex' as being one of the recommendations of the Programme of Action, which he perceived was not appropriate to Malaysian society". There were also reservations about recommendations on abortion and adolescent sexuality, which are "highly controversial and sensitive", particularly for our Muslim communities (researcher's words).

On the relevance of the ICPD document, top management staff of the Ministry of Health (MOH) expressed that "while the Cairo conference was good, it was just a booster". Throughout the MOH interviews, it was constantly stressed that women's health rather than maternal health had been focussed on since 1991 and as "Malaysia is more advanced than other countries, (we) only need to iron out some issues". One of the largest and more mainstream but very influential women NGOs stated: "We don't bother about the Cairo Conference, we go by what is current in the country …".

The Malaysian researcher concludes: "The spirit of the Cairo ICPD, which is its emphasis on women's rights, sexuality and gender relations, is not part of the change here yet". She attributes this to Malaysia's official stand on the right to adopt the Programme of Action "within the context of our social, cultural and religious framework" (statement by Malaysia at the Third Session of the Preparatory Committee, Population and Development Commission, 1994).

In Thailand, some policy-makers remarked that the most important impact of the Cairo conference was that it provoked them to rethink population/family planning policies. The experiences and ideas exchanged led them to a holistic perspective towards the issues. Fiji reported a "complacency" after Cairo due to "a general view among delegates [Cairo] that the principal recommendations were already implemented".

Pakistan noted that although there has been some "excellent analytical features" in the media following both Cairo and Beijing conferences, the critical articles frequently contend that the conferences are "promoting a Western mind-set" and that the ICPD was organised to promote abortion. The Pakistan government has, however, appeared to accept a broad understanding of reproductive health (including a human rights component) which was put forward in the National Report to Beijing and has led to a re-design of family planning and health programmes for women.

In Indonesia, most government officials "claimed that Indonesia has already implemented the issues outlined in the ICPD Programme of Action" and that the country has been carrying out "more advanced programmes relating to family planning and reproductive health" than those advocated in Cairo. The report states that NGOs interviewed are disappointed in the government's lack of interest in the issues, and some even believe that "lip service to ICPD has been going on to equip Indonesia with some bargaining power in the international world".

Acceptance of Key Concepts: Reproductive Rights

Thus far, only the China report had indicated national acceptance of the broad concepts of reproductive health as defined by the international community (which includes a reproductive rights component). The researcher states that "almost all of the people interviewed for the report think that China must have reproductive rights with social responsibilities". As compared to the other country reports, the China report included more mention of individual rights—an issue that may have come up often in the interviews.[1]

The issues of reproductive rights and gender equality are not mentioned at all in the government's reference to the ICPD in Fiji. The focus is to continue long-standing policies.

In Thailand, the concept of reproductive rights was even less clear than reproductive health. Policy-makers believed that there was no serious problem of reproductive rights violations compared to that of developed countries. Thus presumably, reproductive rights is not an issue for government organisations, although women NGOs have a deeper understanding of this concept.

The Vietnam report does not discuss the acceptability of the term "reproductive rights" conceptually. However, women's right to reproduction and to reproductive health is reported to be a recognised part of the MOH's programme objectives.

All government officials interviewed in Indonesia "agreed that individual rights must be matched with individual duty to

. . . only the China report had indicated national acceptance of the broad concepts of reproductive health as defined by the international community (which includes a reproductive rights component).

the community". One official believed only families (i.e. married persons) had a right to reproductive health services. The researcher pointed out that this would exclude all unmarried couples and homosexual couples. NGOs and researchers interviewed in Indonesia, however, also stressed that the essence of the ICPD is to respect individual rights and needs of all individuals, and it is important for the government to give priority to these rights. The ICPD document should not be recontextualised into a nation's culture and values, as this would only limit women's reproductive rights and needs, and lead to discrimination.

The Ministry of Health in Malaysia recognised reproductive rights in terms of women's right to sexuality and decision-making on child-spacing, but this right is not seen as applying to unmarried women. One official from a health NGO explained that the term "reproductive rights" in Malaysia is interpreted as recommending abortion, free sex and homosexuality and therefore, "reproductive health" is the preferred term.

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Population Policy Changes

None of the countries reported any changes in actual national policy statements on population as an outcome of Cairo. The goals, assumptions and principles of population policy are the same. In China, Fiji, Indonesia, Pakistan, Philippines, Thailand, Vietnam, the policies remain ante-natalist, aiming at reducing population growth, whereas Singapore has a pro-natalist policy. At the time of the research, Malaysia's population policy statment remained ambiguous.[2]

Population policies remain demographic-centred and target-oriented in terms of quantified goals, and have not shown any shift towards more people-centred development. In fact, the success of Indonesia and Thailand in achieving the goals of their population policies, as rated by the international population agencies, is reported to have made these countries even more sure that they are on the right track.

Some country researchers (China and Vietnam) stated that population size and growth is such a serious problem for their countries that there is no way that their population policies can change. The Thai research group noted that the Thai population policy has been well accepted by the people who also aspire to smaller families. It has contributed to improving mothers' and children's health as well. For Pakistan, which is the least "successful" of the countries studied in achieving its population policy goals, the researchers felt that women's health and lives have been negatively impacted by this failure to reduce fertility rates.

Policy statements take a long time to change, especially if they are tied to national development plans. The Pakistan researcher comments that although Pakistan's Eighth Five-Year Plan (1993–1998) "has now been modified in light of the ICPD in order to ensure a reproductive health focus", however, "in the Plan itself, despite these refreshingly new strategies, the overall objectives remain disappointingly target-oriented".

It also appears as though there is not yet any new thinking reflected in policy statements regarding the dynamics of fertility decline and the link to women's position. Researcher Dr. Chung (Fiji) notes: "Throughout, the assumption has been that fertility rates in Fiji reflect the state of the family planning programme, not that fertility is responding to economic and other institutional changes".

Family Planning Programmes

Concept

The most widespread change reported was a shift conceptually to expand family planning from promotion of contraceptive use to a concern with reproductive health. Broad changes along this line were reported in Pakistan, Malaysia, China, Thailand, Fiji and Vietnam, while Singapore did not comment on this. Countries like Malaysia and Thailand said this shift was not an outcome of the Cairo process, but had changed according to the health needs of the country, and was part of the development of their maternal and child healthcare (MCH) and family planning services.

Indonesia, on the other hand, reported that "the government claimed to have been committed to women's reproductive health since the very beginning, which was manifested in the existence of various programmes such as family planning (since the l970s), and the safe motherhood programme (since 1988) …".

The meaning of "reproductive health" was not clear in a number of countries (e.g. Thailand and Malaysia), and this, as explained, was due to the newness of the term. China's report stated that "China agrees with the concept of reproductive health" put forward by the international society (the WHO definition). Whether or not this broadened concept was translated into new or amended programme objectives and principles to provide an expanded conceptual framework for programme implementation was not reported. In Indonesia, reproductive health has been translated by the government as reproductive welfare with an emphasis on the family and material improvement.

Population policies remain demographic-centred and target-oriented in terms of quantified goals, and have not shown any shift towards more people-centred development. In fact, the success of Indonesia and Thailand in achieving the goals of their population policies, as rated by the international population agencies, is reported to have made these countries even more sure that they are on the right track.

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Structure and Design of Programmes

Four countries described changes in programme structure as related to Cairo. In Thailand, the Department of Health has proposed a restructuring to reflect a more holistic perspective by integrating family planning and reproductive health programmes as preventive health within a life-cycle approach—infants and mothers; students and youth; working aged people and elderly people. Malaysia's Ministry of Health has renamed its Maternal and Child Health Programme to Reproductive Health. Similarly, in Fiji, the Family Planning Programme in the Ministry of Health has been renamed as the Reproductive Health Programme. In Pakistan, the programme design has been modified to focus on reproductive health with implementation guidelines being developed. More stringent monitoring and evaluation mechanisms are also intended.

Programme Implementation

When health, population and family planning personnel were asked what concrete changes had taken place, their responses were directed to or fell into the following categories:

- range of services
- women-centred lifestyle needs
- improvement of contraceptive range
- quality of care of family planning services
- incentives/coercion
- men's responsibility

Range of Services: Overall, either before or after Cairo, a number of countries have begun to expand their services to cover more reproductive health concerns. The Pakistan government, was at the time of the research, planning to implement a full range of comprehensive reproductive health services, including treatment for sexually transmitted diseases (STDs) and reproductive tract infections (RTIs).

In Malaysia, the Ministry of Health's reproductive health programme had begun prior to Cairo to provide reproductive cancer screening and menopausal counselling for women. HIV/AIDS education and screening facilities have increased, and there is a plan to prioritise family planning services for high-risk mothers and the rural population. Support services for battered women are to be provided in all district hospitals throughout the country with the establishment of one-stop centres. The National Population and Family Development Board's priorities include HIV/AIDS education and safe motherhood.

In Fiji, a research centre on reproductive health established at the Fiji School of Medicine aims to improve the delivery of reproductive health, family planning and sexual health services. More emphasis has also been given to the prevention of cervical cancer.

The Ministry of Health in Vietnam is stepping up its maternal health services and reproductive health education programme for women. Some NGOs in Indonesia commented that the government "only sees the issues of reproductive health, especially abortion, from one side, that is [from a] moralistic [perspective]". Issues such as sexual abuse and marital rape are not being identified as reproductive health concerns.

From the Indonesian report, there appears to be no expressed attention given to the high maternal mortality rate, which the researchers say, is also linked to unsafe abortion. Programme personnel do not discuss safe abortion services as abortion is still regarded as illegal.

Access to services—age, marital status and location:

- *Adolescents*

The Programme of Action states that health eludes many adolescents, because of their lack of information and access to relevant services (ICPD Programme of Action, page 44). Therefore, innovative programmes must be developed to make information, counselling, and services for reproductive health accessible to adolescents. It is suggested that these programmes reach adolescents through school and other places where they congregate (ICPD Programme of Action, page 45).

In Malaysia, the topic of adolescent sexuality was said to be a controversial issue. Nevertheless, it is felt that the ICPD "legitimised" the necessity for the education of adolescents on reproductive health. Recent activities include developing school curricula on reproductive health, since education on adolescent sexuality is still very weak. The MOH plans to introduce adolescent health care into its reproductive health programme, but will refer to it under a different name.

The topic of adolescent sexuality is also a sensitive issue in Thailand and services have not yet been firmly established. While sex education is regarded as a preventive measure against unsafe sex, open discussion about sex is not a common practice in Thai society and thus makes it difficult to organise sex education for young people. As women's pre-marital sex experiences are often disapproved of in Thai society, contraceptives for adolescent females (i.e. young women) are regarded as inappropriate and unnecessary even though men's pre-marital sexual activity is an accepted norm. Clinics for adolescent counselling often lack continuity and die out because of lack of support.

Similarly, in Vietnam, the issue of sex education for youth is still not resolved. Sex education is not officially included in the school curriculum. Nevertheless, some NGOs are working on the issue. For example, the Research

Centre for Gender, Family and Environment in Development has focussed its attention on research concerns related to the reproductive health of adolescent girls.

In China, there is increased attention by researchers to issues of adolescent reproductive health. Sex education for adolescents is quite extensive and has played an important role in the overall development of young people. To increase the awareness of adolescents, population and sex education courses have been carried out in recent years for primary school and middle school children. A telephone hotline on puberty education has been opened in many provinces, providing counselling to adolescents on sex education. In Fiji, the post-Cairo family planning programme is reported to be placing an increased emphasis on education to prevent teenage pregnancies.

- *Older Women*

Only Thailand and Malaysia make any references in current government programmes to the availability of special services for older women.

- *Other Women*

The Thai report points out that besides unmarried women, the reproductive health needs of migrant women, sex workers, and women in remote rural areas have been neglected. In the future, Thailand and Malaysia's health programmes intend to reach out more to women in remote areas.

Quality of care: This is a reported area of increased programme focus in a number of countries such as Pakistan, China and Vietnam. Measures that were reported to improve quality include the following:

- Extending the range of contraceptives available (China);
- Improving information/ education and counselling for women so that they can make "an informed choice" on contraceptives used (China);
- Improving and extending training programmes for service providers (Vietnam, China);
- Improving continuation rates of contraceptive users (Malaysia);
- Ensuring women are not "coerced" into abortion or contraceptive use (China);
- Reducing abortion rates for women for whom too many abortions is a health risk (Vietnam).

However, some researchers noted practices after Cairo which were of concern from a women-centred quality of care perspective, such as:

- The introduction of Norplant injectables in the Fiji programme[3];
- The lack of any feedback from women clients on their needs and their satisfaction with services. Quality seen in terms of supply rather than demand (Malaysia, Fiji);
- Only using contraceptive prevalence surveys to evaluate quality achievement

of contraceptive services, without considering women's perspectives (Thailand).

Incentives/Coercion: The China report emphasised that efforts had been ongoing since 1992 to stop coercing people to use contraceptives, instead, to promote the concept of voluntarism and to prohibit the use of incentives. Although not stated in the report, perhaps the Cairo process appears to have strengthened this trend. Vietnam reports that since the Cairo conference process, emphasis has been on eliminating coercion in contraceptive practice.

Sexual Health/Sexuality: These terms are rarely used in the researchers' reports. There were also no reports of specific services being provided in this area, apart from sex education for adolescents.

Men's responsibility: Few concrete changes were reported in this area. In Pakistan, it is reported that "the male component is still missing" from the newly expanded reproductive health programme although three vasectomy centres have been established and STD services for males will be provided. Similarly in Fiji, vasectomy services have been made more accessible to men through media promotion and clinic-based rather than hospital services. Thailand reported no programme change in this area, although the researchers comment that "to most population/family planning policy-makers interviewed,... the low level of male involvement in contraceptive practice seems to be the only gender concern". The China researcher says increased condom promotion has led to condom use rates going up. In Indonesia, officials interviewed explained that the targets of family planning services were fertile couples but as women were considered "more responsive and responsible, the programme is directed more at women".

In Malaysia, top management staff of the government Population Board talked about "male-friendly" clinics whereas their staff at field level "revealed the realities that male responsibility is simply non-existent. Although invited, men often do not attend most of the programmes. Men will not use any family planning method, and in some instances, they also do not allow their wives to practice contraception". The non-government family planning programmes plan to introduce some changes such as the use of male recruiters and volunteers to talk to potential male clients and the availability of general medical services for men. Some of the FPA programme personnel were aware of the need "to help men recognise their responsibility over their sexual behaviour, which affects the reproductive health of their wives".

Some researchers reported that the term "gender analysis" (and presumably any gender terms) were not understood . . .. No gender analysis of programmes had been done. In fact, there appears to have been little general programme evaluation.

Programme Management

Training / Gender-sensitisation: The increased emphasis on service provider training was reported in this paper under the section on quality of care. Only Pakistan mentioned an established training programme for health officials and providers in gender perspectives, which has been ongoing since 1994 and well-received. Activities have also begun to integrate new concepts of reproductive health and gender into the medical school curriculum.

Gender Analysis of Family Planning and Health Programmes: Some researchers reported that the term "gender analysis" (and presumably any gender terms) were not understood (Pakistan, Indonesia, Malaysia). No gender analysis of programmes had been done. In fact, there appears to have been little general programme evaluation—"[T]here is still no evaluation of our programmes at government level, neither positive or negative" (Pakistan, NGO interviewee). In Indonesia, some NGOs and researchers stated that "efforts to include gender aspects in the issues of family planning and reproduction are invisible" and the focus is still on the role of women and family welfare rather than gender and individuals.

Participation of Women Clients and Community in Decision-making and Evaluation: No new initiatives were reported in this area. The Fiji researcher commented on the recent (post-Cairo) pilot programme of the Ministry of Health to introduce Norplant: "No prior research into Norplant was conducted, nor are women NGOs involved in the implementation or evaluation of this programme". For Thailand, women have not yet been consulted on their needs and problems as contraceptive users.

Budget: Only four countries reported on budgetary allocations. China's report stated that government expenditure on family planning had gone up since 1994. But "in spite of the increase of financial input in family planning every year, the actual needs can hardly be satisfied. The problems of inadequate training, insufficient equipment, limited funds still remain unsolved in some rural areas ...". Vietnam's national budget has also gone up significantly in 1994 and 1995. Fiji reports that "despite the importance ascribed to these developments in reproductive health and population planning, allocation of government resources to these areas and to social services generally has declined in recent years". In Pakistan, budgetary allocation for health is still only one per cent, compared to the 28 per cent spent on defence (pre-Cairo figures).

Barriers to Change

Conceptual Clarity Inadequate

Reproductive health: In most countries, population and family planning personnel are now thinking in terms of the need to provide reproductive health services rather than just family planning or maternal and child health. Reproductive health, however, is narrowly and poorly understood by government programmes which tend to use a more bio-medical point of view rather than a socio-cultural dimension (Thailand, Malaysia and Pakistan). In Indonesia, this narrow perspective does not include a rights or gender dimension and is regarded as nothing new as officials feel it is already included.

Reproductive Rights/Sexuality: The reproductive rights aspect of reproductive health was only mentioned by China. Some countries (e.g. Malaysia, Thailand and Pakistan) are wary of using the reproductive rights concept on its own and prefer the term reproductive health.

Conceptual clarity (as stated in the ICPD Programme of Action) on both reproductive health and reproductive rights is a problem as is acceptance of the relevance and importance of reproductive rights (Malaysia and Thailand). In these countries, reproductive rights is only acceptable by the mainstream for married couples. The concepts of sexuality and sexual health were not mentioned by some countries (Malaysia and Thailand).

Gender Awareness/Sensitivity: Understanding of the concepts of gender equality and gender analysis was low among top government health management. Discrimination of women in the decision-making positions in the Ministry of Health was not thought to be a problem (Malaysia).

Gender equity rather than gender equality is the preferred concept by government organisations and large women NGOs in Malaysia. Women's status in Singapore and Malaysia is evaluated by conventional socioeconomic indicators.

Indonesia reports that NGO perception on the terms gender and empowerment is that they are used "without them knowing the real meaning". The concept of empowerment is regarded as too feminist and western-oriented. Some government officials believe that Indonesia has gone beyond the ICPD and already has clear programmes for women such as income-generating programmes which aim to empower cadres for Village Family Planning services.

Assumptions about Fertility Decline and Population and Development Issues: The current thinking has not yet changed on the role of family planning programmes and contraceptive usage in lowering

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fertility rates. There was no mention in country reports of the awareness of officials on the link between women's position and gender equality, and contraceptive usage. Beliefs on the need for a reasonably sized population to provide national labour remain prevalent (Singapore).[4] Whereas in countries with large populations, the "government has decided that the current population policy could not be changed" (China) and the focus will be on "how to enhance the quality of reproductive health services".

Medical science and social sciences: The gap between these two disciplines in terms of their thinking on reproductive health needs to be reduced as biases exist which hinder collaboration (China). The need for a closer relationship is related to the promotion of a more holistic and broader understanding of women's health and reproductive health.

Weaknesses of the ICPD Programme of Action Post-Cairo Processes

Lack of Dissemination / Discussion: Nearly all countries reported low awareness about the specifics of the ICPD and its Programme of Action, particularly outside the national capital and at operational service delivery levels.

The national sovereignty principle: The national sovereignty principle of the Programme of Action states that: "The implementation of the recommendations contained in the ICPD Programme of Action is the sovereign right of each country, consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural background of its people, and in conformity with universally recognised international human rights" (Chapter II, ICPD Programme of Action).

This national right was mentioned by top policy makers in Indonesia (Bharati's report) during interviews and has been discussed by the Indonesian government in post-Cairo seminars. The Indonesian report explains that NGOs contend that Chapter II of the ICPD Programme of Action has been used to " . . . justify any policies taken", even though the policies contradict the spirit of the ICPD. In Malaysia, in pre-Cairo meetings, the government has also referred to this ICPD principle of implementing the ICPD "within the context of our social, cultural and religious framework" (Malaysia). None of the countries had reported on the extent of understanding of the human rights aspect of the principle.

Accountability and Monitoring Mechanisms: Lack of any official accountability and monitoring process and

structures to ensure compliance with ICPD principles and recommendations by both government and donors was recognised as a barrier in the Fiji and Singapore reports. Donors like UNFPA, when interviewed, commented that they only play a small role in countries (such as Malaysia and Thailand) which receive little funding and moreover, it is the government who decides on ICPD implementation. The absence of a National Plan as a follow-up to the ICPD (as recommended by the Programme of Action) hindered accountability and monitoring. Some countries were in the process of developing such a plan (Malaysia), but by mid-1996, none had been completed.

Weak Influence of Women NGOs

No country reported that women's NGOs had been involved in developing the National Plan post-Cairo. Existing committees such as the National Population and Family Planning Committee in Thailand, which would presumably play the key role in providing inputs, had no women's organisation representatives—either government or non-government. Lack of women's organisation representation in population and family planning policies and programmes began before the ICPD. Researchers in Singapore, Thailand and Malaysia reported that there were no women's organisations in the official delegation to Cairo. Therefore, without representation, women NGOs have no official means of voicing their post-ICPD concerns or opportunity of working together to bring about change.

Specific related problems reported in country scenarios were:

- Few (Pakistan, Vietnam and China) or no women NGOs (Singapore, Malaysia, Fiji, Thailand and Indonesia) working mainly in the area of women's health, including population and reproductive rights, in either advocacy work or service provision;
- A political climate which does not encourage substantial NGO participation in deciding on policies and programmes (Singapore, Malaysia, Indonesia and Pakistan).

The Singapore report states: "The ICPD also relies on NGOs and International Agencies to effect change, assuming a democratic framework already exists. This may not be possible in countries with highly centralised governments which frowns upon NGO activities that advocate change unless such changes are made through government channels".

In the Malaysia and Pakistan reports, the effect of restrictive laws on NGOs is recognised as a barrier to strengthening their influence. The Internal Security Act and Official Secrets Act of Malaysia lead to NGO

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"restrictions and fear" and in Pakistan, NGOs are worried about a new law proposed to "regulate" NGOs.

Bharati reports that the "strongly authoritarian culture" of Indonesia is a restraint for NGO activity in terms of organising, freedom of assembly and criticising the government. In addition, NGOs believe that "open advocacy of rights can lead to a cut in aid" as was done by Suharto in 1992 in relation to Dutch aid for NGO human rights work. The Indonesian report stated that government officials interviewed said that "some NGOs have a bossy attitude and seemed to be too aggressive for the Indonesian context". The government was seen as having the authority and being responsible for its own programmes. Bharati reported that the more critical women NGOs were not invited to discussion with the government. According to the Malaysia country report, limited NGO development in Malaysia has generally meant a lack of a grassroots base of constituents, which would add to the power of women NGOs. The lack of involvement in post-Cairo activities by the Division of Women's Affairs (government) in Malaysia was another barrier.

The China report also comments on the lack of advocacy efforts by women NGOs in relation to the ICPD. Thailand gives insight into other underlying reasons for women NGOs' limited involvement in health and population issues. These include:

- The view that "women's health problems are not very outstanding in Thailand";
- The "lack of technical knowledge and expertise necessary for dealing with such issues as population, family planning and reproductive health";
- The fact that "because family planning services have always been in the hands of the government, women NGOs rarely have an opportunity to get their hands on the issues".

In Pakistan and some other countries in the region (Philippines, India and Bangladesh), NGO influence is known to have been stronger.[5] Based on current information from these research reports, governments are not yet working in "true" partnership with women NGOs.[6] One researcher in Indonesia suggested that women NGOs needed to be more effective in advocacy by providing more extensive empirical data rather than focussing on incidental cases. There were no reports on whether or not NGOs themselves, either women NGOs or NGOs concerned with health, population and family planning, are working well together post-Cairo. Some FPAs and other NGOs interviewed (Malaysia, Thailand and Singapore) explained their role as "supportive" of government's policies. The Thai

report in summary interviews with the four influential family planning NGOs in Thailand, says; "they make it a rule to avoid direct and radical criticism against the government's policy".

In the words of two Thai NGO representatives interviewed:

- "We are pleased with our currently co-operative role with the government. We do not try to criticise or act as an inspector of government's policy and programmes";
- "We will not do anything that would oppose the government ... we and the government may walk on different paths considering our strategy but our goal is the same".

In the Malaysia report, the top management of the Federation of Family Planning Associations, Malaysia (FFPAM) took a similar stand. They explained that FFPAM will not provide any direct services pertaining to safe abortion and adolescent sexuality because these were not endorsed in the National Policy.

Belief that Health and Family Planning Programmes are Completely "On Track" with ICPD

Reports from China, Fiji, Indonesia, Malaysia, Singapore, and Thailand stated that both government and general NGOs (excluding women NGOs) believed that they were already conforming to the principles of ICPD and some felt they were even ahead of the Programme of Action recommendations in terms of providing access to health care. Thus, in Singapore, government population programme representatives claimed that programmes were based on the principle of "informed choice". China and Malaysia health and population officials similarly believed that their reproductive health programmes were completely on track. Indonesia claims that they have been on track "since the 1970s!"

This assessment could be related to:

- Lack of convincing feedback and data to show the areas needing improvement in women's health, family planning and women's status;
- Use of narrow, more bio-medical indicators to assess the success and quality of programmes; lack of use of gender-sensitive and women-centred indicators and qualitative research findings;
- Donors and other international agencies (UNFPA, WHO etc.) continue to use indicators of programme success and achievement which are not gender-sensitive/women-centred;
- Lack of conceptual clarity on the terms of reproductive health, reproductive rights, empowerment of women, men's responsibilities etc. and how these concepts can

be fully operationalised into programmes.

(Note: Above assessment is not from the country reports but are the writer's comments.)

Some researchers did, however, comment on the lack of national data on violence against women (Thailand and Singapore). They also mentioned the difficulties of presenting a convincing case for the need to focus on women's health rather than just family planning or narrow reproductive health; and in tackling controversial issues such as abortion (Thailand).

Insufficient Knowledge and Skills on the "How To" Aspects of ICPD Implementation

Advocacy: In Thailand, researchers commented on the difficulties faced by women NGOs in advocacy work in being able to present convincing data on women's needs. Singapore saw the need to present different arguments and an analysis of the eugenics and labour market perspective behind Singapore's population policy. The report also commented on the need for increased discussion and advocacy on women's roles and public discrimination. The Malaysian report commented that service providers (NGOs) wanted more operational guidelines on how to implement certain aspects of ICPD.

Insufficient Financial Resources

This was given as a barrier by Pakistan, particularly for NGOs who wanted to expand their innovative work. A Malaysian FPA gave a similar comment.

Discrimination and Discriminatory Laws

Pakistan assessed that the existence of discriminatory laws since 1979 related to women (such as the Hudood Law within the Syar'ia—the Islamic law) has "added to women's traditionally subservient status". On top of this, a complacent judiciary and legislative have not enforced other laws which are fairer to women. In addition, consistently low literacy rates for women (21 per cent of women), malnutrition, anaemia and high morbidity are barriers themselves and are related to both discrimination and poverty. Other reports also mention discrimination such as low participation of women in the work force (Fiji), unbalanced domestic work and child care (Singapore) and different moral values for women and men (Thailand).

Poverty and Development Model

Pakistan states "steeply rising inflation" as a big problem which threatens the budget of the social sector.

Political Will

Lack of a strong political will and interest in women's health,

women's rights etc., is seen as a barrier in Indonesia, Singapore, Thailand and Fiji. In Pakistan, however, political commitment under Benazir was good and this was seen as one of the main advantages.

Opportunities for Change

Most reports did not have a separate section assessing the scenario at country level and determining which factors could most likely be utilised to work more effectively towards change. Generally, these factors were the immediate basis for developing strategies. Therefore, this section attempts to pull together what the writer sees as opportunities for change contained in the country reports and poses questions which are hopefully useful for strategy development.

New Initiatives in Reproductive Health Programmes

Nearly every country reported on new reproductive health activities in government and NGO health and family planning programmes extending from macro changes of new programme objectives along with reformed organisation structures, to new ways of carrying out activities and creating research centres or training programmes. The Ford Foundation appears to be a very progressive and innovative donor in the region as it also has influential country offices.

Some pertinent questions regarding these issues are:

- What part have women NGOs been playing in designing, advising, monitoring, supporting or evaluating these new efforts?
- Are women NGOs equipped to carry out some of the above roles and activities?
- How can the Ford Foundation's role be capitalised on?

Donors Influence on National Population and Reproductive Health Agendas

Countries such as Fiji, China, Vietnam, Pakistan, and the Philippines are dependent on donor funds for population and reproductive health activities.[7] Other UN Agencies like UNFPA, WHO, UNICEF and the World Bank also play important roles. Some researchers such as Chung (Fiji) have said that it is donors that determine the national agenda on population and reproductive health.

Some pertinent questions regarding this issue are:

- Are NGOs influencing donor agendas, monitoring accountability, working in partnership etc.?
- Have donors "made the move" or have women NGOs initiated activities?

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Countries which are struggling with problems of poverty, development and population and in which family planning programmes have been unsuccessful . . . may be more open to new programme approaches which integrate women's empowerment and individual rights.

The Beijing Conference Impetus

Pakistan's National Report prepared for Beijing provided the opportunity for a very comprehensive analysis and documentation of women's health and reproductive health problems, human rights, women's position and strategies required. Presumably major input from women NGOs was involved but the process was not described in the report. If national plans such as Pakistan's are similarly comprehensive and include women NGOs' viewpoint, then encouraging their implementation and monitoring their progress in other countries will greatly support the implementation of the ICPD Programme of Action.

Some pertinent questions regarding this issue are:

- To what extent have women NGOs in other countries linked their ICPD efforts to pre- and post-Beijing and with what success?[8]
- Have National Plans on women's health including reproductive health and rights been formulated with NGO input?

Poverty and Development Issues

Countries which are struggling with problems of poverty, development and population and in which family planning programmes have been unsuccessful (in maintaining a sustainable population size, for example, Pakistan in our research), may be more open to new programme approaches which integrate women's empowerment and individual rights.

NGO Effectiveness Strengthened, Post-Cairo and Beijing

Pakistan reported a strengthening of women NGOs' capacity, "clearer goals", and more co-ordination across the country. Also, a new Reproductive Health Network has been formed which includes NGOs. A few governments (Pakistan, Indonesia) have consulted women NGOs post-Cairo, but only on an ad hoc basis.

One pertinent question regarding this issue is:

- Is this the situation in other countries? Has capacity also grown?

Mechanisms to Monitor Coercive Family Planning Activities

The China FPA (1.1 million local members) has been able to interview women and households and has been reporting on any violation of principles of the Provisional Regulation of Family Planning Democratic Participation and Demographic Supervision (June 1995). Other aspects of the programme are to be similarly monitored by obtaining client feedback.

Use of the Women's Convention to Encourage Implementation of the ICPD

Only three country reports have mentioned the Women's Convention as a positive factor potentially—Singapore, Pakistan, Fiji, but with skepticism as to what part the Convention could play in encouraging ICPD implementation especially since a number of reservations have been made on equality clauses, especially in Muslim majority countries. The Women's Convention is an opportunity not yet firmly placed and utilised in national and regional women, health and population agendas.

The More Open Attitudes of Grassroots Service Providers

Grassroots service providers are more progressive. Indonesia, Malaysia, Thailand noted the more open attitudes of family planning service providers who are in contact with the local people, compared to policy-makers or top management.

Strategies Suggested by Researchers

The following list of strategies suggested by researchers would bring about greater change in their own country contexts. Some of these ideas have already been elaborated on in this chapter as opportunities.

Advocacy

- Increase regional and international networking, monitoring and collaboration to ensure the gains of ICPD are fully implemented in the region through stronger advocacy (Malaysia).
- NGOs to play a stronger role in encouraging governments to focus on reproductive health instead of target-oriented family planning (China).
- NGOs to work hard to figure out strategies and actual programmes to implement the spirit of ICPD, particularly Chapter II. NGOs to play a greater role in information and advocacy. More empirical and comprehensive and convincing data to be used (Indonesia).
- Deconstruct the "national sovereignty" arguments currently used to resist the reorientation of population policies and programmes to the new reproductive rights and reproductive health framework (Malaysia and Indonesia).
- Train women NGOs in lobbying skills and how the government system works (Indonesia, Thailand).

Education/Sensitisation

- Inform and train top family planning leaders and policy-makers with critical information and findings from multi-disciplinary studies so that they understand theories on reproductive health (China).

The Women's Convention is an opportunity not yet firmly placed and utilised in national and regional women, health and population agendas.

- Enhance women's status in society and the family as a key path in family planning programmes and put male participation and responsibility in an important position (China).
- Educate decision-makers and society towards greater sensitivity, including viewing men and women as equal partners with joint domestic and financial responsibilities (Singapore).
- Educate as many groups as possible on women's issues, and women's situation and position in society in order to generate change; make information accessible at local level (Sadasivam 1995).
- Transform perspectives towards population/family planning objectives—from quantity to quality (Sadasivam 1995), from population control to reproductive health care, from demographic-centred to people or women-centred (Thailand) and consider cultural factors.
- Work with local health personnel who are in direct contact with the people (Sadasivam 1995).
- Disseminate information on the ICPD and other international conventions to NGOs and the public (Singapore).

Research

- Directly observe programme implementation on the ground to verify views of management and staff in future research and involve middle management and field staff (Malaysia).
- Document both the success and limitations of population related policies and programmes, particularly in the fields of family planning and reproductive health care. Encourage demographic scholars to focus more attention on social structure and culture (Thailand).
- Conduct sound research on what exactly determines a country's economic success in order to try to dispel the reasoning of the eugenics theory (Singapore).
- Strengthen joint research efforts of government and NGO institutions in the area of reproductive health (Vietnam).
- NGOs to play a greater role in identifying problems through basic and action-research.

Accountability/Monitoring

- Establish an external and objective body to monitor existing population policies and work with governments to make improvements (Singapore).
- Assign an organisation nationally to follow-up and monitor the "Cairo spirit" and involve all organisations that play a part in implementing the Programme of Action (Vietnam).
- Monitoring of the ICPD Programme of Action implementation in the Pacific; is there a possible

role for women NGOs and DAWN? (Fiji).
- Monitoring of the National Family Planning Co-ordinating Board (NFPCB) programmes by non-NFPCB staff so that monitoring is objectively and effectively done (Indonesia).
- Establish better co-operation between the government and NGOs in various sectors. NGOs will act as a control mechanism and are more community-oriented.

Family Planning Programmes

Abandon incentives [which have limited success anyway] and emphasise responsible sexual behaviour and family planning (Singapore).

Participation of Women

- The issue that women need to actively participate in improving population/family planning policies needs to be promoted as women have so far played passive roles (Thailand).
- Strategic methods should be designed such as surveys or research studies on women's experiences, needs and views, to convey women's voices to policy makers. Experiences of NGOs and other women's organisations should also be considered (Thailand).

National Plans for Women Post-Beijing

Design and implement effective strategies and actions for change in women's health and status, based on an analysis of past problems, and include government and NGO inputs (Pakistan).

Resources

Government to increase funding for women's health programmes (China).

General

- **Support Services for Child Care:** The government should help married couples cope with dual roles in career and parenting (rather than just promote marriage for selected groups) through the introduction of flexi-time, part-time and "work at home" opportunities for both male and female (Singapore).
- **Expansion of Labour Market:** Find creative ways to expand the labour market such as increasing the retirement age, flexi-time and part-time work (Singapore).
- **National Agenda:** Define a National Agenda beyond ICPD, and relevant to the country to promote more women-centred policies and form a core working group to begin this process (Singapore).

Conclusion

This eight-country research project on *Changes in Population Policies and Programmes Post-Cairo*, points to a number of critical steps

which need to be taken by various stakeholders to ensure faster and more effective implementation of the ICPD Programme of Action. These include the following:

- **Strengthen government implementation capacity:** Increased efforts by government, international organisations and NGOs to practically operationalise new concepts such as reproductive health, reproductive rights, gender equality etc. and to share innovative and successful policy and programme experiences.

- **Stronger advocacy by NGOs:** Both health and women NGOs need to be more confident and skillful in monitoring and advocating for the ICPD implementation, particularly the more complex and controversial areas of sexuality, reproductive rights, abortion, etc. This capacity-building requires additional resources from international and donor agencies towards creating more democratic country environments for NGO functioning; training in monitoring and advocacy; establishing and sustaining national and regional networks of NGOs, particularly women NGOs; and funding national activities in monitoring and advocacy.

- **National mechanisms for implementation of the ICPD Programme of Action:** Mechanisms such as national committees involving all main stakeholders (government, NGO and UNFPA) need to be set up to develop, implement, monitor and evaluate ICPD implementation. Women's Rights NGOs and other development NGOs must be represented in these committees to reflect the diversity of the NGO community and the lead these NGOs are taking in promoting the rights perspective.

- **Core indicators of success in implementation of the ICPD Programme of Action:** A framework for more rigorous and in-depth monitoring and evaluation of actual implementation of the ICPD Programme of Action needs to be agreed upon with indicators, both quantitative and qualitative, especially for broadened concepts like informed choice, male participation, reproductive rights, etc. All stakeholders should participate in the development and use of the framework on a country basis.

All of the above steps require much more interaction among organisations committed to the implementation of the ICPD Programme of Action, at

country and regional levels. Governments, NGOs, international organisations and bilateral donors need to work closely together, respecting and drawing on their different perspectives and contributions towards the achievement of the ICPD goals by the year 2004.

Endnotes

[1] A comment from this writer is that China had a top-level National Seminar sponsored by UNFPA on Reproductive Health prior to Cairo, at which women's health advocates were invited to clarify the concepts of reproductive health and reproductive rights from the perspectives of women NGOs.

[2] Since the completion of the research in Malaysia, government authorities have stressed that the pro-natalist stand first mooted by the Prime Minister is not a policy since there are no programmes in place. This remains a policy statement.

[3] Also in Vietnam, but this was not reported by the researcher.

[4] Also in Malaysia, but this was not stated in the Malaysian report.

[5] This dynamism was not described in detail in the Pakistan report.

[6] Partnerships have taken place with governments, but in most cases, these have been with more mainstream NGOs. Partnerships with women NGOs have tended to be more "tokenism" in nature—providing no or very little avenue for participation in decision-making processes.

[7] Donors mentioned in the reports were UNFPA, USAID, AusAID and the Ford Foundation.

[8] The Beijing Platform for Action has a very good section on women's health which reinforces the need for full and fast implementation of the ICPD Programme of Action.

Appendix 1.1: List of Abbreviations Used

ARROW – Asian-Pacific Resource & Research Centre for Women

AusAID – Australian Agency for International Development

DAWN – Development Alternatives with Women for a New Era

FPA – family planning association

ICPD – International Conference on Population and Development

IPPF – International Planned Parenthood Federation

MCH – maternal and child healthcare

MOH – Ministry of Health

NFPCB – National Family Planning Co-ordinating Board

NGO – non-governmental organisation

RTI – reproductive tract infection

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Appendix 1.1: List of Abbreviations Used (cont'd)

STD – sexually transmitted disease

UNFPA – United Nations Population Fund

USAID – U.S. Agency for International Development

WHO – World Health Organization

Women's Convention – Convention on the Elimination of All Forms of Discrimination Against Women

Appendix 1.2: Framework Questions and Issues

Population Policy and Government Action

1 What are the population issues in the countries being studied? What is the political and historical background in which they were formulated?
2. How, if at all, have they started to change after Cairo? What specifically are the planned changes?
3. Who are the agents of change? Have governments begun to respond to NGO/women's groups' suggestions, and start a process of dialogue, and rethink their priorities in population policies as a result? What, if any, are the formal mechanisms for a consultative process? (Example: Healthwatch in India)
4. What has changed and what has not?
5. To what extent have governments adopted the new post-Cairo rhetoric without matching changes in policy? How far are policies still geared to keeping numbers down than health up?

The Role and Experiences of NGOs

1 Historically, what has been the standing and influence of NGOs in the human rights/women's rights areas in the Asia-Pacific?
2. When and how did family planning policies give rise to a reproductive health movement in individual countries in the region?
3. Which countries have a more positive and active track record and why? What are the factors that advance/impede NGO activity in the area of women's health, reproductive rights in particular? (For example, increased funding from donor agencies for population activities in India could divert women's groups from health issues to distribution of contraceptives.)
4. How can women's groups in Thailand and Indonesia, for example, be stimulated and aided to articulate women's health concerns and have an input into policy?
5. What is the extent of awareness of the Cairo Programme of Action among NGOs and women's groups?
6. How can they be helped to work towards implementation of these principles, to make women's health and empowerment the new indicators of the success of family planning programmes?
7. What is the stance of NGOs on the question of whether they should work within the population establishment, with governments and official agencies, and risk being co-opted, or stay outside and retain their capacity and strength as critics? What is the more effective approach in the context of individual countries' political environment? (For example, in Indonesia, more women's groups/activists prefer to work with the government rather than stay on the outside.)

8. How can NGOs/women's groups working in the areas of trafficking, violence against women, HIV and AIDS, and female migrant workers, be helped to integrate approaches and pool resources?

The Role of International Organisations/Funding Agencies

1 Which are the main organisations that are funding and directing population activities in Asia-Pacific?
2. How far is there a commonality of approach among them in re-ordering priorities from demographic goals to reproductive health? (For example, in the Philippines, of all the international donor agencies funding the Population Commission, only the Ford Foundation has a gender-responsive reproductive health-oriented population policy framework. The USAID framework still blames people for the degradation of the environment and the depletion of resources.)
3. What, if any, are the new measures of "effectiveness"? To what extent have donor agencies' rhetoric changed, while funding priorities and approaches have not?
4. Are women's groups/NGOs involved in the design and strategies of population programmes being implemented by international donor agencies?
5. How can the allocation of resources for population activities by major multilateral, bilateral and non-governmental institutions be monitored to ensure its accordance with the ICPD agenda?
6. How far do international organisations/funding agencies view structural adjustment and privatisation policies as a factor influencing the population and health agenda? (For example, the conflicting positions of the UNFPA and the World Bank.)
7. Do NGOs in the region recognise the need to find new allies and partners in monitoring donor activity?
8. Is there scope to set up accountability mechanisms in more countries in the region, along the lines of that in India by the Washington-based Health and Development Policy Project?

Political and Economic Factors Influencing Population Policies and the Status of Women

1 In what ways have the region's agricultural and industrial policies affected the role and status of women? (For example, in Malaysia, post-colonial agricultural policies, especially modernisation, relegated women to a secondary and reproductive role and heightened gender inequality.)
2. What has been the impact in recent years of the growing trend of rural-urban and regional migration and the resultant phenomenon of female-headed households on reproductive choice and health, family size and patterns of child-bearing?

(The special case of the Philippines which is a major "sending" country of migrant workers, especially women.)

3. What are the cultural and ethnic policies that have influenced population growth and planning? (For example, Malaysian Prime Minister Dr. Mahathir's pro-Malay, pro-natalist policy.)
4. What is the impact of structural adjustment, rapid privatisation and economic growth on: women's health and reproductive choice (being targeted for contraceptive acceptance in Bangkok's factories); women's economic status (loss of employment, relegation to repetitive, low-paying jobs); government allocations for social sector spending, including public health; government allocations for family planning?
5. How far does religion influence population policies? How far do governments pander to religious leaders in order to perpetuate the status quo (as in Indonesia)?

Source:

Sadasivam, Bharati. 1995. "Preliminary Survey and Conceptual Framework" [Interviews and report]. Document prepared for *ARROW's Research Project on Population Policies and Reproductive Rights* in selected countries in the Asia-Pacific one year after the International Conference on Population and Development in Cairo, September 1994. [Unpublished].

Appendix 1.3: A Women-Centred Reproductive Health Framework

AREA	POPULATION CONTROL/ FAMILY PLANNING	WOMEN-CENTRED REPRODUCTIVE HEALTH
CONCEPT		
1 Rationale	The most important aspect of women's health is pregnancy, childbearing and fertility. Women's health is very important as it affects the health of children. When women have fewer children who are better spaced, their health and status will improve.	Women's health has not automatically improved by focussing on contraception and maternal health—maternal mortality rates can still be high even though use of contraceptives has risen. With a narrow family planning and maternal and child healthcare focus, women's other health problems are neglected (e.g. unsafe abortion, RTIs, STDs, cancer and health effects of violence against women). Most resources spent on women's health go disproportionately to family planning programmes. Narrow family planning and maternal and child healthcare programmes with no attention to human rights have contributed to reducing women's control over their lives.

AREA	POPULATION CONTROL/ FAMILY PLANNING	WOMEN-CENTRED REPRODUCTIVE HEALTH
2. Definition of women's reproductive health	A narrow bio-medical meaning as maternal health, or the health of women of reproductive age, focussing on birth and child-bearing without death or disease, and contraception.	A broad understanding which is centred on the right of women to make autonomous choices about reproduction and sexuality, and the right to provision of services of a high standard which are women-centred (based on women's experiences and needs).
3. Goals	Demographic reduction or increase of fertility and population (main goal). Improve women's and children's health and family welfare (secondary goal).	Improve women's health including their reproductive health. Increase women's control over their bodies and ultimately their lives. Change socio-economic conditions which are barriers to the exercise of reproductive rights (e.g. women's legal status, education, poverty level, decision-making power in the household, choice of whether and when to marry).
4. Ethics/Values	Reproduction primarily a social function. Demographic goals of countries are more important than the human rights of individuals.	Women have the individual rights and the social responsibility to decide whether, how and when to have children, and how many to have; no woman can be compelled to bear a child or be prevented from doing so against her will.

AREA	POPULATION CONTROL/ FAMILY PLANNING	WOMEN-CENTRED REPRODUCTIVE HEALTH
4. Ethics/Values (cont'd)		Women have the right to autonomy and reproductive choice within a human rights framework. Men also have a personal and social responsibility for their own sexual behaviour and fertility, and for the effects of that behaviour on their partners' and their children's health and well-being. The fundamental sexual and reproductive rights of women cannot be subordinated against a woman's will, to the interests of partners, family members, policy-makers, the state or any other actors. Due to biology and gender roles and responsibilities, women have a greater right to make fertility-related choices. Women can be trusted and must be respected to make their own reproductive decisions when fully informed.

AREA	POPULATION CONTROL/ FAMILY PLANNING	WOMEN-CENTRED REPRODUCTIVE HEALTH
5. Underlying assumptions	Population size/growth is the main determinant of poverty, under-development and environmental sustainability. Population control will reduce fertility.	Poverty is due to the economic growth model of development. Focus is on meeting basic needs and not population control. Improving women's status and providing quality reproductive health programmes will help to reduce fertility.
PROGRAMME OPERATIONS		
6. Objectives	Demographic and target-oriented with incentives, disincentives and coercion both obvious and hidden.	Not target-oriented but focussing on meeting the individual woman's needs.
7. Service range	Contraception; infertility (if pro-natalist); maternal health; abortion (if culturally acceptable and ante-natalist).	Contraception; maternal health; abortion; STDs, RTIs; HIV/AIDS; sexuality; violence against women; cancer screening; services provided in the context of gender-power relationships (e.g. husband, father, state).
8. Age of women and marital status	Married women; reproductive age (15 to 44 years).	Women of all ages throughout their life cycle, married and unmarried.

AREA	POPULATION CONTROL/ FAMILY PLANNING	WOMEN-CENTRED REPRODUCTIVE HEALTH
9. Service delivery standards	Quality of care is usually not emphasised as the focus is on the quantity/number of women seen. If it is a concern, its value is linked to the positive effect of contraceptive use rates and meeting targets.	High quality of care is promoted as a woman's right and the core of service delivery.
10. Women's empowerment	No special concern for women and no component on women's status and rights. A tendency to use terms such as women's status or women's empowerment loosely without understanding the concept and applying it to the programme.	Increased control/ empowerment of women built into all service delivery components. Women are encouraged to demand services. Efforts at structural reform of society outside the programme supported, such as law reform, policies, development, etc., to eliminate discrimination and violence against women.
11. Contraceptive methods	Focus on permanent, long-acting contraceptives requiring medical intervention (e.g. sterilisation, injectables/ implants); provider preferences dominate and linked to effectiveness in lowering fertility rates.	Emphasis on safe, effective and affordable methods of which women are in control. Efforts to increase male responsibility and use of male methods and to monitor contraceptive testing.

AREA	POPULATION CONTROL/ FAMILY PLANNING	WOMEN-CENTRED REPRODUCTIVE HEALTH
12. Male involvement and/or responsibility	Concern with male involvement in contraceptive use rather than reproductive responsibility. Objective is to increase the contraceptive use and meet demographic targets.	Male responsibility for sexuality, fertility and child-bearing is promoted as a gender equality strategy. Concept included in education programmes, client interaction, and advocacy with women's husbands.
13. Information and education	Communication is top-down, centering on directions for contraceptive use. Persuasion and motivation are the information processes. Provider gives advice on what is best linked to provider's preferences and targets.	Full information provided on risks and benefits of contraceptive technologies so women can make informed choices. Focus on understanding the body and sexuality in order to make decisions and be in control.
PROGRAMME MANAGEMENT		
14. User's feedback	Bureaucratic, little interest in user's and women's perspectives on services.	Women's and user's feedback actively sought to improve services.
15. Research/Evaluation	Demographic, quantitative research related to fertility control (e.g. couple year protection, etc.).	Focus on participatory action-research which listens to women's voices and experiences of reproductive health needs and services.
16. Success indicators	Quantitative and target-oriented related to number of people using contraceptives and decline in fertility levels.	Qualitative measures given more emphasis such as women's satisfaction with services and increase in well-being and control of their bodies and lives.

AREA	POPULATION CONTROL/ FAMILY PLANNING	WOMEN-CENTRED REPRODUCTIVE HEALTH
17. Planning and decision-making	Top-down. Minimal participation from all levels of service providers. No community or women's participation in advisory boards, etc.	Women and community highly involved in conceptualisation and review of programme operations. Less hierarchical work relationships. Women well-represented in all decision-making bodies. Conditions for women staff are women-centred (e.g. breast-feeding, flexi work hours, etc.).
18. Training	Technical competence. Knowledge base in purely medical, not on social issues including gender.	Adequate basic and in-service training following guidelines. Not only technical but also issue-based, including women's rights, gender and empowerment. Sensitisation at all levels.
19. Budget	Funds to priority areas of objectives. Staff needs often neglected.	Sufficient allocations to training, number of staff, level of salaries, etc.
20. Language used to describe programme focus	■ family planning ■ population ■ population control ■ motivation ■ acceptors	■ women's health ■ reproductive health ■ reproductive rights ■ contraception ■ motivation ■ education

Source:
Rashidah Abdullah. 1996. "A women-centred reproductive health framework" [modified version of the conceptual framework in a concept paper presented at the International Seminar on Women's Reproductive Health held in Beijing on 23rd to 25th June, 1994] in Asian-Pacific Resource & Research Centre for Women. *Women-centred and Gender-sensitivie Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific* [Resource kit]. Kuala Lumpur: ARROW.

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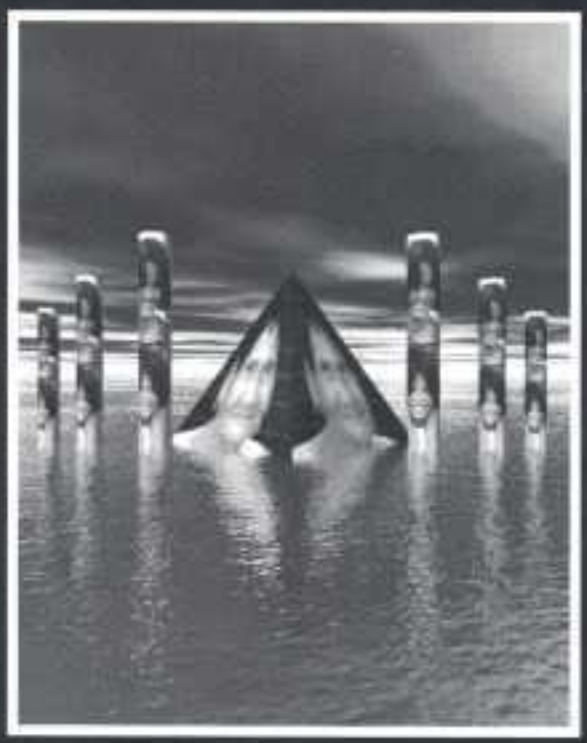

COUNTRY STUDY OF THAILAND

VARAPORN CHAMSANIT

2

Introduction

In November 1996, Thailand welcomed the birth of its 60th million citizen. This coincided with the 25th anniversary of the national population policy declaration. If it was not for the success of the national family planning programme, as declared by population policy-makers, Thailand would have had a population of 70 million instead of 60 million by now.

At the time of this research in 1996, it had been two years since the Third International Conference on Population and Development (ICPD) held in Cairo, Egypt. It was at this conference that new challenges for population policy were raised, and Thailand had made commitments to the Cairo Programme of Action. Thus, it was the right time to re-examine the Thai population policy, its changes and impact on the lives of the people.

This chapter looks into the current population situation in Thailand with an emphasis on family planning policy (see Appendix 2.1 for abbreviations used). Family planning has, through the course of policy implementation, been the prevalent part of Thai population policy. It has been used as a means to achieve desirable quantitative goals for the population. Budgets have been generous and great efforts have been made to increase contraceptive use. As a result, the contraceptive prevalence rate among the married population in Thailand is high. Thailand has become a model of success in family planning programmes. Despite the success, much is left to be done in terms of population distribution and quality of family planning services.

Following this introduction is background information concerning the population scenario in Thailand. Thai population/family planning situations are described, covering the period since the Thai government adopted birth control methods over 30 years ago until present (1996). The impact of the Cairo Conference on Thai population policy is discussed as well as plans for population policy improvement as described by policy-makers. The last part covers the major challenges for family planning/reproductive health policies.

the Researcher

Varaporn Chamsanit is a member of the Women's Health Advocacy Network (WHAN), and is now attached with the Office of the National Commission on Women's Affairs, THAILAND

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Research Methodology

Data and information presented in this chapter are derived from reviews of documents, particularly the ones on population/family planning policies. Detailed interviews were conducted in 1996 with 17 key personnel (see Appendix 2.2). These interviewees include population/family planning policy-makers, health officials and representatives of population/family planning non-governmental organisations (NGOs). Women academics, activists from women's organisations and representatives from international agencies also gave their comments on the policies and situation in Thailand. During the discussion, the interviewees were encouraged to express their ideas and opinions freely. Generally, names of interviewees are stated in this chapter only where facts are concerned. Names of interviewees may remain anonymous where critical opinions are given.

The Thai Population Policy

"Get married young and make the nation prosper"
– A pro-natalist slogan for Thai citizens in 1942

Three Decades of Population Control

It seems not very long ago when Thailand, with a great ambition to become a Southeast Asian giant, took a firm pro-natalist stance and set a population target on the largest numbers possible. Women's ability to reproduce served as a device not only to maintain stability within the family, but to attain national political and economic security as well. Various campaigns were launched and incentives given to convince people to get married and have many children. In 1957 for example, a regulation was enforced which prohibited female sterilisation in hospitals run by the Ministry of Public Health (MOPH) for women with fewer than five children (Wongboonsin 1995).

Marge Berer, editor of *Reproductive Health Matters*, stated in her article that "...between pro-natalism and anti-natalism, women are always caught in the middle. Praised for and encouraged to have children on one hand, but condemned as perpetrators of population growth on the other" (Berer 1993). Thailand is no exception in this case. According to a review of the Thai population policy by Wongboonsin (1995), only a year after the emergence of such a pro-natalist regulation, the World Bank Economic Commission revealed findings of its study on Thailand's economic and social development. The Commission warned the Thai government of adverse effects of an excessively high population growth on economic and social stability of the country. As a result, the government shifted its population stance and adopted a resolution of

"voluntary birth-control" in 1961. It was not until nine years later in 1970 that the Thai government, for the first time, officially promulgated the population policy. The National Family Planning Committee was also established in that same year. It should be noted that external first-world-dominated donor agencies like World Bank and the Population Council had played an important role in this population transition. They also played a supporting and indirect role in the population policy formulation in its early stage.

Nevertheless, the shift of the Thai government's population stance from pro-natalism to anti-natalism during the 1960s was well received by the general public. As Knodel (et al.) found in their study (1984, cited in Archavanitkul; Pramualratana 1990), there had already been a latent demand for smaller family sizes among Thai women. A considerable proportion of Thai people had been practising birth control, including abortion, before the declaration of the population policy (Thai Population Association 1990). This resulted in rapid receptivity of contraceptive practice among Thai women from the start of family planning campaigns. This fact plus the government's strong commitment and extensive family planning programmes resulted in a rapid decrease in the total fertility rate from between 5.4 and 5.8 children in 1970 to 2.20 or near replacement rate by 1990. As for the contraceptive prevalence rate among married couples, the percentage increased from eight per cent during the 1960s to around 75–77 per cent in 1995 (UNFPA 1995). Since 1970, Thailand's population growth rate has declined so rapidly that the situation is often referred to as "a reproductive revolution".

According to Wongboonsin (1995), the process of population policy identification in Thailand was more of a collective approach. There had been no religious-based pressure groups against the government's family planning campaigns. There is no scriptural prohibition against contraception in Buddhism. As for Thai Muslims, although they are less receptive to contraceptive practice and oppose abortion and sterilisation, they generally are not against birth spacing. In addition, the mass media usually plays an advocacy role in family planning campaigns.

Apart from the government's extensive programmes and high receptivity of birth control among Thai women, another factor is said to have contributed to the success of family planning programmes. This is, according to Khunying Amporn Meesuk from the National Commission on Women's Affairs (NCWA), the fact that Thai family planning policy has, from the start, sought to promote birth control on a "voluntary" basis.

. . . Thai family planning policy has, from the start, sought to promote birth control on a "voluntary" basis. This has resulted in women being more willing to respond to the government's family planning campaigns.