



# Meeting the Cairo Challenge

*Lessons Learned and Key Future Actions*



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## **CHAPTER I**

### **The ICPD approach to sexual and reproductive health**

#### **CHAPTER OVERVIEW**

This chapter reviews the central concepts of the ICPD Programme of Action and what they mean for the provision of sexual and reproductive health services. Four sections define and operationalize key components of the ICPD agenda, as well as demonstrate their relevance to the health and rights of people throughout the world:

- 1. Introduction: ICPD Background**
- 2. What Is New about the ICPD Approach?**
- 3. Why Is Sexual and Reproductive Health Important?**
- 4. The Fundamentals: Cross-Cutting Issues in Sexual and Reproductive Health**

*"...when we talk of population today we mean women's reproductive health and rights; we mean education and empowerment; we mean equality and equity. We mean the right to personal development and choice. The role of government, of civil society, of the international community is to enable that choice."*

*Dr. Nafis Sadik, Executive Director, UNFPA*

## CHAPTER II

### Creating a supportive environment

#### CHAPTER OVERVIEW

This chapter addresses some of the key issues involved in creating a supportive environment for the promotion and provision of sexual and reproductive health among different groups and at different levels of society. Five sections focus on changes taking place in laws, policies, and programs; how they have come about; and their impact. The final section explores the effects of health sector reform on service access and quality.

#### 1. Introduction: Changing Hearts and Minds

#### 2. Broad-Based Partnerships for ICPD Implementation

*Case examples:* **Mexico**, National Safe Motherhood Committee; **Southeast Asia**, NGO-government dialogue for women's health; **Indonesia and Thailand**, Partners in Population and Development south-south initiative; **Senegal**, the "Poles of Excellence" program; **West Bank**, Palestinian Coalition for Women's Health.

#### 3. Legal and Policy Reforms in Support of the ICPD Approach

A. *Case examples on legal reform:* **South Africa, Guyana, Cambodia, Albania, Burkina Faso**, expanding legal access to abortion; **Burkina Faso**, penalizing forced marriage; **Venezuela**, preventing violence against women; **Ecuador**, implementing a law against family violence; **Burkina Faso, Central African Republic, Djibouti, Egypt, Ghana, Guinea, Senegal, Tanzania, Togo**, criminalizing female genital mutilation (FGM); **Egypt**, banning FGM and the role of the Egyptian FGM Task Force.

B. *Case examples on policy reforms:* **China**, piloting client-oriented approaches to service provision; **India**, broadening the reproductive health approach nationwide; **Vietnam**, shifting policy emphasis from demographic targets to reproductive health; **Bangladesh**, operationalizing the National Health and Population Sector Strategy.

#### 4. Gender Equality and Equity

*Case examples:* **Bangladesh**, increasing girls' opportunities for secondary school education; **Kenya**, addressing reproductive health barriers to girls' education; **Mexico**, incorporating reproductive health and rights and gender perspectives in population policy; **South Africa**, fostering the role of men as partners in sexual and reproductive health; **Dominica**, educating male prisoners on reproductive health and domestic violence.

#### 5. Sexual and Reproductive Health in Health Sector Reform

A. *Case example on decentralization:* **Zambia**, new structures for district-level planning and implementation of health services.

B. *Case example on privatization:* **Mali**, government/community partnership to finance health care.

C. *Case examples on cost recovery:* **Bangladesh**, sliding-scale fees for care; **Colombia**, *Oriéntame's* financial sustainability.

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#### Broad-Based Partnerships for ICPD Implementation

- Partnerships are essential if the ICPD is to be implemented effectively. However, in some settings, governments still do not recognize NGOs as legitimate partners, and existing power imbalances often make it difficult to establish relationships of mutual respect and trust. NGOs need to find ways to demonstrate to governments their support from particular segments of society, or society as a whole, and must create broader bases of support. Forming alliances with other members of civil society (e.g., trade unions, professional associations, academics, students, and the media) can be a useful strategy to get governments to recognize NGOs as partners, and include them in government mechanisms.
- Institutionalized mechanisms for ensuring dialogue between NGOs and governments are often lacking. Such mechanisms are essential to facilitating equitable partnerships between civil society organizations and governments, and should be advocated.
- NGOs undertaking partnerships with governments may be accused by their members or by civil society at large of being co-opted. In order to counter the appearance, or reality, of co-optation, NGOs must establish internal mechanisms to keep themselves transparent and accountable to their constituencies. In their work with governments, NGOs also need to be clear that they will retain their autonomy and the right to critique government actions or terminate government or multi-sectoral relationships if doing so would benefit their constituents.
- The formation of multi-sectoral partnerships is a labor-intensive and time-consuming process. Diverse groups are finding that it is critical to define and work on common areas of agreement, and ignore or defer other issues. Consistency in leadership, coordination mechanisms, and adequate funding are needed for partnerships to be sustained. NGOs seeking partnerships with governments must put a priority in their own organizations on sustaining leadership; developing specific recommendations for policy or program change along with focused messages; building coalitions; increasing advocacy; and maintaining focus.
- The potential of partnership with the private sector has not yet been fully explored. Such partnerships should be created, tested, and broadened if found to be effective.
- Sustainability of partnerships is uncertain, with long-term funding to support partnerships often unavailable. NGOs are still having difficulty getting direct and sufficient funds from outside sources, such as multilateral and other donor organizations. Donors should revise their funding guidelines to provide direct support to NGOs, allowing them more freedom to start and sustain partnerships.

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#### Legal and Policy Reforms in Support of the ICPD Approach

- In many countries, certain laws and policies continue to discriminate against and subordinate women's sexual and reproductive health and rights. These include restrictions on access to a full range of health information and services, including safe and legal abortion services; gender-based violence; harmful traditional practices such as FGM; and restrictions on adolescents' access to services and information. Efforts must continue to bring these discriminatory laws and policies to the attention of policy makers and the public, and advocate for them to end. Among the means that can be and are being used to bring about change are the legal system, international human rights standards and conventions, public education and outreach, the media, pressure campaigns by key stakeholders, and negotiation with or lobbying of specific government officials. Such campaigns can take a long time to yield results, and advocates must commit to participate for the long term.
- Major constraints to effective legal and policy reform in support of the Programme of Action are incomplete understanding of the sexual and reproductive health approach, lack of political will, and insufficient enforcement of existing laws and policies. Increased technical assistance by donors and NGOs, with a focus on capacity building, should be encouraged to help effect the policy and legal changes necessary for ICPD implementation. In addition, NGOs can monitor government enforcement of existing laws and policies, keeping the public and policy makers informed of shortcomings, and demanding accountability. Civil society groups can also work in strategic coalitions to build political will, both inside government structures and outside, through pressure from the public, powerful associations (e.g., union, medical, legal), and the media.
- Laws and policies have changed, often in significant ways. However, too few individuals are aware of the changes and what they mean for service delivery, their legal status, or their rights; this is especially true in rural or geographically isolated areas. Such changes in laws and policies must be accompanied by outreach and media campaigns that help people--from policy makers to clients--understand what the changes mean and how to benefit from and sustain them. A supportive framework for implementation, including clear action plans, guidelines, and enforcement mechanisms, must accompany legal and policy shifts. Such efforts can benefit from the participation of NGOs and other civil society groups.
- National-level committees to follow up on implementation of the ICPD can be effective, particularly when membership includes high-level government officials as well as representatives of civil society, especially women's NGOs. However, such committees have been established in few countries, or without significant participation of women's health advocates. Countries that have not yet established national ICPD follow-up mechanisms should be encouraged to do so.

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#### Gender Equality and Equity

- The concept of gender and its application in policy and program development is still not well understood. Yet, when given the opportunity, most men and women are interested in the issues raised by the concept of gender, and find them relevant to their own lives. Concepts of gender and equity should become part of all school curricula and be introduced to both sexes at the earliest ages. In addition, in-service training on gender issues should be undertaken for social service providers, including those in the health and education sectors, the police, the judiciary, and the military.
- If the concepts do not become better known, those opposed to gender equality and equity may continue to define the discourse on “gender.” NGOs have an important role to play in defining, or clarifying, what gender equity and equality mean, and demonstrating their application to policies and programs.
- Gender relations and the effect of male power on women’s sexual and reproductive health are still not considered essential to policy-making or program design in many countries. Men’s understanding of their roles in and responsibilities for respecting women’s rights; protecting women’s health; preventing unwanted pregnancy, maternal mortality, and transmission of STDs; supporting their partners’ access to and use of sexual and reproductive health care; and sharing domestic duties should be promoted at all levels and in all situations by a range of actors. These should include governments, NGOs, and civil society organizations (including men’s groups, trade unions, and professional associations), the media, and the private sector.
- Country experience is showing that critical first steps for introducing a gender perspective include: creating public and policy-maker awareness of current problems of women’s inequality and lack of power; educating women and men about their rights; and creating mechanisms to enforce gender-sensitive laws and policies. Countries should adopt policies of zero tolerance for all forms of violence, including rape, incest, and trafficking of women and children. This should entail developing an integrated approach that addresses the need for widespread social, cultural, and economic changes to support gender equity and equality.

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#### Sexual and Reproductive Health in Health Sector Reform

- Within health sector reform efforts there is a danger that sexual and reproductive health services will “slip through the cracks.” Governments need to ensure that sexual and reproductive health care receives priority and adequate funding in the shift from vertical programming to a sector-wide approach to service delivery.
- Caution must be taken to avoid the health reform process becoming an end in itself, rather than a means to improving quality and accessibility of services, particularly for the poor.
- Preventive interventions must be given high priority in reform efforts, to avoid the often greater costs of treating preventable conditions.
- Although decentralization is intended to ensure that services are made more appropriate, available, and accessible, these goals will not be achieved unless infrastructures are in place and local managers are trained to take on increased responsibility; systems also need to be established to hold managers and planners accountable to both higher-level authorities and clients.
- Country experiences in all regions make it clear that existing human and technical capacities for decentralized program development and implementation are generally underdeveloped, and in some settings severely constrained. Donors, international organizations, and NGOs have a critical role to play in providing technical assistance to those undertaking health reform, and in building the capacity of the public health sector at all levels, from local to national.
- The benefits of health sector reform and many of its strategies are still unclear. It is too early to determine what the ultimate impact of such efforts will be. It is essential that full collaboration and communication be established between those working to bring about health sector reform and those working to ensure provision of sexual and reproductive health in order to follow and monitor changes and make corrections when necessary.
- Privatization and cost recovery in the context of health sector reform have been found to be barriers to women’s use of health care services in a number of country programs and projects. Care must be taken to ensure that such macro-level policies do not further marginalize or create disincentives for the poorest of the poor, particularly those in rural areas, to use services. In addition, funds collected from user fees should be reinvested at the service delivery point to improve quality and access. If surplus resources are collected through fees for service in urban areas, these can be used to subsidize care for women and adolescents in underserved rural areas.
- Further experimentation is required with models of community-managed and -financed care. Such efforts will still require cost sharing with governments or the private sector, along with technical assistance. However, they may prove to be an effective and equitable model for delivering high-quality care, in line with local priorities, that is accessible, affordable, and sustainable.

## CHAPTER III

### Broadening the content and range of sexual and reproductive health services

#### CHAPTER OVERVIEW

This chapter discusses strategies for operationalizing the ICPD's vision of comprehensive sexual and reproductive health care. Five sections focus on key choices and actions essential to achieving high-quality, client-centered care within existing health system capacities:

#### 1. Introduction: Making Comprehensive Services a Reality

#### 2. Structuring Comprehensive Sexual and Reproductive Health Services

##### A. Providing Quality Services through Referrals, Links, and Outreach

*Case examples:* **China**, testing approaches for client-centered care; **Pakistan**, improving rural health services and establishing referral networks; **Bolivia**, building links between NGO and public services.

##### B. Service Integration

*Case examples:* **Thailand**, incorporating HIV/AIDS prevention into family planning and maternal and child health services; **South Africa**, translating national policy into integrated STD/HIV/AIDS services; **Colombia**, expanding the range of available services; the **Philippines**, comprehensive sexual and reproductive health services in and out of the clinic.

#### 3. Communicating Behavior Change: Information, Education, and Communication (IEC) Strategies

*Case examples:* **Pakistan**, social marketing for private-sector care; **Tanzania**, promoting reproductive health through radio drama; **Mozambique**, social marketing to enhance access to reproductive health information and commodities; **South Asia**, multi-lingual radio broadcasts on sexual and reproductive health and rights.

#### 4. Setting Priorities for the Provision of Sexual and Reproductive Health Services

*Case examples:* **Nepal**, consultative process to prioritize service delivery; **South Africa**, participatory review to improve care in public clinics; **Kenya**, new service ideas guided by community needs and expectations.

#### 5. Establishing Comprehensive Standards and Protocols

*Case examples:* **Indonesia and Bhutan**, developing new protocols to improve midwifery care; **Ghana**, developing national service and policy standards; **Brazil**, accrediting clinics to maintain high-quality service standards; **Myanmar and Vietnam**, using a three-stage process to improve and expand reproductive health services.

## Section 2

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#### Structuring Comprehensive Sexual and Reproductive Health Services

- Many health systems have historically taken a vertical approach to the delivery of sexual and reproductive health care. It will take time, commitment, and increased capacities and resources to change the orientations of providers and management, and of administrative structures (*see chapter V for a fuller discussion of these issues*).
- Efforts to provide comprehensive sexual and reproductive health services need to build on existing service system strengths (e.g., in the provision of primary health care or family planning), and work creatively with health system planners, managers, and providers, as well as communities and clients. In some cases, change will only be possible one step at a time (e.g., integrating STD services into family planning programs). However, the longer-term goal should remain integrating as many components of sexual and reproductive health care as makes sense and is possible.
- Special consideration and additional resources are needed in situations where even the basic prerequisites for high-quality sexual and reproductive health care are lacking. In such circumstances, supportive partnerships must be forged between national governments and international donors and technical support agencies.
- Efforts to restructure services, whether through links or integration, are likely to fail if providers and planners at all levels of the health system, particularly those delivering services, are not included in the process of developing national or regional strategies.
- The limited capacity of the health infrastructure in many countries is contributing to the slow pace of progress on ICPD implementation, particularly in very poor countries. In an effort not to undermine the quality, however compromised, of existing services, expansion of programs should be phased and limited to areas where the particular organization has developed sufficient expertise. Service gaps can be filled by linking with other services in a given area. In most cases, resources can be maximized by allowing service partners to focus on their comparative advantages and establishing good referral systems.
- Some health facilities have been unable to expand existing primary care to include family planning, let alone provide comprehensive sexual and reproductive health care. However, smaller, more targeted interventions are working in many settings to expand the range of services available and improve quality. Such efforts need to be studied, and the lessons applied to assist scaling up of viable models.
- In some cases, national- and community-level programs have been renamed to reflect the ICPD Programme of Action, but the range, quality, and way of delivering services has not changed. Communities, advocates, and sympathetic program planners must work together to demand and create systems for accountability from such programs to deliver on their promises. Such coalitions can work effectively at the national, regional, and facility or program level.

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#### **Communicating Behavior Change: IEC Strategies**

- A universal or “one size fits all” approach to behavior-change activities does not work. IEC messages must be based on local social and cultural realities and feature messages and role models that are meaningful to target groups. IEC programs should also seek new partners and new venues for their messages in order to reach more people and increase their impact. Programs should seek the technical assistance of the private sector where possible (e.g., media groups and advertising agencies), which may be willing to donate staff time to new campaigns.
- IEC efforts to raise awareness and educate people about sexual and reproductive health should be linked to the provision of high-quality services for prevention, screening, and treatment. Otherwise, programs run the risk of creating a demand for services that do not exist or cannot meet clients’ expectations. This can lead to clients withdrawing from, or losing confidence in, the health system, creating a backlash effect against future service initiatives.
- IEC campaigns should not shy away from confronting controversial issues such as promiscuity or gender relations. Programs that address the broad range of sexual and reproductive health concerns and tackle previously neglected issues and concerns with sensitivity are making it easier to discuss important issues and address them through services.

## **Section 4**

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#### **Setting Priorities for Provision of Sexual and Reproductive Health Services**

- Country experience is showing that it is essential to undertake assessments before modifying or initiating new sexual and reproductive health interventions. Such assessments should use participatory methodologies and be undertaken with the support and full engagement of health providers, managers, and clients.
- New strategies and tools for undertaking participatory and multi-sectoral assessment and prioritization exercises are being developed, including multi-sectoral workshops and other collaborative processes that involve a range of stakeholders. These methods are generating enthusiasm and support for systemic and policy changes from the outset, making it less likely that opponents of change will derail the process of implementation later on. Successful models of and tools for assessment and prioritization need to be more widely disseminated and used.

## Section 5

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#### Establishing Comprehensive Standards and Protocols

- Successfully revising and operationalizing sexual and reproductive health standards and protocols requires collaboration among governments, health professionals, NGOs, and clients, along with high-level commitment by policy makers, health system planners, and medical associations. It also requires adequate resources. Experience in different countries shows that when these elements are in place, efforts yield positive results.
- New standards and protocols must strike a balance between being uniform and dynamic in their ability to respond to changing health needs. Countries should systematically review existing standards regularly, considering changes in health needs or advances in technology.
- Development of fully new standards is not necessary in all countries. In many, existing international protocols and standards, created or revised to reflect the ICPD mandate and approach, can be adapted successfully – saving time and resources. Such adaptation efforts should also be collaborative, involving a range of partners.
- Many standards and protocols that appear effective when drafted fail to bring about expected changes because not enough attention is given to making sure they are properly implemented. Care must be taken to ensure not only that standards and protocols are disseminated widely within the health system, but that providers are trained in their use. Systems should be developed to assess how well and to what extent standards and protocols are being used, and to recommend ways of increasing their use and impact on client care.

## CHAPTER IV

### Increasing access to sexual and reproductive health services

#### CHAPTER OVERVIEW

This chapter examines some of the strategies used to increase access to sexual and reproductive health information and services for underserved populations. Sections focus on existing barriers to care and meeting the needs of several different sub-populations:

#### 1. Introduction: Reducing Barriers to Care

#### 2. Strategies for Adolescent Sexual and Reproductive Health Care

*Case examples:* **Zambia**, improving youth access to reproductive health services; **Brazil**, establishing effective links between schools and health clinics; **Nigeria**, providing youth services and advocating for a national sexuality education curriculum; **Ecuador**, expanding services to meet adolescents' needs; **Jamaica**, providing information and life skills through a youth center; **Senegal, Mali, Burkina Faso**, using film to improve young people's access to sexual and reproductive health information.

#### 3. Involving Men

*Case examples:* **Uganda**, building community support for male involvement in reproductive health; **Trinidad & Tobago**, raising health and gender awareness through interactive drama; **Namibia**, training men in key institutions as reproductive health educators.

#### 4. Reaching Out to Other Underserved Populations

*Case examples:* **Côte d' Ivoire**, employer-provided care for employees and families; **Cambodia**, outreach and clinical services for commercial sex workers (CSWs); **Bolivia**, mobile fair providing sexual and reproductive health information in remote regions; **India**, community-based health information resources for female dairy farmers.

## Section 2

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#### Strategies for Adolescent Sexual and Reproductive Health Care

- In many countries, adolescent sexuality and young people's needs for reproductive health services are still sensitive issues among providers, parents, and teachers. An effective strategy to counter opposition is to build broad-based coalitions in support of youth health with stakeholders. Essential to such efforts is having as many facts as possible about threats to adolescents' sexual and reproductive health (e.g., rates of maternal mortality, unwanted adolescent pregnancy, STDs/HIV infection, and unsafe abortion), and bringing them to public and community attention. Enlisting the support of the media can also be effective.
- In a number of countries, laws and regulations prevent adolescents from receiving sexuality education and sexual and reproductive health services. In addition, most countries do not have pre- or in-service training programs that offer specialized training for health providers or educators working with youth. Increased advocacy and public education should be undertaken to emphasize the urgency of adolescent sexual and reproductive health needs and dispel the myth that information and services lead to promiscuity. Policies should be revised and providers re-oriented to address the special needs of adolescents. In some cases, national-level changes, such as implementation of a sexuality education curriculum for youth, can be achieved by bringing key stakeholders together.
- Although more research and evaluation are needed on the many facets of adolescent sexual and reproductive health, a growing foundation of useful experiences already exists. Programs seeking to serve adolescents should review progressive national policies on adolescent sexuality and youth-friendly service initiatives that have been adopted. Providers and planners should also explore opportunities for providing sexual and reproductive health services or information to youth through existing channels, such as schools, well-established clinics for adult women, youth clubs, religious organizations, and community associations.
- Few services for adolescents are truly youth-friendly and many existing programs are narrow in focus (e.g., on abstinence only). Listening to and consulting adolescents in the planning and implementation of youth services is essential for the services to be used, valued, and effective in meeting adolescents' real needs.
- IEC programs for adolescents are generally not linked to services. Outreach educators and providers need to work harder to establish such links, and to make the availability of services integral to all IEC efforts.
- Promoting increased opportunities for young women through better access to education and skills training can help change the expectations of families and societies, and encourage them to value increased roles for women in addition to marriage and motherhood.

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#### Involving Men

- Male clients have unique needs that should be addressed if programs are to be effective and accepted. Policy makers, program planners, and clinic managers should ensure that service providers receive gender training to make them sensitive to the needs of male clients, and the role of men in ensuring women's sexual and reproductive health.
- When given the opportunity, most men are interested in discussing reproduction and sexuality. This opportunity should be seized to increase men's awareness, responsible behavior, and support of their partners' freedom to make informed choices.
- IEC efforts directed toward men can be crucial to ensuring women's sexual and reproductive health and rights. Such efforts can and should raise "sensitive issues" and encourage honest and open discussion, but must be creative in how these issues are addressed (e.g., through interactive drama and male reproductive health educators).
- Building support for male involvement in sexual and reproductive health often requires changing gender roles and assumptions. This can be done most effectively when individual men, including adolescent boys, have the support of their community, particularly of religious leaders, professional associations, unions, elders, and elected or appointed officials. In addition, male policy makers, sports figures, business people, and celebrities should be encouraged to speak openly about gender issues and how men can play more-positive roles in the lives of their partners and children.
- There is a danger that focusing on men's needs will lead to decreased attention to or resources for women's sexual and reproductive health. Care must be taken to ensure that programs and services for men do not direct limited resources away from sexual and reproductive health initiatives for women, or otherwise detract from the provision of high-quality care.

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#### Reaching Out to Underserved Populations

- Countries that invest the majority of health care resources in large, technically advanced tertiary care hospitals often have few funds left to reach rural and other underserved populations—sometimes the majority of the population. In low-income countries, policies or protocols to balance the use of health system resources more equitably between preventive and curative care are critical to increasing access to needed sexual and reproductive health services.
- In order to reach underserved populations effectively, alternative service delivery strategies are essential, such as delivering services where people are (e.g., in brothels or homes), empowering local individuals and NGOs to take a leadership role in service provision, and integrating health information and services within the structures of existing community or professional associations.
- Interventions must be gender and culturally sensitive, and support should be created for them within target communities through the participation of potential service users. IEC campaigns must be linked with high-quality services. Health systems and public or private providers should not create a demand for services without having an infrastructure in place to be able to meet that demand.
- Reaching underserved populations may not be easy, and can be costly, given the geographic or social isolation of many of the groups with the greatest need for information and services. Program-planners and providers will have to be creative, working through receptive community structures, and establishing partnerships with businesses, vendors, and producer cooperatives, among others. Mechanisms to ensure sustainability of interventions should be sought from both the public and private sectors and, where possible, from the served communities themselves.

## CHAPTER V

### Strengthening provider, management, and community capacity

#### CHAPTER OVERVIEW

This chapter addresses issues central to building the capacity of service providers to ensure provision of high-quality sexual and reproductive health care. Four sections focus on key systems-level components of quality service delivery:

#### 1. Introduction: Availability, Placement, and Responsibility of Health Personnel

*Case examples:* **Brazil**, increasing the availability of health services at by enabling midwives to play greater roles in service provision; **Mozambique**, revising the midwifery curriculum and expanding the scope of practice; **India**, training traditional birth attendants to provide services in underserved areas; **Ghana**, expanding the provision of STD treatment and postabortion care to different categories of staff.

#### 2. Skill Building through Training

*Case examples:* **Bolivia**, using provider attitudes on abortion-related care to improve training and services; **Bangladesh**, improving counseling skills of NGO providers; **Bolivia**, providing client counseling from a gender perspective; **South Africa**, building health workers' skills through participatory workshops; **Nepal**; competency-based training for postabortion care; **Mexico**, redesigning hierarchical training methods to improve quality; **Burkina Faso**, developing a new curriculum for nurses, midwives, and primary health care workers.

#### 3. Management Skills

*Case examples:* **Kenya**, encouraging self-evaluation by managers and staff for service improvement; **Tanzania**, strengthening supervision and management of services through a team approach; **Vietnam**, improving clinical and management training.

#### 4. Involving Communities and Clients in Sexual and Reproductive Health

*Case examples:* **Peru**, promoting community mobilization to increase service quality; **Burkina Faso**, **Dominican Republic**, **Ghana**, **India**, **Tanzania**, encouraging community solutions to reproductive health problems; **Philippines**, involving community members as service promoters; **Zimbabwe**, training volunteers as health counselors and making community concerns central to service design.

## **Section 1**

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#### **Availability, Placement, and Responsibility of Health Personnel**

- Legal and policy reforms to enable non-physician health personnel to deliver a wider range of reproductive health services have, for the most part, had a positive effect on service quality and availability. However, in such cases, changes must be accompanied by initiatives to address facility-level, professional, and attitudinal barriers, if the full benefits of these legal and policy changes are to be realized at the service delivery level.
- Training TBAs to provide basic reproductive health care can work well, if the TBAs are supervised by a skilled health professional. In some cases, however, “trained” TBAs have been ineffective in providing care. Programs need to be careful when vesting responsibility in providers of care who have not received long-term formal training.
- The quality of women’s health care services can suffer from limited availability of female providers and services that do not consider their unique needs. Women should be encouraged to enter the health care field and provisions made (such a maternity leave and day care) to facilitate their multiple roles as wives, mothers, and employees. Planning and delivery of health services must be gender sensitive if women clients are to use them effectively.

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#### Skill Building through Training

- Service providers are the major contributors to making the ICPD approach to sexual and reproductive health work. But still, too many providers do not have adequate formal preparation in the comprehensive approach to care. As a result, they often view reproductive health as family planning and maternal health only, rather than an integrated, holistic approach to meeting clients' needs. Greater emphasis must be given to updating pre- and in-service training curricula and strategies, and to better preparing providers to deliver high-quality services from the clients' perspective.
- Viewing service users as "clients" helps to redefine the patient-provider relationship and establish mutual trust, respect, and responsibility. To overcome the barrier of poor provider attitudes, training should focus on the improvement of providers' interpersonal and counseling skills, as well as on ways they can solicit client input and develop more client-oriented services.
- Students can only be good as those who instruct them. Teaching and training personnel need to be prepared and committed to including the elements and philosophy of the ICPD approach to sexual and reproductive health in their courses and instruction. They themselves will often need additional preparation and the support of those who supervise them.
- Not all training initiatives need to create their own materials. A growing body of training manuals, guidelines, and curricula exists within countries and at the international level. Efforts should be made to share such materials (many available on the Internet) and learn from others' experiences before developing new ones.
- Experience from multiple countries shows the value of a team-based training approach. Such training can help break down existing hierarchies and create a sense of shared responsibility, mutual support, and collaboration. This approach to training is new in many countries and still rarely done. It may be difficult to carry out, due to logistics and the reluctance of administrators. However, efforts should be made to extend training to all relevant staff members where the opportunity exists.
- Developing necessary human resources by providing service providers with additional skills and strengthening technical and management support will all have cost implications. These must be carefully analyzed and addressed in the planning for service expansion and quality improvement.

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#### Management Skills

- Good management is critical to the provision of quality care, although it is often overlooked, particularly in large, under-resourced public health systems. Good management means creating an environment in which staff members feel they have a voice in making decisions and are treated with respect. Such an approach, in turn, tends to have a positive effect on staff members' interactions with clients. Approaches to improving management skills must be broadly applied at all levels of the health system, and particularly at the lower levels, to expand clients' access to quality service provision. Where possible, a team approach to client care and clinic management should be built in from the beginning stages of program planning.
- Managers may be reluctant to delegate authority to lower-level staff, or to adopt a less hierarchical approach to decision-making and problem solving. However, experience shows that managers can become receptive to new ideas and new structures. Benefits of improved management for client care and for the managers themselves must be made clear, and managers should be partners in efforts to upgrade their own and their staff members' skills.
- There has been a tendency to make non-physician health care providers the "dumping ground" of the health care system. To add more to their current workload will not prove effective or lead to higher-quality care unless they are consistently supervised, provided with positive and constructive feedback, and given opportunities to maintain and refine their skills.
- Some key quality issues can be addressed with managerial and structural changes, and do not have to cost a lot. New ways of building staff capacity and improving management-staff relations should be promoted and applied, including a team approach to service provision, horizontal management, and participatory problem-solving.
- Inclusive management structures that have been adopted suggest that some authority is better exercised at the local level and that junior-level staff can make important contributions to solving problems. Such decentralization of decision-making should be encouraged, and necessary training provided to promote staff success and maintain service quality.

## **Section 4**

### **Lessons and Key Future Actions**

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#### **Involving Communities and Clients in Sexual and Reproductive Health**

- Participatory processes and decision-making are often worth the time and effort they take; patience and determination are essential if such efforts are to be successful and sustained. Inclusive training, decentralized decision-making, cross-sectoral partnerships, and community involvement are important for ensuring the availability of efficient, effective, and high-quality sexual and reproductive health services. As such, these strategies should be promoted and extended.
- Communities know best what their needs are. Too often, though, community members are not included in health system management, even at local levels. Service providers and health planners must develop more effective and extensive mechanisms to ensure community participation in the design and delivery of services. Such mechanisms will be most effective when they are institutionalized and sustained over the long term.
- Service providers at first may be reluctant to share power with communities. Program planners need to demonstrate to providers the benefits of community participation, including increased service use and the potential for improvements in health behavior. It is also helpful to gain support for community involvement from senior health system officials and managers, as well as community leaders. Such initiatives must be careful to ensure adequate representation of women, particularly in places where men exercise power over women's health choices, and where women are not generally recognized as community leaders.
- Broad definitions of “community” and innovative involvement of different groups are essential, including, where appropriate, street vendors, trade unions, youth, and CSWs.

## CHAPTER VI

### Upgrading systems and tools to assess and improve sexual and reproductive health service quality

#### CHAPTER OVERVIEW

This chapter reviews the need for systems and measurement tools to assess and improve the quality and efficacy of sexual and reproductive health services. Its sections describe progress and continued gaps in developing and operationalizing methodologies in three key areas:

##### 1. Introduction: Infrastructure and Logistics Systems

*Case examples:* **Ecuador and Tanzania**, improving national logistics management systems; **Pakistan**, expanding access to essential drugs; **Egypt**, a simultaneous improvement approach to service delivery.

##### 2. Tracking Progress

*Case examples:* **Brazil, Chile, Colombia, Nicaragua, and Peru**, NGO monitoring of ICPD follow-up actions by governments; **Peru**, the Tripartite Commission for the Follow-up of the ICPD Programme of Action.

##### 3. Research Needs

*Case examples:* **China**, community-based research for client-centered improvements in care; **Zambia**, action research by midwives to better meet women's sexual and reproductive health needs.

## **Section 1**

### **Lessons and Key Future Actions**

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#### **Infrastructure and Logistics Systems**

- New and better systems for meeting comprehensive logistics and infrastructure needs for ICPD implementation are essential. The successes achieved in these areas in the provision of family planning services should be built upon and applied to, or integrated with, a wider range of sexual and reproductive health services. Such systems should be developed through partnerships at the international, national, and local levels, with best practices shared and adapted.
- Little has been done to develop comprehensive and sound infrastructure and logistics systems, and there is a need for new efforts and strategies. Involving communities, NGOs and the private sector can be useful to ensuring supplies, equipment, and functioning infrastructure for health facilities.

## Section 2

### Lessons and Key Future Actions

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#### Tracking Progress

- Client-centered record keeping is helpful in improving and maintaining quality of care. Facility-based records must be carefully designed to be simple and efficient to use, and properly applied to facilitate service monitoring and follow-up care for clients.
- In many cases, current systems of record-keeping are overly bureaucratic and collect too much information, much of it not useful for improving service quality. Such systems, at national and facility levels, need to be redesigned, with the input of service providers, to ensure that they are well-used and maintained. Doing so will increase the likelihood that records become useful tools to improve service quality and client follow-up.
- There is a demonstrated need for continued work to identify and implement standardized sexual and reproductive health indicators, both quantitative and qualitative. Such work will require additional resources and capacity building, and must be supported at the international, national, and local levels.
- Donor-supported programs tend to focus more on tracking donor inputs than on measuring overall program impact based on quantitative and qualitative successes and failures. NGO, government, and donor partnerships to monitor progress can be highly effective and help ensure two-way accountability. It is important for such partnerships to be facilitated and supported, with the results of monitoring exercises made public and used for improving policies and programs.

## **Section 3**

### **Lessons and Key Future Actions**

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#### **Research Needs**

- Gaps exist in many research areas related to comprehensive sexual and reproductive health services. Additional and further operations research is required and should be disseminated widely to facilitate the processes of improving service quality.
- Training providers in operations research methodologies can enable them better to manage their own work and improve the quality of service delivery. Such research should link providers, communities, research facilities, and policy makers.
- Not enough sociocultural studies are undertaken, reducing opportunities to improve the quality, accessibility, and appropriateness of services. Such research needs to be better funded, and incorporated into service delivery and policy-level planning and evaluation processes.
- Some routine sexual and reproductive health procedures are neither necessary nor beneficial. Further research needs to be done on these, with the results widely disseminated to program managers and policy makers. Such research could both save health systems the costs of those interventions deemed non-essential and improve the quality of the care clients receive.

## CHAPTER VII

### Mobilizing and allocating resources for sexual and reproductive health

#### CHAPTER OVERVIEW

This chapter documents donor and national resource commitments for ICPD implementation and the impact of the current gaps in meeting the agreed-upon funding targets. It also explores country-level and international strategies to maximize the use of scarce resources, and examines the shortcomings of donor-driven programs. The chapter contains three sections:

- 1) **Introduction: Global Resources for ICPD Implementation**
- 2) **National Programs**  
*Case examples: Sri Lanka*, impact and cost-effectiveness of health and development expenditures; **Jamaica**, national resource mobilization and service delivery strategies ; **Bangladesh**, introduction of user fees in the private sector.
- 3) **Impact of International Donors**  
*Case examples: Sri Lanka*, potential impact of withdrawal of donor funds; **Uganda**, results of donor-driven health financing.

## Section 2

### Lessons and Key Future Actions

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#### National Programs

- A better balance is needed between resources spent for prevention and health promotion and those spent on treatment of illness and disease. Policies are needed to prevent over-medicalization of care and skewed investment toward tertiary care facilities. Public campaigns to promote health care and preventive practices are essential complements to the health care delivery system.
- Although additional funds are urgently needed to meet the ICPD's mandate for sexual and reproductive health, it is possible to do more with currently available resources through multi-sectoral partnerships, cost sharing across sectors, reallocation of resources, and administrative changes. Policies and strategies are also needed that ensure maximal use of existing funds for sexual and reproductive health, and cut costs and reduce inefficiencies in health systems.
- Donor assistance should be used in a way that complements, rather than substitutes for, national public- and private-sector resources. Increased experimentation with public- and private-sector approaches may contribute to improved service access and quality, and should be pursued.
- Health sector reform efforts, particularly cost recovery, can in the short term at least reduce use of services, particularly by the very poor. governments need to monitor and prevent such impacts. Cost recovery systems should be undertaken with caution, and should seek to ensure continued high usage rates for preventive care (e.g., prenatal care, family planning, STD screening and treatment) that pays off in the longer term, in both improved individual health and costs saved by the health system on treating conditions that could be avoided.
- governments have the ultimate responsibility to guarantee basic minimum health care for all. As they experiment with fees and private involvement in the health sector, governments must retain oversight of the health sector, through national standards for quality of care and universal access.

## Section 3

### Lessons and Key Future Actions

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#### Impact of International Donors

- Current shortfalls in donor resources for sexual and reproductive health are a real problem, and are contributing substantially to weak and slow implementation of the ICPD objectives to expand service access and improve quality of care. This is particularly true in the most financially constrained situations.
- Provision of technical assistance in low-income countries is essential, along with a focus on and resources for capacity building.
- governments and NGOs in donor countries need to expand their public education and outreach efforts to strengthen grass roots support for population assistance, along with the necessary political will. Within recipient countries, national stakeholders need to build political support for comprehensive sexual and reproductive health programming. The willingness to allocate additional resources and redistribute what is currently available are indications of national and international commitment to ensuring that ICPD goals are met.
- The US, Japan, and Germany must increase their development and population funding to set an example and better reflect their roles as the world's three largest economies. Achievement of overall ICPD funding will depend in large part on the cooperation of these three countries.
- Donor-driven policies are generally ineffective and often counter-productive. At the country level, closer coordination between national governments and donors is essential to match national and local reproductive health priorities with technical and financial resources available from different donors. Donor institutions and development banks must set up systems to better coordinate -- and increase the impact of -- their efforts, and should also work more closely with NGOs, channeling funds to them directly where relevant.
- To facilitate analysis of financial trends, national governments, civil society organizations, and donors need to define population assistance in a consistent way and improve the quality of their financial reporting. Improved financial data and tracking are necessary to hold both low-income and donor countries accountable to meeting their ICPD commitments.