The ICPD Vision: How Far Has the 11-Year Journey Taken Us?

Report from a UNFPA Panel Discussion at the IUSSP XXV International Population Conference

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NOTES:

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FOREWORD

I have the pleasure to issue this publication, which is the result of the great interest generated by the lively panel discussion that was organized by UNFPA at the XXV International Population Conference of the International Union for the Scientific Study of Population (IUSSP), held in Tours, France from 18 to 23 July 2005.

The UNFPA sponsored panel discussion, organized in the context of the continued assessment of the implementation of the 1994 International Conference on Population and Development (ICPD), was entitled: "ICPD Vision: How far has the eleven-year journey taken us?" It was listed as Session 39 and was the first of the seven Plenary Sessions of the Conference.

The discussions, put into context in this publication by an observer's commentary, provided different perceptions on the impact of ICPD. Some of the views were critical of ICPD for not paying sufficient attention to population-level demography, and advocated for a much stronger focus on population dynamics and the consequences for development. The other views were supportive of the Cairo agenda, stressing some important gains in the eleven years since the ICPD, while indicating some of the constraints, including inadequate attention to health systems and the roles of wider political and cultural shifts.

The Panel Discussion would not have been possible without the strong partnership and collaboration between UNFPA and the IUSSP Secretariat and members, who generously contributed their time and efforts toward making the event a true success. I would also like to thank the distinguished panelists and the commentator for their commitment and hard work in preparing their contributions to the discussions and to this report.

I would like to acknowledge the contributions of Francois Farah, Kourtoum Nacro, Sharyn Sohlberg and Chaudhary Suleman of the Population and Development Branch of UNFPA Headquarters for organizing and coordinating the panel and for the production of this report.

I hope that you will find this publication informative and useful.

Rogelio Fernández-Castilla
Director
UNFPA Technical Support Division

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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AST	Age-structural transition
CPR	Contraceptive Prevalence Rate
DAC	Development Assistance Committee
FP	Family Planning
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICPD+5	The five-year review of ICPD
IIASA	International Institute for Applied Systems Analysis, Vienna
IUSSP	International Union for the Scientific Study of Population
LDCs	Less Developed Countries
MDCs	More Developed Countries
MDG	Millennium Development Goal
NEPAD	New Partnership for Africa's Development
ODA	Official Development Assistance
POA	Programme of Action from ICPD
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
STI	Sexually Transmitted Infection
SWAP	Sector-Wide Approaches
TFR	Total Fertility Rate
UN	United Nations
UNCED	UN Conference on Environment and Development
UNFPA	United Nations Population Fund
UNGASS	UN General Assembly Special Session
WHO	World Health Organisation

EXECUTIVE SUMMARY

UNFPA, the United Nations Population Fund, decided to sponsor a Panel debate at the 25th IUSSP International Population Conference on progress towards achievement of the Plan of Action following the International Conference on Population and Development (ICPD), which took place in Cairo, Egypt in 1994. The title of the debate was "The ICPD Vision: How far has the eleven-year journey taken us?" Four distinguished speakers were invited to act as panel members. Two demographers, Professors John Cleland and Ian Pool, both advocated for a much stronger focus on population dynamics and were critical of the ICPD and, to some extent, also of the Millennium Development Goals (MDGs) for not paying sufficient attention to macro-level demography. Two supporters of the Cairo agenda, Dr Pascoal Mocumbi and Professor Gita Sen, both stressed some important gains in the eleven years since the ICPD, but also stressed some of the constraints on significant progress including inadequate attention to health systems and the roles of wider political and cultural shifts.

This document begins with an introduction and commentary on the panel debate by Professor John Hobcraft, which tries to place the discussions in their wider context. The second part contains revised statements from the four Panel participants: Professors John Cleland, Ian Pool and Gita Sen; and Dr Pascoal Mocumbi. The discussion was lively and the issues raised are of huge importance. The panelists were asked to relate their remarks not only to the ICPD, but also the MDGs, particularly the first goal of halving poverty by 2015.

Part I

Introduction and Commentary

The ICPD and the Panel in Context: An Introduction and Commentary

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Introduction

This section summarizes the contributions of the four participants in the Panel discussion on "The ICPD Vision: How far has the 11-year journey taken us" and places these in the wider context. Inevitably contributors to such a discussion are asked to take positions and to focus on separate topic areas in order to reduce overlap. The theatre of the occasion (at a Plenary Discussion, which took place in a very large conference hall with several hundred people in the audience) tends to make contributors dramatize their positions. The short time available, combined with the need for a lively presentation, also leads to an emphasis on shortcomings and criticisms. However, as the discussion was lively, UNFPA believes that a written record should be made available for wider circulation.

The four contributors and their broad topics were:

John Cleland, on the relationship between population growth and poverty;
Pascoal Mocumbi, on reproductive health issues and goals;
Ian Pool, the discussant, who focused on relationships between changing age-structure and development;
Gita Sen, on gender equality and human rights.

In each case the contributors had an opportunity to revise their statements after the discussion. Those with a passion for the actual debate and responses can view a video recording (http://www.canalc2.tv/video.asp?idvideo=3813) and note the significant revisions that took place for this document, especially by Ian Pool.

As most readers will know, the International Conference on Population and Development (ICPD) took place in Cairo in 1994. This was the third decennial inter-governmental UN Conference on Population, although the first to include "Development" in the title. The previous two took place in Bucharest in 1974 and in Mexico City in 1984 and were also concerned with the links of population to development, but perhaps less explicitly. The ICPD broke much new ground, particularly in the areas of sexual and reproductive health and rights and in gender equality, equity and empowerment of women. It emphasized an individual rights-based approach and also included much on human development. The ICPD was followed up with a special session of the UN General Assembly (UNGASS) in 1999, known as ICPD+5. This reinforced and extended the Cairo Conference's Programme

of Action, and, among other shifts of emphasis, placed greater stress on pro-poor policies and on opportunities for young people.

The 1990s were a decade of unprecedented activity for UN Conferences: the 1990 World Summit for Children in New York; the 1992 Conference on Environment and Development (the "Earth Summit" or UNCED) in Rio de Janeiro; the 1993 World Conference on Human Rights in Vienna; the 1994 ICPD in Cairo; the 1995 World Social Summit in Copenhagen; the 1995 Fourth World Conference on Women in Beijing; and the 1996 Human Settlements Conference ("Habitat") in Istanbul. Just as for the Cairo Conference, each of these also spawned follow-up Conferences, usually in the form of a UN General Assembly Special Session.

During the 1990s it became apparent that this overload of UN Conferences was unsustainable and the result was the Millennium Summit in 2000, which produced the Millennium Development Goals (MDGs) that have become a major focus of development activity since then. The eight goals are:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/ AIDS, malaria, and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

Almost all international agencies and governments have placed highest priority on the first MDG, which aims to halve proportions experiencing absolute poverty and hunger by 2015 (compared with 1990 levels). But the Goals also reflect a much deeper realization that development requires an interlocking package of interventions and that it includes dealing with hunger, health and gender equity as well as economic development.

Supporters of the Cairo ICPD agenda were deeply frustrated that achieving universal sexual and reproductive health, or at least universal access to sexual and reproductive health services, did not become one of the MDGs, especially since reproductive health not only encompasses maternal health and HIV/AIDS but also covers reproductive choice and a host of other key elements. Many also saw the MDGs as failing to be sufficiently embedded in a human rights approach, illustrated by the fact that the only target on gender equity was the elimination of gender disparities in education. These views are in part reflected in the contributions of Pascoal Mocumbi and Gita Sen to the discussion at Tours.

Many demographers, especially those involved in family planning programmes, had already felt that their concerns with macro-level population issues were marginalized by the ICPD and particularly by the strong antipathy towards targets for population growth or contraceptive use that arose from concerns about coercive family planning programmes. Thus, John Cleland's contribution perceives UNFPA's historic mandate as being "to coordinate international response to the problems of population growth". The ICPD, in his view, shifted the mandate "towards a broader, more diffuse agenda

of women's health, gender equality, and reproductive sexual rights". Both he and Ian Pool emphasize macro-level population issues in their contributions to the discussion and see the MDGs and related processes, including the ICPD, as being inadequately attentive to problems posed by population growth and age structure.

It is hardly surprising that two of the speakers in the debate, John Cleland and Pascoal Mocumbi, focused much of their attention on sub-Saharan Africa, the region least likely to achieve the MDGs. Sub-Saharan Africa has the highest overall poverty rates, mortality rates, and fertility rates of any world region. Cleland concentrates on population growth and on HIV/AIDS, whilst Mocumbi takes a broad reproductive health perspective and stresses the need for investment in health systems.

Projections of the incidence of poverty to 2015 are highly uncertain. Both the World Bank and UNDP project a decrease in the numbers in absolute poverty for sub-Saharan Africa from 313 million (46.4%) at the start of the Millennium to 340 to 350 million (38.4%) in 2015. On the other hand the two agencies differ widely in their poverty projections for South Asia, agreeing on 431 million (31.3%) in 2001/2002, but suggesting reductions by 2015 to 395 million, according to UNDP, or to 216 million (12.8%) according to the World Bank. Both agencies expect absolute poverty to have been almost eradicated in East Asia and the Pacific by 2015, with the numbers reducing from 271 million in 2001/2 to 17-19 million by 2015. The World Bank projects that 55% of those in absolute poverty will live in sub-Saharan Africa by 2015, whereas UNDP suggests this fraction will be 43%. In comparison this fraction was 29% in 2001/2002.

Thus Cleland is correct in identifying absolute poverty as an increasingly sub-Saharan African problem. The numbers *not* in absolute poverty in sub-Saharan Africa will have grown from around 360 million in 2001 to around 545 million by 2015, an increase of 185 million, whereas the numbers in poverty would have grown by about 25 million over the same period. This is still lamentably short of the MDG target on poverty for sub-Saharan Africa, which calls for a reduction in overall poverty levels to 22.3% (half the level of 1990) by 2015 and for 140 million to be lifted out of absolute poverty during the same time frame.

The demographic critics of ICPD

Both John Cleland and Ian Pool are predominantly concerned with giving much greater prominence to the role of macro-population change in discussions of development. They both see the ICPD as having undermined concerns about population growth and the perceived need for population control. Neither provides a real assessment of "how far the 11-year journey has taken us"; their positions do not take stock of progress, but suggest rolling back some of the consensus achieved at Cairo. This is a legitimate position, though one I disagree with, and it attracted much support from the audience of demographers in the debate at Tours.

John Cleland propounds a measured argument that population growth (and by implication, the need for population control) is of critical importance for development in many sub-Saharan Africa countries. For him, this issue is important enough to warrant rolling back UNFPA's mandate to a pre-Cairo one; and the modern, post-

Cairo emphasis on regarding family planning as an integral part of reproductive health is deemed inadequate, though the terminology is used.

Ian Pool also concentrates almost exclusively on macro-demographic issues, though giving greater prominence to the consequences of "age-structural transitions", which are largely the result of population growth and subsequent fertility reductions. His rhetoric is sometimes colourful: for example "Congo or Nigeria will also face momentum effects, a tidal wave that will just get stronger and stronger, the famous doubling phenomenon". Nevertheless, the impact and long resonance of very large changes in numbers of births (or survivors to age five, to include reductions in child mortality), both upwards and eventually downwards, do play an important role in development.

Cleland's central thesis, echoing Malthus and the neo-Malthusians of the 1960s and 1970s, is that rapid population growth is a bigger threat to development than HIV/AIDS in most countries of sub-Saharan Africa. He does acknowledge the key importance of HIV/AIDS for southern Africa, where this epidemic has contributed to increasing poverty and to wiping out some 40 years of development gains in life expectancy in the worst-hit countries. Over the period 2005 to 2050 the population of sub-Saharan Africa is projected to more than double, with an increase of 941 millions, or 36% of the world's increase; in 2005 sub-Saharan Africa comprised 11.6% of the world's population, and by 2050 this fraction is projected to increase to 18.6%. To add emphasis, Cleland picks out several examples (and many more could be given) of countries set to triple their population size over this 45-year period, including Burkina Faso, Mali, Niger and Uganda. Afghanistan and Yemen could have been added to the list from outside this region, but this does not in any way negate the point that rates of population growth are generally still highest in sub-Saharan Africa, excepting those parts of southern Africa worst hit by HIV/AIDS.

Debate has raged for many years over whether "development is the best form of contraception", as famously enunciated by Dr. Karan Singh of India at the 1974 Bucharest Conference, or contraception and fertility control a key route to development as proposed by Cleland here (and espoused by Singh by the time of the 1984 Mexico City Conference). Both positions are perhaps too simplistic. Cleland cites the recent literature that shows some development gains attributable to fertility reduction, but also importantly shows gains from mortality reduction that usually precedes, and probably plays a causal role in, fertility reduction.

Cleland recognizes that advocacy of fertility control is treading on contentious ground and acknowledges the potential for unacceptable coercion and the need to integrate family planning provision and information to enable choice in a broader reproductive health framework. However, he poses two key questions in the context of sub-Saharan Africa. The first is whether attention to HIV/AIDS is distorting priority away from family planning (or, perhaps more broadly, from other aspects of reproductive health). Many other commentators are even more concerned that HIV/AIDS is eating up huge fractions of the overall health budget. His second concern is that the focus on poverty reduction among the MDGs (and perhaps the lack of attention to reproductive health, including family planning, as a package) has failed to pay sufficient attention to the challenges of rapid population growth.

The second demographic contribution, by Ian Pool, is again concerned with macro-level issues. His main focus is on the rapid changes in age-structure that are under way in the developing world. He sees demography as having been "badly misrepresented" at Cairo and takes the view that "a population is no more than the people as a collectivity". Yet he accepts that "all reasonable observers see reproduction, and intimately linked factors of female empowerment and gender equality, as among the core issues of population and development". The differences of emphasis that arise from concerns about individuals and their rights to a sole focus on populations as collectivities seem to get lost here; redressing the balance towards the former was at the heart of the ICPD. Many observers of the ICPD seem to perpetuate this potential misunderstanding. The debates and negotiations were indeed dominated by sexual and reproductive rights and health because these were new and contentious issues. The major shift of emphasis of the entire conference to a rights-based approach was also novel and contentious. But the document as a whole did pay considerable attention to a very broad range of development issues, with chapters on: principles; interrelationships between population, sustained economic growth and sustainable development; gender equality, equity and empowerment of women; the family, its roles, rights, composition and structure; population growth and structure; reproductive rights and reproductive health; health, morbidity and mortality; population distribution, urbanization and internal migration; international migration; population, development and education; technology research and development; national action; international cooperation; partnership with the non-governmental sector; and follow-up to the conference.

The one fundamental shift at ICPD, that seems to be at the heart of much opposition from many demographers, was the (near complete) refusal to countenance population control (with its potential for coercive programmes) as a rationale for family planning together with the consolidation of a health rationale and very strong emphasis on an individual rights and reproductive choice. An implicit element of such discussion was that provision of quality reproductive health services, which enable individuals and couples to choose whether and when to have children and how many to have, would indeed lead to reductions in population growth through the meeting of "unmet need" for contraception that had been a major plank of arguments for funding family planning for many years. Cleland, however, makes the point that the measured "unmet need" for contraception in many West African countries is low. A major consequence of this shift at ICPD was the conscious avoidance of any explicit goal or target for population growth, contraceptive use, or fertility reduction, because of the experience of coercion; rather there was an all encompassing goal of achieving reproductive health for all by the year 2015.

Pool explicitly recognizes these concerns and sets out a population and development perspective that is "not the same as the pre-Cairo agenda, which was not demographic in the wider sense employed in this paper, but instead revolved around family planning targets". Pool's concerns are with the development problems caused by major changes in the age-structure, that he terms "compositional shifts"; many development commentators would want to pay at least as much and probably more, attention to urban/rural compositional shifts.

Age-structure shifts are an inevitable part of the demographic transition. Initial reductions in mortality are differentially concentrated in children under five, resulting

in rapid population growth and significant increases in the proportion of the population who are below age 15. This creates immediate development challenges in terms of health and education infrastructures. Subsequently these cohorts of increasing size reach the age where they can enter the labour force, marry and bear children. The childbearing of these growing cohorts creates a "secondary momentum" through adding rising numbers of births to better prospects for survival.

Once fertility decline is established, the rates of increase in the numbers of births often decline, though the growing numbers of parents can offset this for some time, as illustrated by Pool's Table 2. Eventually, when fertility decline has really taken hold, the numbers of births begin to decline and the large cohorts begin to move through the age distribution. In world terms, we are now at a stage where the numbers of young people aged 15-24 are at an all-time high, with the numbers of those who are under age 15 reducing. (This of course masks considerable inter-region and inter-country variation.) The relative reduction in numbers of children is now seen by many to create a window of opportunity, where the race to increase child health and schooling for ever-growing numbers has eased and resources can be shifted towards greater investment in generating employment. But gloomier views see the challenges posed by huge numbers of young adults meeting with underemployment and the possibilities that holds for unrest.

A longer-term concern arises when these young people age. The peak numbers in the 15-24 age group today are going to be reaching age 65 around the middle of this century. Pool, probably correctly, sees the future ageing problem as having received disproportionate attention from demographers compared with the current youth transitions.

Both Cleland and Pool thus argue that macro-level population changes and trends matter for development and that both the ICPD and the Millennium Development Goals do not pay enough attention to these issues. Both see key roles for the UNFPA in poverty reduction; both want to roll back what they perceive as an undue emphasis on broad reproductive health goals. John Cleland wishes to see an unlikely shift back to advocacy of fertility control, and Ian Pool's "programmes relating to reproduction should be seen as instruments of much broader population policy" seems to edge towards this conclusion too. Both certainly want to strengthen the commitment of UNFPA to (macro-) population and development, although this has never gone away.

The supporters' views

The other two contributors to the Panel debate both strongly support the innovative aspects of the ICPD agenda. Pascoal Mocumbi tackles the key area of reproductive health and Gita Sen the key area of gender equality; both also emphasize human rights aspects of the ICPD. Both take a broad canvas and spread the discussion to encompass health systems and the politics of funding, among other concerns. They also assess progress in the implementation of the Cairo agenda and pay considerable attention to barriers to such progress.

Pascoal Mocumbi begins by stressing the importance of the 1994 ICPD and of the 1995 Fourth World Conference for Women in Beijing for shifting the focus of debates about development to concerns with the individual, rather than dominantly at the

societal level. He suggests that "addressing individual human rights and choices" has contributed "to the enormous progress observed in adoption of poverty reduction strategies and development programmes". He outlines the range of issues covered by sexual and reproductive health care services as: "family planning information, services and counselling; postnatal and delivery care; health care for infants; treatment of sexually transmitted diseases and reproductive tract infections; safe abortion services and management of abortion-related complications; prevention and treatment of infertility; and information, education, and counselling on human sexuality, reproductive health, and responsible parenthood".

He then addresses the progress towards achieving reproductive health goals. Unsurprisingly, he places considerable emphasis on sub-Saharan Africa, where the problems are most severe (true for development as well as for reproductive health). His tour of reproductive health issues and challenges for this region includes extremely high maternal mortality, HIV/AIDS, unmet need for contraception and unsafe abortion; space limitations may have precluded reference to progress on female genital mutilation/cutting. Progress towards achievement of the reproductive health goals in sub-Saharan Africa, in contrast to much of the world, has been slow at best. There is very little evidence of a reduction in maternal mortality, despite the shockingly high levels; little progress has been made on unsafe abortion; and the lack of economic development and a failure to make real progress in health systems, combined with rising incidence of HIV/AIDS in Southern and Eastern Africa, has often led to a stalling (or even reversal) in improvements in infant and child mortality.

Mocumbi then shifts his attention to how to ensure progress. Four key topics are considered: strengthening health systems; increasing community and societal commitment to health promotion; ensuring integration of reproductive health services, particularly bridging to HIV/AIDS interventions; and resource mobilization and partnerships to deliver at the national, regional and global levels.

There is now a fairly strong consensus that adequate health systems are essential to reductions in maternal mortality and to further progress in reducing infant and child mortality. Mocumbi stresses the need for a sustained commitment to the development of good quality health systems at community, national and international levels. He also calls for a much greater involvement of individuals, communities, NGOs, and their leaders as active partners in health promotion, including sexual and reproductive health.

Mocumbi also laments the failure to adopt a holistic view of reproductive health, as envisaged by the Cairo Programme of Action. He sees the integration of all elements of sexual and reproductive health being hampered by different development agencies investing in separate components: This leads to separation of family planning programmes from HIV/AIDS interventions, although both are often concerned with affecting changes in sexual behaviour and their integration could prove synergistic. Similarly, the separation of reproductive health from broader health concerns is seen as undesirable.

Finally, Mocumbi stresses the need for promotion of partnerships (the eighth MDG) to create an enabling environment for fighting poverty and achieving health, including sexual and reproductive health. He points to some hopeful developments in this

context, including the New Partnership for Africa's Development and the outcomes of the G8 Summit held in Gleneagles. Fundamentally, Mocumbi sees sexual and reproductive health and gender equity as crucial to achievement of the MDGs, including poverty reduction. He perceives many difficulties in successfully achieving the agendas from the ICPD and from the Millennium Summit, but, while wanting much more, welcomes the progress that has already been made.

Gita Sen also begins with an overview of some of the progress on reproductive health for all developing countries (the South). She points to the need for much greater progress in meeting unmet need for contraception, reducing maternal mortality (and unsafe abortion), improving quality of services, tackling the HIV/AIDS pandemic and its feminization, and making much greater progress on enhancing sexual rights, in addition to reproductive rights.

The difference in tone and context of her advocacy for family planning from that of John Cleland is noticeable. Sen sees family planning as an integral part of sexual and reproductive health, rather than as the key intervention (even for West Africa). She stresses unmet need, rather than demand creation, and is concerned with reproductive rights rather than population control. Her key concerns are with providing quality services that are sensitive to the needs of the users across the broad range of sexual and reproductive health concerns. She sees some progress as having occurred since Cairo, but notes how much more needs to be done.

Reducing unsafe abortion, in part to combat maternal mortality and morbidity, is also stressed. Sen recalls the ways in which the funding constraints imposed by the US Government have prevented many organizations from continuing their strong support for better family planning services because funds have been removed as a result of their "promotion" of abortion (usually funded from other sources and often only referral to other abortion providers).

Sen is also more concerned with the HIV/AIDS pandemic worldwide. Rather than just focussing on the already-high incidence in sub-Saharan African countries, she comments on the imminent high risk of rapid spread in several Asian countries. She stresses the increasing feminization of the epidemic and the crucial need to address issues concerning sexuality and the human rights concerns that result from a denial of women's sexual rights, including genital mutilation, sexual abuse, rape, enforced prostitution, sexual violence and trafficking for sexual slavery. Sexual rights, especially those of young women, are often deemed too controversial to address, and Sen argues that this needs to change: the ICPD and Beijing are seen as having contributed positively to these debates.

Sen goes on to place these developments in their much broader political economy context. Her discussion covers the impact of globalization and the negative impact of structural adjustment programmes on health systems. The relatively poor performance of donor countries in meeting targets for ODA is next discussed, as are the funding challenges for health care, including other elements of reproductive health, posed by the HIV/AIDS pandemic. This in turn is linked to the needs for funding innovative programmes on behaviour change in all areas of sexual and reproductive rights and health, including HIV/AIDS. This broader funding context is clearly of critical importance for development as a whole, including for realization of the MDGs, as

well as for the ICPD Programme of Action. Sen is gloomier in her prognostications here than either Mocumbi or Cleland, who both see quite positive signs emerging, perhaps especially from the G8 Summit in Gleneagles, with its commitments to substantial debt relief and to increasing donor commitments to ODA to reach 0.7% of GNP

Sen also argues that the ICPD agendas for sexual and reproductive rights and for gender equality face another major challenge:opposition from conservative forces that are hostile to progress in these areas. This challenge is much more directed to the Cairo agendas for sexual and reproductive rights and health and for gender equity and empowerment of women.

The role of the Holy See and its acolytes in opposing sexual and reproductive rights and health at Cairo is well known. What is more curious is that an organization totally dominated by men could apparently sign on to the ICPD chapter on gender equality. Sen provides examples of the Catholic Church views on the status of women that show this commitment to be unreal.

The (re-) emergence of a neoconservative administration in the United States has also threatened the Cairo consensus. At the UN Asia and Pacific regional meeting on Cairo + 10, the US was only stopped in this endeavour by the (very unusual) calling of a vote, which they lost 33 to one! The US has also reinstated the "Global Gag" rule, which removes all US reproductive health funding from any organization that in any way is seen to "promote abortion", wherever the funding for that element of their programme comes from. Trying to prevent access to legal, safe abortion in poor countries while it is legal in the US seems perverse, Sen noted.

Sen's final broad theme is the (mis-)use of culture in debates about women's rights. She concludes that "culture is not therefore an innocent weapon in the hands of those who oppose women's human rights; it may be the only weapon they have left".

Her contribution ends with a plea to integrate the ICPD goal of universal access to reproductive health as a target for the MDGs. Subsequently, some progress was made in this direction, through the incorporation of paragraph 57g in the *2005 World Summit Outcome* from the UNGASS five-year follow-up to the Millennium Summit:

> Achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty;

Conclusion

Among many other achievements, the ICPD played a significant role in broadening development agendas by firmly placing reproductive health and population in its wide sense (i.e. including reproduction, partnership, health, migration, family, size, and age structure) in a framework that encompasses human rights, gender, human

development, sustained economic growth and sustainable development. The ICPD+5 Key Actions strongly endorsed these agendas and strengthened links to the priority needs of poor people.

The two cornerstones of the demographic transition are improved health and reduced fertility. Contrary to perspectives among economic demographers a decade ago, the evidence currently suggests that both reduced mortality and reduced fertility play a significant and non-trivial part in generating economic growth. Regrettably, this research is not well informed by a gender perspective. However, other research strongly suggests that gender equity and equality play a crucial part in ensuring that women can play a fuller part in increasing economic growth or reducing poverty.

In the context of sustained economic growth and sustainable development, broader human development goals concerning education, health, empowerment of women, and freedom are all of considerable importance. Reproductive and sexual rights and health are an integral part of this development package, as are ensuring safe motherhood, avoidance of infection with HIV/AIDS, and enabling choices concerning whether, when, and how often both to form sexual partnerships and to bear children. These are especially relevant to achieving gender equity and empowerment of women, but have been shown to play a much wider part in poverty reduction and alleviation.

Several of the contributors to the debate quite properly emphasized key roles for organizations such as UNFPA in achieving poverty reduction. Figure 1 (produced with Gemma Hobcraft) brings together some of these concerns in a summary form. Three key elements, population dynamics, gender equity, and reproductive health, are all identified on the left. The various roles of such organizations, are identified in the second column and the key requirements for partners in this process illustrated in the third column. It is through these many routes that these organizations can work with others to enable poverty reduction.

Some of the key pathways involved in linking the concerns of ICPD to poverty reduction are summarized in Figure 2. This brings together both population-level and individual concerns and was again produced with Gemma Hobcraft. By no means all the issues covered in the diagram are included in the contributions to the panel, partly because contributors were constrained by time.

However, both John Cleland and Ian Pool concentrate on population dynamics at the macro-level, with Cleland emphasizing the need for (and likely benefits from) fertility reduction and Pool stressing the benefits from a reduced dependency ratio. These are seen by both as directly related to development (or to inhibiting development) and poverty reduction, without a great deal of time being spent on elucidating the pathways through which these benefits arise. Neither say much about ensuring and promoting human rights.

Both Mocumbi and Sen do spend a considerable part of their contributions elaborating and evaluating the issues, levers and goals identified in the lower part of Figure 1. Again, the links through the consequences and gendered pathways identified in the diagram are not always clearly elucidated, though consequences for poverty reduction are claimed.

The study of all of these linkages at the micro-level (and even at the macro-level) provides a substantial new agenda for demographic research that was not covered at all by members of the Panel. To me the most remarkable feature of the response of many demographers to the ICPD is the manifest failure to perceive and grasp the wonderful opportunities for creative research that arise out of this broader agenda for population and development. Many demographers still see the ICPD as a threat – especially to the funding heyday for family planning programmes – rather than as an opportunity for a much wider range of research. I would certainly have liked to see a member of the panel take stock on the positive implications of the ICPD for the research agenda of demography, rather than simply go for fairly narrow special pleading that population dynamics matter.

Surely population dynamics plays an important role in development. Surely, too, population dynamics cannot be accorded primary importance. The MDGs framework recognizes the crucial need for balanced attention to an interlocking and highly interdependent series of goals required for development. We all want to ensure that our own concerns are included; demographers pay special attention to population dynamics and supporters of the broader Cairo agenda to the combination of sexual and reproductive rights and health with gender equity and female empowerment. Such committed advocacy is essential in order to ensure that we do not lose sight of the big picture. All four contributors make a cogent case that their concerns are not getting quite enough prominence in the MDG process. All would equally agree that the overarching goal of poverty reduction is a desirable one, though probably arguing that development requires an integrated package involving wider capabilities and functionings and realisation of the full set of MDGs together, including attention to population, reproductive health, and gender equity.

It is fitting to end this commentary with a quote from the UN Secretary-General, which shows an appreciation of the issues:

> "The MDGs, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women's rights, and greater investment in education and health, including reproductive health and family planning". (Kofi Annan, 2002, Bangkok)

FIGURE 1. A POTENTIAL ROLE FOR ORGANIZATIONS WORKING IN THE AREA OF POPULATION AND POVERTY REDUCTION

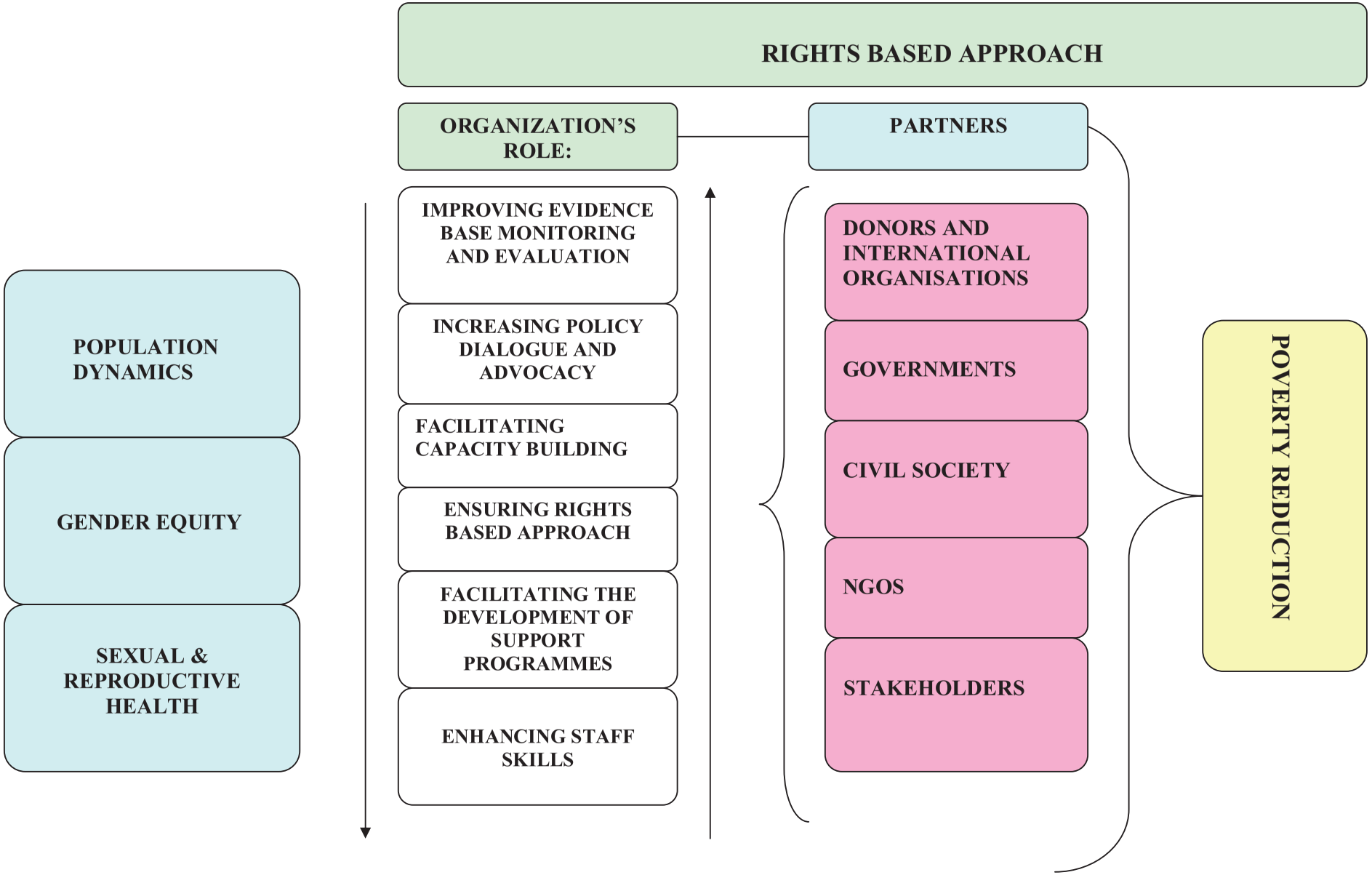
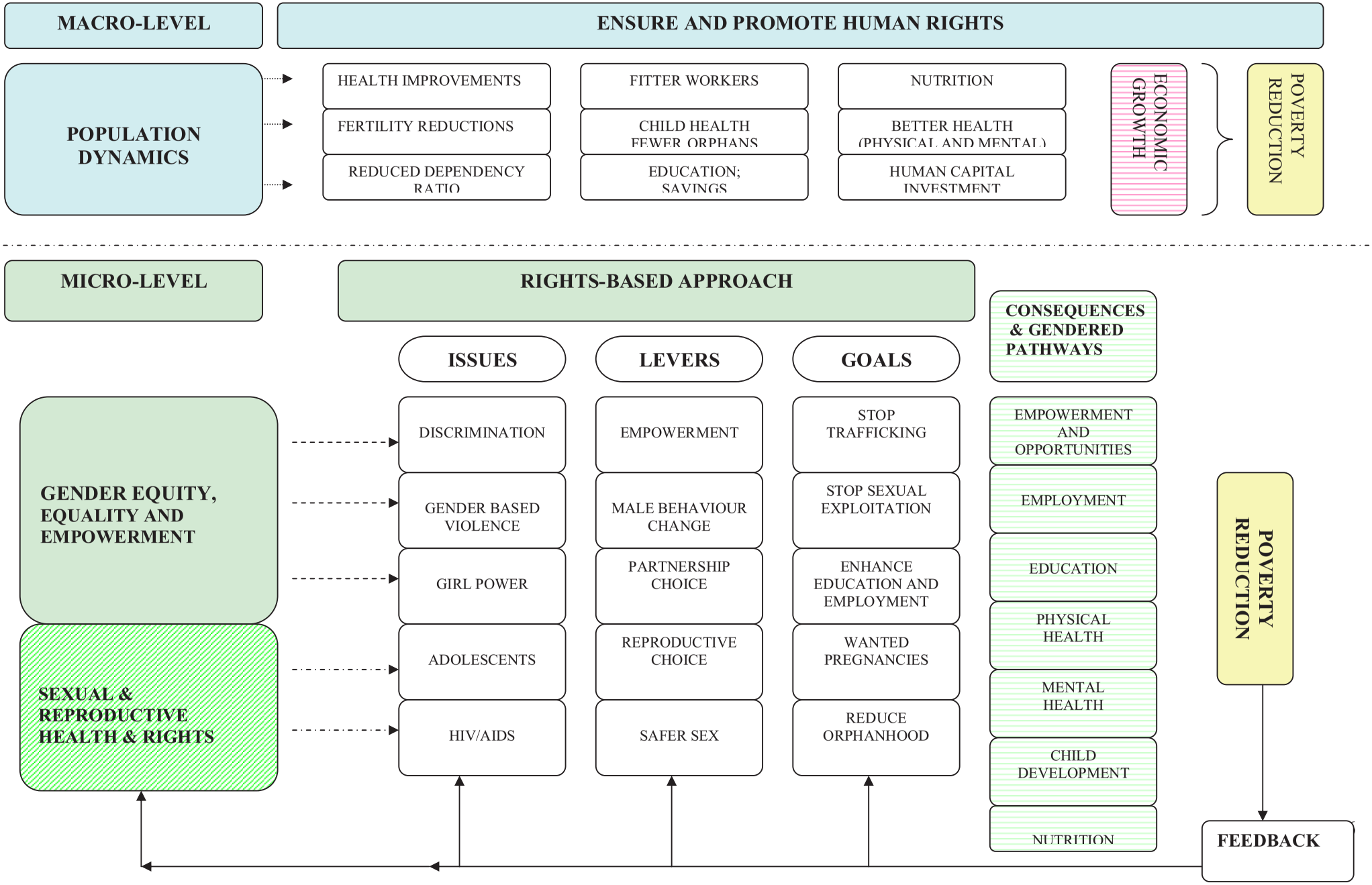


FIGURE 2. PATHWAYS TO POVERTY REDUCTION



Part II

The Panel's Contributions

The Continuing Challenge of Population Growth

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The presentation will make one central point but to do that I need to start well before the 1994 ICPD.
UNFPA was established as a separate agency in 1969 to coordinate the international response to the problems of rapid population growth in the poorer regions of the world, which were perceived to be a major barrier to economic advancement.

Since 1969 efforts to moderate rapid growth, primarily through the promotion of family planning, have succeeded beyond the expectation of many experts. In Asia, Latin America and to a lesser extent the Arab States fertility has fallen sharply and the end of high population growth is in sight. UNFPA can take much of the credit for this success

I draw the following three lessons from the past 40 years:

1) National family planning programmes can, and often have, accelerated fertility declines and less commonly initiated them, even in poor and largely illiterate societies, such as Bangladesh and Nepal in the 1980s.

2) Most effective programmes devoted considerable energy and funds to mobilisation of public opinion in favour of family planning and the concept of smaller families. The simple provision of services was rarely sufficient and a large body of research has failed to demonstrate convincingly that physical access to services is the all-important factor. But, of course, an emphasis on mobilisation of pubic opinion can easily transform into authoritarian programmes and, in extreme cases, into coercive ones.

3) Improvements in the position of women in society have been more a consequence of smaller family sizes than a cause of them.

Paradoxically, during the heyday of UNFPA and the heyday of international investment in family planning in the 1980s, economists could adduce precious little evidence that rapid population growth did indeed impede economic and social progress (US National Research Council 1986). But in the last 10 years or so, the work of US economists Kelley, Bloom, Williamson and others has led to a new, more confident understanding of population-economy links (Birdsall, Kelley & Sinding 2000). The crucial shift in the evidence was due, at least in part, to the disaggregation of population growth as a unitary concept into its components (mortality decline, fertility decline and changes in the age structure). The results of this relatively new work by economists may be summarised as follows:

a) Mortality decline has a beneficial effect on human progress as it allows greater investment in human capital and is associated with better health, leading to higher productivity.

b) Fertility decline has several beneficial effects on economic progress: an immediate one because of the fall in child dependency burdens; a culture-specific one because of freeing more women to enter into the labour force; and a longer term one, acting through the impact on the age structure.

c) Neither mortality nor fertility decline guarantee rising prosperity, because many other factors including the policy environment are influential, but they do make economic gains more feasible.

Before the advent of this new evidence, however, UNFPA had made a decisive break from its historic mandate towards a broader, more diffuse agenda of women's health, gender equality and reproductive sexual rights. The reasons for this shift at the 1994 ICPD have been widely debated, but perhaps one key factor was a feeling that the population problem was largely solved and that radically new goals were required to prevent UNFPA from sliding into irrelevance.

I have been asked to talk specifically about the ICPD Plan of Action and poverty reduction, which is the overridingly important MDG. I will focus the rest of my presentation on Africa. There are good reasons for this:

1) Sub-Saharan Africa is the only region where poverty has worsened in the past 20 years rather than improved.
2) On present trends, it is likely in the next 2 decades that extreme poverty and underdevelopment will become a predominantly African problem
3) There now appears to be a realisation among the rich nations of the world that a continuation of the status quo in Africa is totally unacceptable and requires radical action: hence the agreement of the G8 in 2005 to write off debt, increase aid and begin to dismantle trade tariffs that disadvantage African countries.
4) Africa is the one remaining region where the end of rapid population growth is NOT in sight, but also the region where HIV/AIDS is having the most severe effects.

Population projections

The population of sub-Saharan Africa, now about 750 million, is projected by the United Nations to increase by almost 200 million per decade, reaching the 1 billion mark in about 2020 and 1.7 billion by 2050. Thus population size in this region is expected to more than double in the next 45 years. By mid century, Africans will comprise nearly 20% of world population. The regional figures, however, mask huge inter-country differences. In Southern Africa, populations are projected to remain static or even drop because of the combination of well-entrenched declines in fertility and high AIDS-related mortality. At the other end of the spectrum is a group of countries with exceptionally high fertility levels, whose populations may treble in size by 2050. For instance, the populations of Burkina Faso, Mali, and Niger, currently 10-15 million each, are projected to reach or even exceed 40 million by mid century, while Uganda's population is projected to grow from 29 to 127 million.

The validity of these projections depends largely on the future course of fertility. Continuous falls in fertility are projected by the UN, with Southern Africa reaching replacement level in 2020 and other sub-regions of sub-Saharan Africa reaching about 2.5 births per woman by 2050. Only time will tell whether these expectations of fertility decline are valid, but to me they appear somewhat optimistic, at least for Central and West Africa, where desired family sizes remain high (5-7 children) and use of modern contraception is still below 10% in most countries.

HIV/AIDS in Africa

The validity of population projections also depends on the future course of the AIDS pandemic. The prevalence of HIV infection in adults aged 15-49 in the region as a whole has been stable at about 7.5% over the last 5 years, indicating that AIDS-deaths have been balanced by new infections. Disaggregated trends since 1997 show: a continued increase in the very high levels in Southern Africa; modest decreases in Eastern Africa; and little change in the low levels of infection in Western Africa. At the end of 2003, HIV prevalence estimates were available for 38 countries in Africa. Six of these recorded HIV prevalence of 20% or more; 5 had a prevalence of 10-19%; a further 8 had a prevalence of 9%; and the remaining 19 were below 5% (UNAIDS 2004).

The most thorough published attempt (by the UN Population Division) to project the future course of the AIDS pandemic suggests that HIV incidence may already be declining in many African countries and that epidemics in West and Middle Africa will not follow the devastating trends in Southern Africa (United Nations 2002). The reasons for the huge difference between the sub-regions of Africa in the dynamics of HIV are still poorly understood but probably have more to do with biological factors (in particular the circumcision of men) than with behaviour. An epidemic that peaks at 3-5% prevalence in the adult population, which may prove to characterise many African countries, corresponds to an average lifetime risk of infection of 12-16% and, in the absence of drug therapy, would reduce life expectancy by 3-6 years. The direct effect on population growth will be modest and the impact on macro-economic prospects is also likely to be minor, bearing in mind that most African countries currently have high levels of unemployment or have to absorb surplus labour into the ill-paid informal sector.

From this brief sketch I draw 2 lessons:

1) In a minority of African countries – mainly in Southern Africa – AIDS is a far bigger threat to poverty reduction than continued population growth – not least because it robs so many families of their main breadwinner. In these countries expenditure on AIDS therapy and HIV prevention is a humanitarian and economic priority.

2) However, in the majority of countries the reverse is true – on present trends rapid population growth is a greater threat to achieving the MDGs than AIDS. In countries whose populations are expected to double or treble in the next few decades, there is a very real danger that the number of people living in abject poverty will increase rather

than fall. Food security will be jeopardised in already malnourished populations, pressure for international migration will increase and dependence on foreign assistance prolonged. And rapidly growing populations will place a huge strain on environments, particularly in the fragile eco-systems of the Sahel.

I am not alone in holding this perspective. Individuals far more powerful than me tend to agree in private. But in public statements and agendas for action, there is a conspiracy of silence. The problem of HIV/AIDS is widely discussed and frequently characterised by top figures such as Kofi Annan and Tony Blair as the main barrier to poverty reduction in Africa. However, no-one appears willing to discuss the implications of continued rapid population growth and high fertility for the achievement of MDGs in the region. Let me illustrate the point with two influential reports released this year:

1) **UN Plan to Achieve MDGs** – this 74-page report dispatches the topic of population growth in two paragraphs (UN Millennium Project 2005).
2) **Commission for Africa Report** – in 13 pages of recommendations, no mention is made of the need for, or even desirability of, population stabilisation (Commission for Africa 2005).

The very high profile accorded to AIDS in conjunction with a reluctance to address rapid population growth is already having unfortunate consequences. First, HIV/AIDS programmes in Africa are becoming progressively decoupled from reproductive health/ family planning programmes. Second, funds are drifting away from reproductive health/family planning to AIDS (United Nations Population Fund, 2004). From Ghana, for instance, comes disturbing evidence that family planning services are suffering because of the diversion of staff and funds to AIDS: this is a country where more women die of unsafe abortion, itself an indication of lack of adequate contraception, than from AIDS (Mayhew & Adjei 2004).

Conclusion

My central conclusion is this:

If UNFPA is to play a major part in poverty reduction and in achieving the MDGs in Africa, it has to return, to some degree, to its pre-ICPD mandate – one that links fertility-decline and lower population growth to better prospects for poverty reduction. Universal access to high-quality family planning and reproductive health services is, of course, important but of equal importance is advocacy and publicity to legitimate modern contraception and the concept of smaller families.

Such a return to UNFPA's historic mandate can be accomplished without jeopardising the core values of sexual and reproductive rights, enshrined in the ICPD. UNFPA should say loudly and clearly that there need be no contradiction between: vigorous promotion of family planning as one pathway to poverty reduction; a more holistic approach to reproductive health; respect for freedom of reproductive choice; and continued efforts to check the spread of HIV.

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The Way Forward: Changes in Population Structure [1]

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Population, ICPD+10, & the MDGs

The Cairo International Conference on Population and Development (1994, ICPD) set out an agenda to be followed by the international community and by agencies. This paper looks at what is needed to respond to the major questions of population and development unfolding over the next 10 years, and beyond. It asks how well the international community is prepared, on the baseline inherited from Cairo and on major relevant policy pronouncements since then, to address the issues population change generates. It will focus on the Millennium Development Goals (MDGs) which represent the most widely accepted post-Cairo global consensus on and summary of these questions. This paper thus has three objectives:

Firstly, it asks what the emerging demographic patterns are, and thus what are the broad parameters for programmes in ICPD + 10. The ICPD + 10 is a programme whose overarching *raison d'etre* is to address issues of population and development: it must therefore respond to population needs that have changed very significantly since Cairo. Thus an evidence-base relating to demographic changes must set the agenda not just for the ICPD + 10, but as a corollary it should also provide the basic parameters for the programmes to be pursued to achieve the MDGs. This paper argues that the dialectic pursued at Cairo set an agenda that did not satisfactorily address some major population and development issues. It is also necessary to criticise the MDGs for being a-demographic. These are not academic issues, for, in both cases, these *lacunae*

[1] **Acknowledgements:** In March of this year I carried out a mission for the Namibia UNFPA office. This provided me with the opportunity to refresh and test some of the ideas I was developing for this paper. I am particularly grateful to the Representative and her Field Staff there, and the many Namibian officials, who, in discussions on Namibia, helped me to sharpen my ideas. I would also thank Christopher Mwaijonga of the Tanzania office who was there at the time and with whom I had a number of very useful discussions. Statistics South Africa also invited me to present a paper, coming out of CICRED work (eg Pool *et al* eds, forthcoming), and I value their responses. That said, I am solely responsible for all comments here, and they do not necessarily reflect the views of either the individuals or agencies noted above. I am also grateful to the participants in the two UNFPA – supported CICRED Seminars in Paris (Feb 2004) and Trivandrum (Feb 2005) on which I will draw heavily. Empirical data used here has been analysed as a part of funding support from the New Zealand Foundation for Research, Science and Technology, under the "*New Demographic Directions Programme"*. Finally, I thank Sandra Baxendine, formerly Research Statistician, Population Studies Centre for the assistance with the statistical data presented here.
[2] **Support**: I wish most sincerely to thank UNFPA for inviting me to participate in this Panel in a Plenary Session. The significance of the session, to provide an interface between the policy and scientific communities, was underlined by the Deputy Executive Director of UNFPA in his comments to the Opening Ceremony of the Conference. I also thank the other panelists whose ideas were challenging and interesting, and were so well articulated that my role as discussant was minimised; thus in this paper I have focused on what was my other brief for the session, to look at the way forward.

significantly reduce the likely effectiveness of policies and programmes on population and development.

Secondly, it then asks, briefly, how well the international community is situated to respond to meet these needs –this takes it into a brief discussion of the Millennium Development Goals (MDGs). In the MDGs, one of the three major planks of the Cairo ICPD has already been redefined by the international community, which has shifted the focus from population and development in general to poverty reduction. Of course, civil society has not abandoned development as a generic goal, for poverty is essentially the flip-side of the broader development question, the failure of development, but this does signal a significant shift in emphasis and therefore in programme implementation.

Finally, it will ask can the ICPD 0-9 move seamlessly, or not, into ICPD + 10, in this case focussing on the experiences UNFPA might bring to this. The argument here is that UNFPA has specialist experience and expertise that could enrich the programmes directed to poverty reduction.

Population & Sustainable Development

Central to all agendas pursued in the ICPD + 10 must be responses to emerging population patterns and trends, and population must also be integrated far more effectively into planning for the MDGs. It should not be necessary to define what is meant by the term demographic, but, unfortunately, what demography is about was badly misrepresented at Cairo as something akin only to pure head counting or as setting targets for reductions in population growth, and this somehow, and perversely, became translated almost into seeing any focus on macro-demographic issues as antithetical to concerns over people.

Those of us who were working in the population and development field in the 1960s and 1970s did see population growth as a central issue, as it was, but by the 1980s other questions such as those of population structures and migration were coming to the fore, only to be brushed aside as economic planners adopted uncritically and wholeheartedly the doctrines of the market and enforced instruments such as privatisation and de-regulation, and restructuring regardless of their consequences for human capital. This is the core concern of demography and of population programmes; in the market model the bottom line is efficiency, not effectiveness in responding to the needs of the people.

The issue of rapid population growth has not, however, disappeared over the horizon forever. John Cleland's paper in this series, highlights how it is still very much a social and economic development issue, for example being at the heart of concerns about poverty in Sub-Saharan Africa. The calculus has, of course, become more sophisticated since Cairo, so that analyses of the quantum of human capital, for example, are modified by research on its quality (see *POPNET,* Autumn, 2005, summarising many studies by IIASA and its collaborators, eg Goujon forthcoming). In reality, of course, a population is no more than the people as a collectivity, and thus population must be the unit of reference of the ICPD. As we say in New Zealand *He tangata, he tangata, he tangata* -- it is the people, it is the people, it is the people.

The reasons for the misrepresentation of demography at Cairo are not clear and in any case are not particularly important for this paper. This strategy may simply have been tactically advantageous for some groups with focussed agendas. Whatever the cause, a consequence has been that over the ensuing years there has been a downplaying of the significance of broader questions of population and development. Often other parts of the United Nations family such as UNDP have assumed from UNFPA some of the lead roles in population activities. As Gavin Jones has pointed out, the consensuses achieved in the lead up to Cairo at regional conferences on broader wide-ranging questions of population and development, not just growth and population control, were "upstage[d]" at the final preparatory stages before the global meeting. This produced a document that emphasised reproductive choice and reproductive rights, and conversely other population issues were not given priority (Jones 2005).

All reasonable observers see reproduction, and intimately linked factors of female empowerment and gender equality, as among core issues of population and development, but at Cairo they became its overarching agenda. This emphasis was enhanced by the publicity accorded to the work of the Main Committee charged with drafting the Programme of Action, whose deliberations gained a high profile in the media, and even among post-conference commentators[3]. In contrast, the questions raised at Cairo by many Third World countries in the Conference's plenary session, in country paper after country paper[4], from the tiny nation-state of Tuvalu that faces inundation through global warming right up to the joint plea of the African countries, dealt with the classical, fundamental issues of development and the role that population plays in this.

The consequences of this may have extended beyond the Cairo agenda and could well be extremely detrimental for the science of demography and its policy applications – they certainly appear to have been sidelined. It is a sad fact, for example, that the MDGs have been framed seemingly almost in the absence of any understanding of the central role of population patterns and trends in shaping the problems they address, and also in addressing some of the solutions.

There is also a pragmatic aspect to this. If programmes to implement social, cultural, health and economic policies, including, *inter alia*, those on reproductive health and choice, are to be efficient, and, assuming that resources will always be finite, this means that they must be prioritised by targeting them most at groups in need. In short, the donor community and executing agencies must know a lot about such groups: they must understand their demography – their numbers, their gender, their ages, their cultural characteristics, their health levels, their family characteristics, where they live, their incomes, and other relevant attributes. During implementation phases we must also be able to monitor how these changes have affected these groups, and finally to evaluate impacts of macro-demographic, health economic and other policies on the population, including most urgently poverty reduction.

In passing, one should note that the population and development perspective outlined here is not the same as that in the pre-Cairo agenda, which was not demographic in

[3] Notable exceptions were the critiques by francophone scholars, such as that by Vallin (1994) who said "this conference on population and development hardly ever dealt with development" (my loose translation); see also Loriaux's (1994) commentary entitled "Les mysteres de la Grande Pyramid".
[4] The author was in the New Zealand Official Delegation and monitored that session.

the wider sense employed in this paper, but instead revolved around family planning targets and population control. As John Cleland has argued, these were valid for their time, and had wider development implications that probably still apply today for Sub-Saharan Africa. But, as will be shown later in this paper, development agendas in Africa must take into account not just growth, but also age- and other structural changes, recognising that the mix of growth and various sorts of structural transition varies between Sub-Saharan Africa countries.

There is another dimension to this. Populations are also the universes that policy makers address, and thus demography is the core material of all policy[5], not some exogenous afterthought. The recent work by economic-demographers, such as Bloom et al (2003) and by former IUSSP President Jose de Carvalho (these and other studies are summarised in Pool and Wong forthcoming; see also CICRED Policy Paper, Adieotomo et al 2005), has demonstrated how central demographic factors are to the whole development process. This extends well beyond the social sectors into the economic and even financial sectors (eg Higgins and Williamson 1997). This research has underlined the need for the serious endogenisation of population factors into development, in all its sectors, and thus provides a basis for the most important arguments here.

To achieve the overarching goal for the global community, sustained economic growth and sustainable development (a catch-cry at Cairo), the ICPD + 10 must start off by setting out the population parameters, to see if they differ from what we have seen over the last 10 years. This is because significant shifts have occurred in both population dynamics and structures. Thus the next three points I will cover in my paper are demographic and are as follows:

1.That the world and most regions are no longer facing simple issues of growth but instead also will have to meet head-on the impacts of compositional change. That said, as will be discussed later, momentum effects coming from these changes will have major impacts on growth.
2.That major development issues for the second decade of the ICPD revolve around the implications of massive demographic structural changes.
3.Thus, that there is a need to refocus some parts of the ICPD Programme of Action so as to account for shifts from growth-driven change to structure-driven changes; this is not a call to rewrite the Programme of Action, but to refine parts of it to meet emerging needs.

Population Trends Affecting Development

In the past, population factors have been poorly integrated into development, and overlooked in analyses of both success and failure. For example, Yan Hao (forthcoming) has commented that China's economic growth 1980-2000 "[is] commonly attributed to government introducing policies such as economic restructuring, market liberalisation, and opening up to the outside world. Rarely

[5] The interest in demography by agencies such as the CIA witnesses this. In contrast, fiscal and financial policy is typically seen as unrelated to anything that happens to the population, but a moment's reflection shows that this is a false view. Who pays the tax is very much demographically driven, as is the question of who needs tax support.

mentioned is the contribution made by a growing labour force and a falling dependency burden…" A major reason for such failure to recognise the role of population factors has been that the analyses used were very crude, typically involving simply looking at the co-variance of population growth and changes in GNP.

The recent research noted earlier (eg Bloom *et al* 2003) has, however, changed the population and development equation. Its focus, instead of growth, is on age-structural transitions (ASTs) driven primarily by fertility declines, and it has demonstrated very strong linkages between these population trends and development, far stronger than had been shown in the past. This is a relationship that does not, however, constitute a "stunning new argument" but had been established many years ago by Ansley Coale and Edgar M Hoover (Jones 2005:7). Moreover, it can draw on powerful theoretical mathematical investments -- albeit limited in number -- that relate to ASTs (eg Coale 1972; Keyfitz 1968). Nevertheless, these important studies barely flowed into the related empirical areas, for a reason that is obvious: over the last decades of the 20th century empirical demography, as well as its theory and methodology, had to devote its energies to the population growth crisis. The age-structural work was typically directed towards solving issues relating to stable and quasi-stable population analysis, and thus the elaboration of indirect estimation techniques.

This paper will focus on ASTs, and is directed at national level populations, but it must be noted that for many societies other structural imbalances will also be as important, sometimes more important. Rapid urbanisation and other aspects of geographical distribution, or labour force transformations, come immediately to mind. In most of these cases, however, there are also coterminous age-structural transitions, while labour market dynamics are intimately linked to population redistribution, which, in its turn, is likely to have major age-structural implications. Socorro Gultiano and Peter Xenos (forthcoming) have shown how in the Philippines all these trends come together, in particular affecting youth, an age-group of major concern. In a sense, therefore, the emphasis here is simply to use ASTs to highlight what are likely to be very complex multi-dimensional changes in population dynamics and structures. While for practical reasons in a paper of the length of this one, structural changes other than ASTs will remain very much minor sub-plots, this should not imply that they should be ignored. ASTs and the other closely interrelated transitions (the links are spelt out in Pool forthcoming) together constitute both the demographic determinants and the consequences of the major issues being addressed by the MDGs.

Turning back to ASTs, there is a very simple reason why the passage of cohorts of differing size across various life-cycle phases has effects on both policy and markets: each life-cycle phase has different needs and market demands. As if to reinforce this, sectoral policies tend to focus on different age-groups (eg education for the young; housing for people at family-building ages; income support for the elderly; etc). To add to the power of this argument, planning methodologies recently have moved away from the highly centralised model of the 1960s or 1970s to more flexible forms, typically focused on sectors. This basic idea – that needs vary across the life-cycle -- is hardly new, but was formalised, in relation to health services, as least as far back as the early 1970s (Corsa and Oakley 1971; developed further in Pool 2005). But given

this new outburst of interest, it is necessary to ask how emerging population trends, particularly age-compositional changes, will force us to amend the Cairo agenda[6].

The World and most regions are shifting, or have shifted, from change driven primarily by natural increase, modified by migration in the case of some countries (I will call this growth-driven change), across to change driven by shifts in composition. In part the composition-driven changes come from problems of momentum produced by large cohorts born in the past working their way up the age pyramid.

Growth-driven change had been the dominating global population factor of the last few decades, but growth rates are now declining. Table 1 summarises the deceleration in growth rates. This shift is not even. Growth is still the driver in most of the least developed countries. But even within Sub-Saharan Africa there are differences between South Africa that will have a growth rate of only 5% in the first 15 years of the new millennium, as against Congo that could see an increase of 56%. And momentum is not just a factor affecting countries whose growth rates have dropped at every life-cycle phase in succession – Congo or Nigeria will also face momentum effects, a tidal wave that will just get stronger and stronger, the famous doubling phenomenon. In contrast, for Kenya the momentum takes the form of a wave, followed by a trough, and when the first wave hits the parenting ages the number of births will increase, producing a follow-up wave, even though fertility rates have dropped – I will call that process secondary momentum.

Table 1.
Total population growth (%), over 15-year periods, 1970-1985, 1985-2000 and 2000-2015, regions and selected countries

REGION/COUNTRY	1970-85	1985-2000	2000-2015
WORLD	31	26	19
MDCs	11	7	4
LDCs minus LEAST DEV.	38	29	19
LEAST-DEVELOPED	46	47	41
South Africa	46	38	5
Kenya	74	56	44
Congo	58	55	56
Nigeria	51	50	37

Source: UN *World Population Prospects 2004*. Regions used in this paper are defined by the Population Division in their publications and data sets.

[6] The comments come in this part of the paper draw on work I was involved in on the IUSSP Committee on age-structure and policy headed by Shripad Tuljapurkar – our first book has been published this year (Tuljapurkar et al eds 2005). Also work done for CICRED and funded by UNFPA, summarised in a policy paper (Adieotomo et al 2005). Greater detail will be available in chapters in a book in press edited by Ian Pool, Laura Rodriguez Wong and Eric Vilquin. The various AST analytical frameworks are discussed there in a chapter by Pool and Wong.

Table 2
Secondary momentum effects, 1955-60 to 1995-2000, declines in fertility and changes in the numbers (000s) of births, selected countries undergoing rapid declines in rates

COUNTRY	1955-60	1975-80	1995-2000	2015-2020
Bangladesh				
TFR	6.8	5.6	4.0	2.5
Births	2,506	3,519	4,483	4,065
China				
TFR	5.6	3.3	1.8	1.8
Births	23,735	19,948	20,658	18,157
Kenya				
TFR	7.8	7.9	4.6	2.8
Births	430	703	1,066	968
Mexico				
TFR	7.0	5.3	2.8	2.0
Births	1,684	2,507	2,434	2,052
Thailand				
TFR	6.4	4.0	2.0	1.8
Births	1,174	1,390	1,109	980

Source: Population Division (UN) (2004)

Because of secondary momentum the volume of births remains very large in numerous countries, even though fertility rates have declined. For example, in Kenya and Bangladesh, as Table 2 shows, even though there were significant declines in their TFRs from 1955-60 through 1995-2000 (41% in both cases), they also faced increases in birth cohort sizes of 1.8 and 2.5 times respectively. Moreover, the projected numbers will continue to be high in future even though their rates will go right down towards replacement. Beyond this, in many countries the age structures of parenting have changed very significantly, often leaving the force of reproduction at young ages (< 25 years), despite the fact that the TFR may be much lower today. The programmes of reproductive health discussed in Pascoal Mocumbi's paper will not only have to be reinforced, as he so rightly advocates, but will also have to be targeted in much more refined ways (eg less focus on married couples and more on sexually active young individuals) if they are to be successful – this requires good health demographic planning.

For some countries the cohort waves will take the form of tidal waves to at least the year 2015, whereas in other countries, India and France for example, the age-structural transitions will be gentle. A third set of countries will face a series of waves of different magnitudes followed by troughs of different depths and durations – China and Russia are two extreme examples – in short disordered cohort flows. A tidal wave will make programme implementation extremely difficult to achieve as efforts in all sectors will have to be increased simultaneously and exponentially. John Cleland captures this in his paper. Yet equally well, the population needs for much slower growth countries with a high degree of turbulence due to disordered cohort flows will also require complex responses, often demanding rapid increases in social services, then downsizing them as the wave passes.

This brings this paper back to Bloom *et al (*2003*)* who talk of a "demographic dividend/bonus", a phenomenon that they have empirically demonstrated, and which should occur when youth dependency rates drop but aged dependency rates have not yet gone up. Their model is rather deterministic, arguing that, as a result of this bonus, over a defined period, nations will be able to make the transition from less-developed to more developed. Putting to one side the objection that improvements in some macro-economic indices could be accompanied by growth in inequalities, and assuming that their argument applies to social as well as economic development, there are other concerns. Firstly, the period for the demographic dividend will typically be shorter in some less-developed countries that have undergone rapid fertility declines, and secondly many of these lack the capacities for take-off. Jose de Carvalho and his colleagues thus refer instead to the dividend as a "window of opportunity", in my view a much more realistic term, a potential but not a certainty. Secondly, more refined work on cohorts with small age ranges by the IUSSP Scientific Committee on Age Structure and Policy, and in research presented at a recent CICRED meeting funded by UNFPA has shown that the reality, and thus development planning, will be even more complex and confounded because of the age-structural perturbations produced by disordered cohort flows (Tuljapurkar *et al* (eds 2005; Adieotomo *et al* 2005; Pool *et al* eds forthcoming).

Whether some Less Developed Countries, and especially the Least Developed, will be able to realise on the demographic bonus or will miss the window of opportunity it might afford remains to be seen. But this raises other important wider issues stemming from the international mobilisation and support proposed in MDG 8 on partnership. This will have to be initiated immediately and effectively if the window of opportunity is not to be missed. In turn, effectiveness will be determined to a significant degree by rapidly changing demographic trends during ICPD + 10 to be discussed below. This then poses another more basic question coming from the fact that demographic factors play a major role in determining poverty, and can be seen as a consequence of it. As these factors are changing rapidly and, in the case of ASTs, inexorably, might an emphasis on poverty reduction *per se*, rather than development in general as a means of avoiding poverty (coupled of course with targeted programmes for those genuinely in need), be less effective in the sense that agencies look for instant cures but do not introduce preventive measures? After all, a failure to accord development support to populations that are not yet facing poverty may take them across the line to swell the numbers of those who are already poor, and who are presumably the targets of MDG1. Furthermore, will the concentrating of resources towards poverty reduction mean that development programmes will be deprived of resources and thus further poverty produced? And what about the World Bank and IMF programmes of restructuring that are enforced on many countries and that have increased inequalities? Will these programmes continue unabated but outside the domains in which the MDGs will be operating?

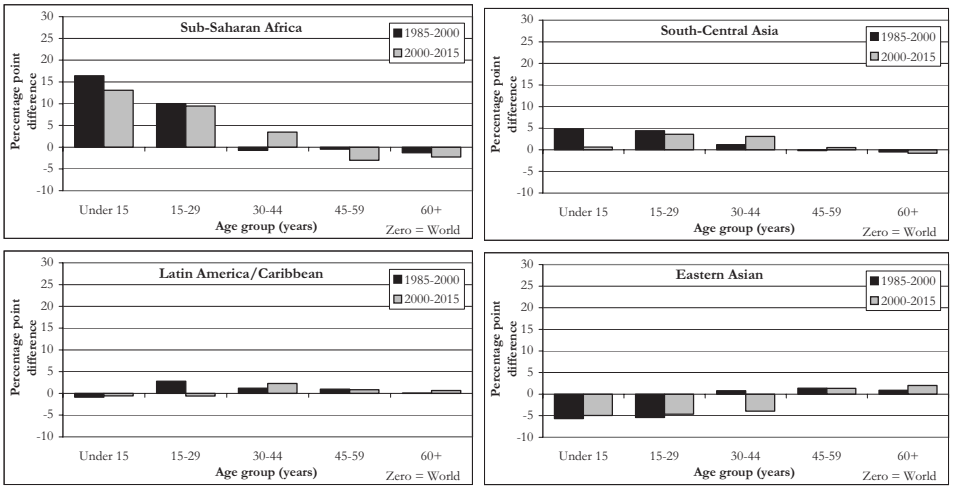
The empirical evidence shows that age-structural transitions have been unfolding over many decades. Typically they were launched by the improvements in survivorship at young ages that increased the sizes of child populations, and then following this the fertility declines of the 1970s and 1980s, or earlier in many cases, that took the AST in an opposite direction. But as was noted above, over the next decade or two age compositions will change significantly.

The perturbations created by population waves are, therefore, not just phenomena that will unfold over the long term, but they will have an impact in the immediate future. To illustrate this very important point age-structural changes for major age groups representing life-cycle phases are graphed in Figure 1 for two periods, the recent past (1985-2000) and the near future (2000-2015). These graphs show how case-study populations will deviate from world's patterns. Figure 1 refers to selected regions (UN classification) while data relating to case-study countries are cited from a paper in the press (Pool forthcoming, using data from Pop Div, United Nations, *World Pop: 2004 Revision*).

The period over the next 15 years is going to be structurally turbulent, especially for many Third World populations. Because of the ASTs alone, many developing countries will face waves passing through key life-cycle stages, often with marked ebbs, over very short durations. Most radical in some ways, at least in terms of deviations from world patterns, is Sub-Saharan Africa, and two of its giant nation-states, Nigeria and the Democratic Republic of Congo, that are even more extreme. High levels of divergence from global patterns indicate that, relatively, pressures on policymakers for strategies affecting 0-29 year-olds will be severe, but will that decision-makers will also have to deal with the fact that the wave will have shifted to 30-44 years over the period 2000-2015. This is a "tidal-wave" effect coming largely from simple momentum, especially for Nigeria and the Congo.

Not all African countries fit this pattern. South Africa and Kenya , even more so, have structures that look more like those of South Asia, a region which, to a significant degree, is driven by what happens in India. In all these cases relative pressures shift from the child ages (0-14 years), remain strong at the youth ages (15-29), but also shift up into age group 30-44 years.

Figure 1
Growth by age: percentage-point difference between the world and selected regions



Latin America and the Caribbean will have moved further along this path. Relative to the world as a whole pressures will be less at childhood, will decline and become less at 15-29 years, but will increase at 30-44 years, and start to appear at older ages.

Mexico and Brazil are more extreme versions of this pattern producing, in the case of Mexico, marked waves. Thailand from outside this region is an even more extreme version of the pattern also seen in Mexico and in Latin America and the Caribbean.

East Asia is dominated of course by China. There, the declines in pressures at 0-14 are particularly strong. By 2000-2015, pressures will accelerate at 45+ years. In the MDCs the Russian Federation is notable for the waves and ebbs in adjacent 15-year age groups, constituting a very destabilised pattern.

It will be evident that this paper has not discussed ageing – instead it has emphasised a far more urgent issue -- changes over the next few years due to population wave effects. The emphasis here thus contrasts with the focus on ageing, as against youth, in the discourse on age-structures. It is the emphasis on ageing that has played a significant role in the direction of regional or country programmes since the ICPD in the area termed "population and development" (as against reproductive health and gender inequalities that are typically separate components). This problem goes back to an unfortunate bias in the programme of action prepared for and adopted at Cairo. In the key chapter (VI), youth, belonging to the narrow age-span of 10 years (15-24 years), comprising just under 20% of the world's population, were bundled into a section along with children – together these two age groups almost made up a majority of the world's people (49% in 1995). Within that section more of the emphasis was on children, and only two "actions" were directed specifically at youth (6.13 and 6.15). Yet persons aged 15-24 years are arguably an age-group pivotal to all social and economic change, for as Rindfuss (1991) points out they are a "high demographic density" age-group, facing biological maturation, likely to be mobile, completing formal education, starting a job and also perhaps starting a family. All of these are behaviours central to the population and development arena. In contrast the aged (anyone over 65 years) who at the time of Cairo comprised only 6.5% of the world's population, received their own section. It is not for me to speculate here why such a bias should have occurred, but the implications have been obvious to persons working in the field: ageing has been given far more attention in both policy and research than the urgent problems of youth and development, even in countries that will not become aged until far into the 21st century, and that face major more immediate crises coming from ASTs and their attendant momentum effects.

Throughout the ICPD + 10 period youth will continue to constitute about 18% of the world's total, although there will be marked inter-country differences between, for example, Russia where only 11% of the population will be aged 15-24 years in 2015, and most African countries where they will comprise more than 20%. In contrast the population aged 65+ years will still only be 8% of the total in 2015, and a mere 6% in the LDCs. It is only for that minority of the World's population (17%) who will live in MDCs in 2015, where the elderly will outrun youth (18% of the total vs. 12%). Youth then are clearly a constituency around which the ICPD + 10 must urgently formulate and implement a range of demographic, social and economic policies.

Many of the world's youth will have grown up surrounded by chronic poverty –- in fact this will be disproportionately their lot simply because they are overrepresented in the Least Developed Countries. This further underscores the point that the demographic bonus is not something that is assured. If lowered dependency ratios and higher proportions at working ages, set the key parameters for the potential

achievability of the ICPD agenda, as Bloom *et al*'s (2003) findings so persuasively argue, then we must also recognize that the ranks of the working age-groups will be being increasingly joined by those from the South who, through no fault of their own can bring few skills and little equity to the equation (see *POPNET*, 2005).

Emerging Strategic Directions: The ICPD and the MDGs

This paper now turns to the policy environment and uses the MDGs as a guide. They are somewhat imperfect, or as we say in English "a camel, a horse designed by a committee", but they are there and thus can not be ignored. To cite a wider context for the discussion here one can refer to Gita Sen's paper, which has set out many aspects of the policy environment. Her comments at Tours covered all of the population and development issues, for which she sees gender equity as the central factor. The present paper differs slightly in that it views MDG1, poverty and hunger, as the central goal, with MDG3 on empowerment of women as an essential component of that. But equally well it is impossible to see how the other Goals, especially those dealing with mortality, are separate from poverty and hunger[7]. In this regard there is a need to "demographise" the MDGs, as a major step to making them responsive in an efficient way to the health, social and cultural needs of societies, or populations, instead of being simply baskets into which to toss bucket-loads of money.

It is here that ICPD + 10 must play a central role, and UNFPA must coordinate this. It has real expertise in pioneering policy strategies in the field. Much of its programmatic work at the country level should continue to be focused in its major domains of competence, reproductive health and the empowerment of women. But it has to extend its vision into the broader areas of poverty more assertively than is being done at present, emphasising their social dimensions and showing how the different MDGs, except for MDG8 which properly speaking is an enabling MDG not a substantive one, are really elements of the same picture that portrays population and poverty as the central dual problem. This even includes MDG7, on the environment, for people are the main ecological actors.

This then relates to the issues, but what about the implementation of programmes? It is at this point that an appeal can be made to the strategies formulated at Cairo and implemented since, especially by UNFPA. This agency could be seen as the action arm of the demographic community, intervening to mediate the problems produced by disjunctions between population and development.

In passing, one must recognise that UNFPA has its own limitations. It is not so much a donor agency – many other multi-national and bi-lateral agencies, and even non-profit foundations, have far more means at their disposal. Rather UNFPA must be a catalyst including of course in those areas such as reproduction where its experience is most well-developed: its particular role is to sense out emerging issues, to pioneer programmes in the field and to mobilise donors. This special role as animateur is recognised in the strategic directions the agency has recently formulated for itself; as these are on the public record they do not need to be spelt out here. But to be more

[7] This was the most central conclusion of a Policy Paper written by a committee drawing on the UNFPA-funded CICRED Seminar, in Trivandrum in Feb 2005: "Poverty, Mortality and Hunger".

effective, UNFPA will have to pay more attention to the highlighting of emerging demographic issues so as to play a lead role in resolving them, and thus it will have to invest more heavily in population data collection and research by cooperating agencies.

There are also other factors that limit the ICPD's effectiveness. Because of the foci in the Cairo document, at a substantive level in the past there has been an over-emphasis on issues of reproduction. This has meant that UNFPA has, unfortunately, been seen too often as the "United Nations Family Planning Agency"[8]. As noted already, reproduction must be a central concern of UNFPA in budgetary terms and because of the experience it has built up in this domain, and the agency must spearhead the global community's programmes on this. Moreover, reproduction must be seen as an issue in its own right in the pre- and post-Cairo sense of helping couples achieve the levels and patterns of reproduction they desire, in the post-Cairo sense of reproductive and sexual health and rights, in the post-Cairo sense of empowering women, and in the MDG sense of maternal health and the promotion of gender equality. But programmes relating to reproduction should be seen as instruments of much broader population policy and not as the central objectives. An unbalanced focus on reproductive health to the detriment of other urgent population issues, particularly the emerging questions discussed earlier, could have significant negative implications for the resolution of the population and development problematic[9].

The continuation of an imbalanced focus on reproduction might mean that the Cairo agenda will not be facing directly the most difficult emerging population issues. As was shown earlier in this paper, the population issues confronting the globe are not any easier, and may be more difficult, than those identified in the 1960s and 1970s. Then, the challenge may have seemed overwhelming but it was simple – rapid growth. Now, however, the challenge is very complex, requiring policy built on well-developed knowledge bases that recognise the complexities of both population dynamics and demographic structural changes. Certainly the challenges will require multi-way responses, many indirect, whereas for growth the reduction of its impetus through family planning was a direct and singular response.

The strategic focus of UNFPA is, of course, prescribed by the ICPD. In turn the Programme of Action was driven by the issues that were identified at Cairo. Most of the issues identified there were ones about which the global community could have consensus at that time; controversy revolved more around strategies by which to address these. In retrospect Cairo was much more about instruments and mechanisms, reproductive choice or gender equality, than about issues, goals and strategies by which these might be addressed. There is nothing wrong necessarily with this, but what it has meant is that in many ways the ICPD has lacked a vision of where the human species, the global population, should be heading. And it was the downsizing of the demographic dimension in the population and development equation, and thus in UNFPA's strategies, that probably caused this – the ICPD did not provide such an overview.

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[8] In the field this will often be the appellation applied to UNFPA even by other UN agencies. The acronym UNFPA originally stood for the UN Fund for Population Activities and has been retained after renaming it the UN Population Fund.

[9] More pragmatically, this could mean that, once major donors see rates of reproduction decline even in recently high fertility countries, they could decide that UNFPA has fulfilled its mission. This would be disastrous for the UN System, and for population and development.

This is witnessed by the MDGs: they have been written almost as if each sectoral agency, except UNFPA, was to have its own uni-dimensional goal to occupy itself with -- WHO appears to have several. The MDGs read more like the symptom-specific treatments for specific aetiologies, not holistic care of the entire corpus. Beyond this they do not fit some integrated overarching schema, they do not link back tightly into development, which should be the overarching goal, and they are "a-demographic". Essentially, however, the ICPD did not give a platform from which to exert leverage so as to ensure that the goals enunciated in formulating the MDGs would more effectively serve the peoples. This is unfortunate as the ICPD and UNFPA have significant attributes that could serve civil society well. But to realise on these there is a need to turn to the trilogy of: analysing and responding to population trends, that should drive the core business of UNFPA; elaborating the development consequences, and policies formulated to deal with population and development; and UNFPA's own inherent strengths in implementing programmes.

Conclusion

All is not lost, for, to conclude, the ICPD and UNFPA also have many strengths that can be applied to ensure the success of the ICPD + 10. UNFPA can play two immediate roles. Firstly, it should seek to demographise the MDGs in order to make them more socially responsive. To do this UNFPA should exploit the community of demographic experts to help plan, monitor and evaluate programmes – all of which require the analysis of demographic parameters in the way these terms were defined earlier.

Secondly, UNFPA is well equipped by its experience in successful programme implementation at the country level to play a coordinating role, particularly at the field end of such programmes and especially those that deal with reproduction and with gender inequalities. It is clear that addressing these issues will consume a large proportion of their budget. In passing it should be noted that UNFPA is also well qualified to plan and test projects as case-studies at the local level in the field, and then to upscale these to provide a framework for national-level programmes. For these operations to be effective and to achieve the goals of ICPD + 10, the steps necessary for them to be taken down in scale to the local level, and then brought up again to the national level, will require careful planning, monitoring and extrapolation using demographic parameters. And clearly these programmes must be carefully geared to meet emerging population needs.

Cairo provided civil society with a powerful action programme, particularly as this related to reproductive health and the empowerment of women. Whether or not it succeeded as far as its framers would have desired, is arguable. Beyond these two concerns my paper has identified at least two imbalances that have limited the capacity of ICPD to act as a comprehensive blueprint for global population and development, or population and poverty as this might now be rephrased.

In the meantime the World's demography has changed inexorably. John Cleland points to very significant declines in fertility in countries such as Nepal, and the present paper has argued that the emerging population profile is becoming far more

complex. Meantime, through the MDGs, civil society has set out a new global "consensus" on the development issues of the next decade or so. While they need to be stroked and poked to make them more effective, they do provide a useful overall consensus, hopefully for mobilising the international community as per MDG8.

That said, mobilisation is far more than Bob Geldof and the G-8; far more than mere debt relief and other financial measures. At the heart of the success of the MDGs rest the existing and emerging population questions, the people issues, which will ultimately determine failure and success in implementing the objectives far more than the financial dimensions that have the spotlight. Even the simplest question of accountability-- how to target the MDGs most efficiently -- depends on assessing population needs. Thus, the stress in this paper has been on the need urgently to demographise the MDGs.

It is in this endeavour that the special competencies of UNFPA, and the enormous expertise it had built before Cairo and has extended since, must play a particular role. There are two paramount ways, then, in which UNFPA might exploit ICPD years 0-9 to achieve a very effective ICPD + 10. In these regards UNFPA will need to be the catalyst collaborating with other agencies, especially the United Nations Population Division and NGOs, rather than attempting to be the principal or sole player.

Planning and programming

The ICPD set out a number of action programmes for the evaluation, analysis, planning, monitoring and re-evaluation of the key population and development issues. As a matter of urgency age-structural changes and other demographic compositional trends must be given greater emphasis in this agenda because the globe has shifted from an era in which growth-driven change has dominated into one in which structural factors will be the major drivers. Outside the MDGs and perhaps a few other countries where ageing is more advanced, there is a need turn the research and funding devoted to ageing, which is largely the crisis that comes *AFTER* the MDG-era, towards urgent analyses and planning on age-structural and other compositional changes.

The conclusion here must be that UNFPA, in its role as an animateur and by the authority given to it at Cairo, should devote modest but strategically directed sums to generating urgently some sort of interactive planning process that really assesses the emerging demographic trends and fits these to the MDGs. Again it was the Cairo consensus that gave UNFPA its rights and obligations to entertain such arbitrage.

Action programmes in the field

It is here that the Cairo baseline becomes particularly pertinent, for UNFPA has the expertise to move from goals and plans to get applied strategies into the field. These must be country-focused and centre not only on reproductive health and gender equality, but also issues of poverty must be an increasing component. Both improved reproductive health and gender empowerment are, of course, among the significant factors in reducing poverty. Problems surrounding poverty were implicit in the Cairo document but were overshadowed by concerns relating to reproductive choice and

gender equality. Here as noted earlier one might envisage UNFPA as the lead agency, as a pioneer, and with three specific roles in mind:

(i) Scaling down to the local level and implementing there.

(ii) Then scaling back up to the national level so that other larger agencies can come in and build on UNFPA's baseline in full-scale programmes. It should go without saying that both scaling down and scaling up will require the collection and analysis of demographic data so as to make these operations far more efficient.

(iii) And UNFPA must play its traditional function as the member of the United Nations family that identifies key dimensions of and coordinates regional and country population programmes. This should be done within the frameworks provided by the MDGs, as these are amended over time, and would greatly enhance the operational capacity of the international community to meet these global development objectives.

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Reproductive Health Issues and Goals

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Introduction

My first words are of appreciation for the honor of being invited to participate at this special session convened by the UNFPA on the occasion of the XXVth IUSSP International Population Conference. I am particularly privileged and pleased to join the eminent persons who played an important role in building the ICPD 1994 consensus and now dedicate their efforts to implement the Programme of Action.

I will dwell on Reproductive Health issues and goals and in doing so I will explore: how the ICPD vision has shaped our thinking on population and development; and how it has influenced policies and program design at national, regional and international levels to address present and future health challenges. Recognizing that the progress made is far from meeting the objectives established, I will identify issues to be taken into consideration as we pursue the journey to achieve the ICPD and Millennium Development Goals.

How the ICPD Vision shaped population policies

By putting human beings at the centre of concerns for sustainable development and calling for universal access to reproductive health by 2015, the Programme of Action of the1994 ICPD has influenced a shift away from demographic concerns and targets to an emphasis on rights-based population policies and programmes aimed at improving the quality of life and well-being of human beings. Based on the consensus reached at the Cairo ICPD in 1994 and the subsequent Beijing UN Fourth Conference on Women 1995, affirming women's right of access to appropriate health care services in pregnancy and childbirth, governments worldwide translated their commitments to meet peoples' needs and made legal and policy changes in their respective countries. Addressing individual human rights and choices, these changes have contributed to the enormous progress observed in the adoption of poverty reduction strategies and development programmes.

In order to meet the objectives and goals of Cairo Programme of Action, countries have introduced into their health systems sexual and reproductive health care services that include: (i) family planning information, services and counselling, (ii) postnatal, and delivery care; (iii) health care for infants; (iv) treatment of sexually transmitted diseases and reproductive tract infections; (v) Safe abortion services and management of abortion-related complications; (vi) prevention and treatment of infertility; (vii) information, education, and counselling on human sexuality, reproductive health, and responsible parenthood.

These measures have contributed to improve the health and well being of many mothers, children and families in many countries. The analysis of maternal mortality ratios in countries that have sustained investment in reproductive health care has shown a considerable decline in maternal deaths from 1000 per 100,000 live births to 26 per 100,000 live births over a span of 30-60 years, except in Africa where maternal death ratios are still often around 1000 per 100,000 live births. The considerable progress that has been achieved, both in developed and in developing countries, demonstrates that if the known cost-effective interventions are implemented it is possible to meet the ICPD objectives.

The 2000 Millennium Summit, the main objective of which is to raise the standard of living, adopted a set of quantified targets for dramatically reducing extreme poverty in its many dimensions by 2015 - overcome poverty, hunger, disease, exclusion, lack of infrastructure and shelter - while reducing maternal and child mortality, combating HIV/ AIDS, malaria and promoting gender equality, education, health, and environmental sustainability.

Where are we on Reproductive Health goals?

As we move forward in our journey to achieving the MDGs, despite the progress made, it is important to look at the unmet needs for sexual and reproductive health care, particularly in low income countries with highest burden of mortality and ill-health, and growing inequities.

Only 65% of women in developing countries receive prenatal care, and fewer than 30% get postnatal care. Nearly half of all births take place without skilled attendance. Pregnancy, childbirth and their consequences are still the leading causes of death, illness and disability among women of reproductive age in developing countries - more than any other single health problem (WHO Health Report 2005). Over 300 million women in the developing world currently suffer from illness brought about by pregnancy and childbirth. Over 500 thousand women die each year from pregnancy related causes leaving behind children who are more likely to die because they are motherless. Of these maternal deaths, 95% occur in Africa and Asia compared to 4% in the Americas. Maternal mortality in sub-Saharan Africa is estimated at 1,000 deaths/ 100,000 live births and is the highest in the world. Every day at least 1,600 women die from complications of pregnancy and childbirth.

The lifetime risk of maternal death in sub-Saharan Africa is 1 in 14 compared with 1 in 2800 in developed countries, and adolescent childbearing contributes to this risk. About 11% of all births are to adolescent women. In the majority of countries in the African region, 50% of the first births are among adolescents. Pregnancy related complications are among major causes of death for girls aged 15-19 years. Every year, 75 million unwanted pregnancies occur, and 20 million illegal abortions take place - 95% of them in developing countries.

More than one million people per day are infected with sexually transmitted infections (STIs) - the highest reported rates being among young people aged 15-24 yrs. Young people are also the hardest hit by HIV/AIDS, with females having a higher risk of

HIV infection compared with males of the same age. We must understand the reasons why girls and women cannot, on their own, protect themselves from unwanted, unsafe, violent, or coercive sex, across highly desperate communities and societies where HIV/AIDS has already led to feminized epidemics. More than 80% of young women aged 15-24 years have insufficient knowledge about HIV/AIDS.

Understanding the root causes behind the phenomena is crucial for defining appropriate reproductive health policies and strategies in the era of HIV/AIDS epidemic. The1994 ICPD in Cairo addressed this problem. The list of realities in developing countries, particularly in sub-Saharan Africa, is long. Let me just mention some: (i) marriage of young girls to older, usually sexually experienced, men; (ii) sex between young girls and older men outside marriage; (iii) violence and sexual coercion inside and outside marriage; (iv) husbands who engage in extramarital affairs or visit commercial sex workers; (v) taboos against giving girls factual information about sexuality and reproduction, even after marriage; (vi) lack of or negative attitudes towards condom use in marriage or long-term relationships; (vii) traditional and socio-cultural factors in specific communities. Better understanding of these factors will enable more focused interventions that will contribute to induce required behavior change in families and societies.

In most countries in the African region, the health system remains weak and cannot adequately respond to the health needs of mothers and newborns – hence quality of health care is inadequate in most countries. Inadequate skilled personnel, increasing brain drain, lack of needed equipment, drugs and supplies, and poor referral systems all characterize the health system.

In sub-Saharan Africa, the contraceptive prevalence rate (CPR) is still estimated to be very low at 13%[10] for married women, the total fertility rate (TFR) is 5.5 and the lifetime risk of maternal death is 1 in 14. These facts compare unfavourably with developed countries where the CPR is high and the TFR has declined to 1.6. The millennium development goals (MDGs) call for a three-quarters reduction in maternal mortality and a two-thirds reduction in child mortality between 1990 and 2015.

Since the mid-1980s, most countries have developed national programmes for reproductive health, including family planning. Despite this, available data indicate high-unmet family planning needs. Over 120 million women in sub-Saharan Africa still have unmet needs for family planning, and 350 million lack access to a full range of contraceptive methods.[11] The majority of these are the poor and adolescent populations who are at high risk of unwanted pregnancy, HIV, STIs, and other reproductive ill health.

In the six years following the ICPD 1994, the world's 1.3 billion women of childbearing age experienced more than 1.2 billion pregnancies of which more than 25% were unintended. These unwanted pregnancies resulted in the deaths of nearly 700 000 women. The majority (over 400 000) died as a result of complications of illegal and unsafe abortions. Sub-Saharan Africa, which is home to only 10% of the world's women, contributes annually, 12 million unwanted or unplanned pregnancies

[10] UNFPA, State of the world population 2002, New York, United Nations Population Fund, 2002.
[11] UN, 2001 World population prospects: The 2000 revision, New York, United Nations Population Division, 2001.

and 40% of all the pregnancy-related deaths worldwide. As a result of unwanted and unplanned pregnancies, women under 20 years of age account for almost 70% of abortion complications. Reducing unwanted pregnancies significantly lowers the number of maternal deaths. Studies on maternal and child mortality have shown that longer birth intervals reduce maternal mortality and improve nutrition. An under-five year old child is twice as likely to survive and be better nourished if the previous birth was two to five years. Effective family planning (FP) services, which will enable women to achieve the optimal birth spacing of 3 – 5 Years, are therefore, critical for the attainment of the ICPD and Millennium Development Goals.

What ought to be done to complement the ICPD Agenda?

Tackling the SRH unmet needs and addressing the related high disease burden poses major challenges to the African Region.

To complement the ICPD agenda, we need to take stock of the experience of the eleven-year journey and scale up our response to improve sexual and reproductive health for achieving the Millennium Development Goals. Four critical issues that will shape policies and resource allocations at community, national, and global levels, must be considered - the role of health systems, community & society participation, linking sexual reproductive health and HIV/AIDS interventions, and mobilization of resources and promotion of partnerships at national, regional and global levels.

1. **The role of health systems** - In response to the challenge of meeting ICPD agenda, countries have invested in health systems, but because of the crisis in local health systems that do not work, people are suffering from exclusion of the poor, abuse, and marginalization of women. Political commitment at global, country, and community levels must ensure that adequate resources are well spent in strengthening local health systems, and ensure universal access to health care for women, girls and adolescents. *We will need national ownership and a strong coherent and coordinated leadership, from community to country and global levels, to ensure increased funding for predictable and sustained long-term investment in health systems of good quality, particularly in low-income countries.*

2. **Community and society participation in health promotion**: We must draw lessons from our eleven-year journey implementing the ICPD Vision, on how we are working with communities in different countries. Most of the time, the consensus made is transmitted top down as strategies and action plans for implementation. We should not forget that the ICPD vision major objective is to *"raise the quality of life and well-being of human beings and promote human development"***.** Women, as individuals and as organized collective communities, need to be empowered not only to demand their rights but also commit themselves to take initiatives to fight poverty and to adopt behaviours that protect and promote their health status. Therefore, *communities and their leaders must be seen as active partners that participate not only in implementation but also in planning and management that includes evaluation of concrete actions in sexual and reproductive health programmes*. In the process, coordination mechanisms of the multiple partners, including community based NGOs, local leadership, and local public authorities, need to be improved. This also allows for regular opportunities to be created for systematic identification of weaknesses and strengths to ensure effective and efficient interventions, including adequate training

and updating of community health activists and health professionals. More research and demographic studies are needed to adjust policies and strategies to meet the ICPD and MDG goals.

3. **Sexual and reproductive health and HIV/AIDS interventions**: Influenced by global initiatives targeted to specific problems, many low-income countries have adopted vertical approaches that distorted national systems. Aiming to reduce maternal mortality, combat HIV/AIDS and other STIs, reproductive health services should be used as entry points for HIV/AIDS prevention, treatment, care and support and can provide cost-effective interventions and facilitate women's access to integrated and more relevant services. The Africa Regional Roadmap for accelerating reduction of maternal and newborn morbidity and mortality needs to be adopted and implemented by all countries as a means of integrating all RH services.

4. **Mobilization of resources and promotion of partnerships at national, regional and global levels**: Success in fighting poverty, improving reproductive health and achieving the MDGs depends on accountability of governments. There is need to create an enabling environment to engage their respective peoples in the implementation of national plans and to build partnerships with national stakeholders to ensure sustainable economic growth. Because the vast majority of people in low-income countries are too poor to generate savings and capital, which they require for their development, the extent of poverty and underdevelopment makes it impossible to attract significant amounts of private capital. It will, therefore, be necessary to look for public sector grants, other forms of aid or soft loans to be allocated for investment in public goods and to promote development. At a regional level, the establishment of partnerships such as the New Partnership for Africa's Development (NEPAD), the development programme of Africa adopted by the African Union, have succeeded and mobilized international partners to consider debt relief and increase financing for development. I look forward with expectation to the implementation of outcomes of the recent G8 Summit held at Gleneagles.

Conclusion

At the global level we need a health partnership, involving governments, civil society, the United Nations system and the private sector, to contribute to scaling up our response to improve development planning towards reducing poverty, improving maternal and child health, combating HIV/AIDS, increasing gender equity and equality, and achieving the ICPD and Millennium Development goals.

Gender Equality and Human Rights: ICPD as a Catalyst?

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Introduction

The eleven years since the International Conference on Population and Development transformed the population paradigm have also been among the most challenging in recent decades for advancing towards greater gender equality and fulfilment of human rights. Despite commitments to empower women and promote their reproductive rights, the challenge has been how to move forward to meet this agenda in the face of crumbling health systems, inadequate resources, the rapidly spreading HIV pandemic, and a right-wing backlash against women's human rights, gender equality and sexual rights.

Gender equality and women's empowerment are at the core of the ICPD agenda. The Programme of Action's sexual and reproductive health and reproductive rights goals are strongly linked to, and mutually reinforcing of, its goals for women's empowerment and gender equality. However, according to the UNFPA's Global Survey of 2003, while a number of countries have introduced laws and policies, less has been done to translate these into programmes, implementation or monitoring. More than half of the 151 responding developing countries had adopted national laws, ratified UN conventions and established national commissions for women, but only a third had formulated policies or programmes, and only 13 countries had developed advocacy programmes for gender equality.

The Challenges

Demographic and health factors

In the first decade after ICPD, considerable effort was made to translate its commitments into action. Yet significant gaps remain. While contraceptive prevalence has increased, 29 per cent of women in the South still have an *unmet need* according to the UNFPA's Global Survey of 2003. There are around 340 million new cases of *Sexually Transmitted Infections* (bacterial) each year but a large number go untreated and are a leading cause of infertility as well as elevated HIV risk. *Maternal mortality*, including through unsafe abortion, lack of access to, and poor quality of, services continues to take the lives of over half a million women each year, and renders millions more ill or incapacitated, sometimes permanently so.

According to WHO 68,000 out of the close to 20 million women who resort to *unsafe abortions* die each year. Five million more are temporarily or permanently disabled. Over the last decade a great deal of work has been done by NGOs, UN agencies and governments to address unsafe abortion through contraceptive use, emergency

contraception, post-abortion care programmes, and new policies and laws. Despite this progress, we still lack the necessary financial resources, particularly in the era of the Global Gag Rule, to make abortion safe for women.

Another critical issue is that of *service quality*. During the past decade, as efforts have been made to increase the provision of a broader range of sexual and reproductive health services than were available before, the extent to which service quality and access are constrained by the overall functioning of the health system, and by the lack of sensitivity of health care providers to service users who may be poor, non-white, lower caste, unmarried, or female has become amply clear. But access to services also depends on the ways in which families value and prioritise the health of girls and women, and the willingness of husbands and partners to take responsibility for women's health and their enjoyment of their human rights. While some headway has been made on this front, a great deal more needs to be done.

The impact of the *HIV/AIDS* pandemic has been one of the most significant changes in the global landscape since Cairo. Population projections today are lower than even a decade ago because of the impact of HIV, particularly in the 38 African countries most affected by the pandemic. What is also alarming is the fact that the infection in Asia appears to have broken out of the high-risk groups and into the general population. This is the stage when the spread becomes very rapid; only 12 years ago, African countries' infection levels were comparable to Asian levels today.

Feminisation of the HIV pandemic goes hand in hand with its spread into the general population, as their partners infect married women who have little control over sexuality. According to UNAIDS, 60% of all new infections are now among women. NGOs working on the ground are finding rising incidence rates, even in poor and remote rural areas, as a consequence of short-term, circular migration from rural to urban areas in circumstances of drought and dire poverty. Poor women in rural areas have even less knowledge about HIV than their urban counterparts, and many women, rural and urban, lack the power to negotiate condom use with their husbands or partners. Progress in arresting the HIV pandemic will not be made without universal provision of comprehensive sexual and reproductive health services, and a strong push to protect and promote sexual and reproductive rights, including educating women about their rights and sensitising men to their responsibilities.

As the HIV pandemic is being feminised, it is also hitting hard at *young people*. Fully half of all new infections are among people in the 15-24 age-group, indicating that not enough is being done to ensure that they have access to reliable sexual and reproductive health information and services. The culture of silence surrounding sexuality continues to put young people at enormous risk.

Following ICPD, the 1995 Beijing conference established that a woman's right to control her own *sexuality* was an indivisible part of her human rights. Respect for sexual rights as human rights provides the basis for the elimination of violence against women, which impairs and nullifies girls' and women's fundamental freedoms, leaving them at risk of genital mutilation, sexual harassment and abuse, rape, enforced prostitution, battering, and sexual slavery.

Understanding the importance of working on *sexual rights* as part of the work of implementing ICPD and not shying away from the term because of the controversy it arouses has been a challenge for many organisations. Denial of sexual rights makes it difficult for a girl or a woman to affirm the integrity of her own body, to live without fear of rape or violence, whether within or outside the home, and to make life choices that are not constrained by fear of discrimination or shame; in short to experience sexuality free of coercion, discrimination and violence. The eleven years since ICPD and Beijing have led to greater clarity about the meaning of sexual rights and sharper understanding of its links to freedom from violence and a positive affirmation of an intrinsic aspect of human existence.

Global economic and political factors

Probably the most significant long-term factor affecting support for the ICPD agenda is the transformation under way in the global economy during the last 30 years, and with accelerated force in the last ten. The pressures of operating within an increasingly global economy have affected the capacity of most governments to have independent national macroeconomic and other policies.[12] Most countries now face the problem of keeping fiscal deficits under control, and managing their trade and capital accounts so as to prevent destabilising financial movements. Such pressures when combined with their own unemployment and growth / productivity problems have made many high income countries less than willing to increase development assistance in a stable manner.

The complexity of these changes and the concomitant instability in the expanding global economy have led to the breakdown of the so-called Washington Consensus[13] without a clear, widely accepted replacement. This Consensus was the basis of structural adjustment programmes in many countries during the 1980s and 1990s followed by Poverty Reduction Strategy Policies and more recently the Millennium Development Goals (MDGs). In the health sector, reforms emphasising privatisation and user charges have been transformed into sector-wide approaches (SWAPs), but the crisis in the health sector and health systems remains severe and rendered more so by the HIV pandemic. There are serious problems of: inadequate funding for key health problems; growing inequity in health outcomes and access to health services by economic class, gender, sexual orientation, and race / ethnicity /caste; crumbling infrastructure and out-migration of health personnel from poor to rich countries; and increasing impoverishment due to rising and unmanageable health care costs and out

[12] To greater or lesser extent, the reduction of economic policy autonomy has affected both high- and low-income countries, and made all susceptible to the requirements of open economies – keeping inflation low and reducing budget deficits. National level Keynesian policies are no longer as effective as before in reducing unemployment and boosting GDP without also generating balance of payments problems.

[13] The Washington Consensus (so called because it involved agreements between the US Treasury, the IMF and the World Bank, all physically located near each other in Washington D.C.) propounded the view that the best way for a country to deal with a macroeconomic crisis caused by destabilising movements of foreign capital is through fiscal austerity, high interest rates, and guarantees for easy capital outflows and inflows. This view dominated thinking in Washington from the late 1970s until the Asian crisis of 1997-98 consequent to which critical perspectives spearheaded by the World Bank's then Chief Economic Advisor and Nobel Prize winner, Joseph Stiglitz, led to the cracking of the Consensus.

of pocket expenses for households. This crisis requires not only sectoral but macroeconomic solutions.

Financing and ODA

Financing for development and development assistance are caught up in and constrained by these processes. Even if donor countries were to meet their Monterrey pledges of an additional US $ 16 billion for the MDGs, this amount would still fall short of what is actually required to meet the MDGs by 2015.

To some extent, however, this is a smoke and mirrors game! Economic difficulties in the high-income countries may actually be less important than the mindset of insularity and isolationism bred by economic and political instability and uncertainty. Despite renewed calls for increased resources to meet the MDGs and agreements reached at the Financing for Development conference in Monterrey, ODA trends indicate that development assistance from DAC countries has failed to keep pace with growth in wealth per capita.

While funding for HIV/AIDs continues to increase, funds to family planning and reproductive health are in decline. In contrast, private foundations have been increasing their support for population programs, from US $100 million in 1995 to an estimated US $400 million in 2003.[14] Those who can capture the imagination of funders are going to be the gainers in the competition for both public and private funds.

It is important that calls by funders for more effective use of funds are not interpreted as a narrowing of the action agenda to only those activities that are familiar from the past or believed to be easily quantifiable. Behaviour change is a vital, and indeed a core part, of the ICPD Programme of Action. Imaginative programming in this area is not only essential but also quite possible to ensure, provided it is well funded. Indeed, during the past decade, innovative and practical approaches to measure and quantify such issues as rights and empowerment have been evolving. [15] Such efforts and others should be encouraged. It is also clear that purely redistributive (and competitive) approaches to the problem of resources will never meet the needs of poor countries and people for the full range of health care, education, livelihoods, and participation in decision-making.

Human rights and geopolitics

While funding and ODA trends are a critical element of the current context, there are other factors that are equally important. It took half a century after the original signing of the Declaration of Human Rights for the human rights of women to be specifically recognised at the World Conference on Human Rights in Vienna in 1993. Nonetheless, this consensus was powerful and global. The world community has since been evolving the means to translate this consensus into practice so that women can feel

[14] Countdown 2015, p.39

[15] See for example Ruth Dixon-Mueller and Adrienne Germain, "Reproductive health and the demographic imagination" and Sunita Kishor, "Empowerment of women in Egypt and links to the survival and health of their infants" in Women's Empowerment and Demographic Processes: Moving beyond Cairo (eds) Harriet B Presser and Gita Sen, Oxford University Press, 2000.

real and tangible impacts on their lives and those of their daughters. Some key actors have, however, attempted to develop political strategies to subvert the global consensus.

It is important to understand the nature of these strategies in order to develop effective responses, and ways for moving forward. One of the challenges to advancing human rights, during a highly controversial period in global economic negotiations, is how different stakeholders position themselves and are viewed in the overall picture. The preoccupation of key actors, especially national governments, with economic issues could well increase the pressure for trade-offs to be made between economic gains and commitments to human rights, including those promoted at ICPD and Beijing and their 5-Year Reviews. Civil society organisations, that have been key advocates during and after the conferences of the 1990s, have drawn attention to these risks.

This analysis has focused particularly on the attempts by the Holy See to project itself as a 'moral' authority for the world, espousing poverty and debt reduction (popular issues among G77 countries) on the one hand, and opposing gender equality and sexual and reproductive health and rights on the other. This projection began in a major way around the time of the UN Rio Conference on Environment and Development in 1992. There the Holy See made a major plea for addressing the root causes of poverty and debt, a plea that was quite at odds with its ongoing suppression of those within its own congregations, most principally 'liberation theology' supporters, who were actually engaged in tackling poverty on the ground.

Because of the harsh nature of the current global political economy, the difficulties and stalemates in economic negotiations, and the persistent sense of unfairness among South countries, some stakeholders and negotiators have shown themselves willing to form alliances with the Holy See's 'moral authority'. In doing so, they enhance the credibility of an organisation whose actual support for the struggle against poverty (especially during the last pope's rule) has been ambivalent, and whose opposition to gender equality and women's human rights has been implacable.

As is well known, the Holy See, though only an observer state at the UN, has played a key role in developing both strategy and tactics for the opposition to gender equality and women's human rights. By creating alliances with conservative governments across traditional religious divides, and by bringing its skills to bear on coalescing a non-governmental opposition as well, the Holy See played a critical role throughout the first decade after the ICPD. Part of this role has recently been taken over by the neoconservative US administration that was recently re-elected. Key members of the Holy See delegation have shifted over to the US delegation in recent negotiations. This has enabled the Holy See to play a quieter role in recent meetings, leaving it to the US to play a more vocal oppositional role.

Protecting and promoting human rights

The deepening of the human rights agenda that took place through the conferences of the 1990s has as yet only taken partial and uneven hold within countries. It is true that, as countries have come to better understand the nature of the paradigm shift, and as they have gained experience implementing it, they have become more and more

engaged and supportive.[16] However, a paradigm shift of this magnitude takes more than ten years. In the meantime, cultural conservatism, often wearing a religious mask, has grown rapidly in some parts of the world including the global superpower.

During ICPD and after, preservation of 'culture' and tradition has been used as an argument to support gender roles and practices that violate women's human rights. Such arguments surfaced during the conferences of the 1990s and have continued until now. Women are seen in these views as the bearers of culture, not only in the sense of being responsible for protecting and promoting culture, but also as those in whose very being tradition and culture are somehow embedded.[17] Women's lives, bodies and behaviours are seen as needing to be controlled by men, families, communities, religious authorities and the state in order that culture may be preserved. Individual women and women's movements for rights, equality and justice have naturally challenged such views, sometimes with great bravery and in the face of tremendous odds.

But it may be helpful for us to step back and reflect a little on why, in this historical phase of the movement towards full and real citizenship[18] for women, the opposition is so focused on culture and religion. History tells us this has not always been the case. The opposition to women's rights during an earlier phase of the women's movement – during the struggle for women's suffrage – used the language of biology rather than the language of culture. It made the argument that women's emotional and mental faculties are dictated by their reproductive biology, which renders them unstable and unfit for political participation. Biology was, in a word, destiny. Women were viewed as biologically different and incapable of being socially equal to men.

This dependence on biology to justify gender inequality has declined in the current period, even though it hasn't completely disappeared. While the birth control revolution of the 20th century is still incomplete, the demographic transition has occurred and is occurring. The ability to enforce motherhood (by denying women the rights and methods to decide whether, when, and how many children they will have) has declined dramatically almost everywhere. It has also become abundantly clear that there is little scientific basis to ideas of biological destiny that have been used to argue that women's mental and emotional faculties are different and inferior and thus to rationalise gender inequality. Other arguments have therefore had to be called into play to make the case against gender equality. Even among those like the Catholic

[16] This is part at least of the reason for the overwhelming support for ICPD during recent regional meetings where delegates representing health and family planning ministries and departments were present. It is also one of the reasons why negotiations are more favourable when conducted by representatives of the implementing ministries rather than by diplomats whose principal concerns are geopolitical or strategic.

[17] It is useful to note in this context that such arguments, if they were to be used to defend caste untouchability or racial apartheid today, would be viewed as unworthy of a place in civilised debate, even though they may still have their protagonists at local or even national levels. But violence against women is still justified as protective of 'culture' and 'tradition'.

[18] I use the term 'citizenship' not in the narrow sense of political rights within democracy, but in the broader sense of full equality, subjecthood, and agency in all spheres of human existence. This concept of citizenship has gained widespread acceptance within women's movements.

hierarchy who privilege 'motherhood', it is no longer treated simply as a biological given.[19]

Calls to 'culture' and 'tradition', and shrouding these in religious authority that is beyond the realm of science and human reason are therefore absolutely central to the framework of the current opposition to gender equality. It is important to understand this as being, in some sense, the final stand of an opposition that has substantially lost and is continuing to lose its main argument – women's subordination to reproductive biology. 'Culture' is not therefore an innocent weapon in the hands of those who oppose women's human rights; it may be the only weapon they have left.

Political directions

Protagonists of the ICPD POA are not the only ones who can learn historical lessons. It must also be anticipated that the anti-equality right wing and its strategists would have analysed their failures in the regional population meetings of the recent past, and may well have drawn up a different plan for the coming four years at least. In fact, we should expect a planned and sustained onslaught on the international front; political analysis may lead their strategists to believe that they have a four-year window of opportunity provided by the recent US election to roll back ICPD and Beijing, and this may well make them take desperate measures. It is important to have a good analysis of the directions they are likely to take.

One such direction that is already emerging is towards gaining political credibility for patriarchal family structures, and consolidating political alliances across conservative religious strands on this basis. The strongest counter to this has been and will continue to be documenting, analysing and mobilising against violence against women, and in favour of the rights of children and adolescents to choices, information and services.

At the global level, another factor requires careful monitoring and understanding. Unlike the political shift in the US, the countries of the European Union have been up until now, strong supporters of the ICPD agenda. The expansion of the EU to include countries such as Poland, Malta and Slovakia that have been strong supporters of the

[19] In his 'letter' to Catholic Bishops issued on May 31, 2004, Cardinal Joseph Ratzinger (now Pope Benedict XVI) on behalf of the Vatican's Congregation for the Doctrine of the Faith (formerly known as the Inquisition) and with the authorisation of Pope John Paul II, declared remarkably that "…motherhood can find forms of full realisation also where there is no physical procreation". (para 13; Ratzinger 2004). Furthermore, he states that "…the feminine values mentioned here (viz., 'listening, welcoming, humility, faithfulness, praise and waiting' – *my note*) are above all human values: the human condition of man and woman created in the image of God is one and indivisible. It is only because women are more immediately attuned to these values that they are the reminder and privileged sign of such values…In this perspective, that which is called "femininity" is more than simply an attribute of the female sex. The word designates indeed the fundamental human capacity to live for the other and because of the other". (para 14; ibid) While other parts of his letter are shrouded in esoteric metaphors, this conception is far removed from pure biological determinism, even though it is clear that biological motherhood is the basis for women's being "more immediately attuned to these values". Indeed Ratzinger is at pains to declare that women are not inferior to men. But, if motherhood is not biological, and women are not intrinsically inferior, then Ratzinger is left with nothing except esoteric doctrine with which to explain both his thesis of 'complementarity' between women and men (based on repeated referral to bride-bridegroom metaphors drawn from different parts of the Bible), and practices such as the denial of ordination to women. See Joseph Ratzinger, "Collaboration of men and women in the church and in the world", Letter to the Bishops of the Catholic Church, May 31, 2004

Holy See's positions in the past may well modify this support. Traditional supporters of SRHR among EU governments are unlikely to easily change their positions, and Spain is emerging as a new and strong supporter. However, the EU has many problems to cope with simultaneously – the relationship between older members and new entrants, the issue of migration, its own political relationship to the US, and its economic positions in WTO and other negotiations. Priority and clarity of support - strategic, moral and financial - for the ICPD agenda and institutions by the EU is critical to ensure in the midst of conflicting and confusing pulls and pressures. In addition, opposition groups are emerging throughout Europe, often modelled after their US counterparts. Monitoring their activities and countering their messages at the level of the EU parliament, for example, will become increasingly important.

To sum up: while significant progress has been made in implementing the ICPD POA during the past decade, the context for the next decade of implementing ICPD includes three sets of factors: 1) key demographic and health factors; 2) instability and uncertainty in the international development context, continuing weakness of ODA and their implications for the health system and its ability to support ICPD implementation and address HIV/AIDS and its feminisation; and 3) the further rise of conservative anti-women forces, religious and other, emboldened by their success in the recent US Presidential election.

The current situation is fluid and contains room for both pessimism and optimism. On the pessimistic side, global development resources are still well below what is needed. Right-wing anti-equality forces are powerful and appear to be going from strength to strength. On the optimistic side, although the outcome of the September 2005 UN Summit for Millennium + 5 cannot be predicted, many countries have already expressed their support for integration of the ICPD goal of universal access to reproductive health as a target for the MDG of improving maternal health.[20] While this is still a long way from the real actions needed, it is at least a step in the right direction.

[20] Both the Stockholm Call to Action and the Delhi Call to Action (both in April 2005) affirmed this in the context of high-level meetings sponsored by the UNFPA / Government of Sweden and the WHO respectively.

Part III

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Pascoal Mocumbi, M.D., is former Prime Minister of Mozambique. He now serves as the High Representative of the European and Developing Countries Clinical Trials Partnership (EDCPT) and WHO Goodwill Ambassador for Maternal, Newborn and Child Health in Africa. In addition to being Prime Minister, he was Minister of Health and Minister of Foreign Affairs. In these various capacities, he contributed to maternal mortality reduction in Mozambique, through ensuring that non-physician health workers were trained to provide emergency obstetric care. He responded to the growing HIV/AIDS crisis by calling for intensified prevention efforts and by shedding light on the gender inequalities that are fuelling the pandemic. He has also contributed to substantially reducing poverty, improving human development, and transforming war-torn Mozambique into one of the fastest growing economies in Africa.

Ian Pool, Professor of Demography, University of Waikato, New Zealand and James Cook Fellow, Royal Society of New Zealand, currently writes on New Zealand historical and general demography. But, since1965 he has also worked for international and non-profit agencies (Africa, Asia and the Pacific), on population and development and on fertility surveys. His most recent books, Tuljapurkar, Pool and Prachuabmoh (eds) Riding the Age Waves: Population, Resources and Development (Springer, 2005), and Pool, Wong and Vilquin (eds) Age-structural Transitions: Challenges for Development (CICRED, in press), relate to macro-demographic themes in this report.

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