REPRODUCTIVE HEALTH: A STRATEGY FOR THE 1990s

A PROGRAM PAPER OF THE FORD FOUNDATION

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PREFACE

The Foundation has had a longstanding interest in problems related to population and development. During the 1950s and 1960s grants helped develop demography as an independent discipline, supported research in reproductive sciences and contraceptive development, encouraged broad public discussion of population policies, and assisted in the design and delivery of family-planning programs. By the 1980s, the Foundation's commitment to the field had shifted somewhat to include increased emphasis on key factors influencing the demand for family planning. Aiming to improve the lives of disadvantaged women, the Foundation focused its grants on maternal and child health programs, efforts to advance women's education and income-earning opportunities, and programs encouraging public attention to population issues and the need for high-quality services.

After an extensive review of the Foundation's work in population, the Board of Trustees recently approved a ten-year, $125 million commitment to a reorganized program that makes reproductive health its centerpiece, emphasizes the social, cultural, and economic factors that influence reproductive health, and pays special attention to disadvantaged women of developing countries, in both rural and urban areas, throughout their reproductive life cycle. The program will also support efforts to control sexually transmitted diseases, including AIDS, and address the special needs of adolescents. This paper describes the main features of the new program, which encompasses work in three interrelated areas:

- social science research and training to expand knowledge about the socioeconomic and cultural factors affecting reproductive health;
- projects that help women articulate and act on their reproductive health needs both within the family and at the community and policy levels; and
- public discussion aimed at developing ethical and legal frameworks for reproductive health appropriate to the culture and traditions of different societies.

The paper was originally prepared for presentation to the Foundation's Board of Trustees. It is is being published for a wider audience because of the

importance of the subject and in the hope that other donors will join us in supporting this comprehensive approach to reproductive health. The principal authors are José Barzelatto, M.D., former official of the World Health Organization, who is directing the new program in reproductive health, and Margaret Hempel, program officer in reproductive health. They benefited greatly from the comments and suggestions of other Foundation staff members and outside consultants.

Franklin A. Thomas
President
Ford Foundation

THE DEMOGRAPHIC CONTEXT

During the past forty years the world has witnessed an unprecedented increase in population, from 2.5 billion in 1950 to 5.3 billion in 1990. Most of this growth has occurred in developing countries, where modest improvements in standards of living during the 1950s and 1960s were accompanied by a rapid decrease in death rates, including large declines in infant and child mortality rates. In many developing countries the crude death rate fell by more than 50 percent, reaching levels near those of developed countries. Birth rates also decreased, but more slowly, in some cases remaining at three to four times the rate in developed countries.[1]

In the absence of sharp fertility declines and with more children surviving, the populations of many developing countries continue to grow rapidly. As a result, the world population is now increasing by about 91 million persons a year. If present trends continue, the annual increase will reach 97 million over the next decade. Growth will continue at a slower rate in the twenty-first century before leveling off at an estimated 11 billion people. Most of this growth will occur among the poor of the world; 94 percent will be in developing countries. Europe is projected to grow by only 6 million from 1990 to the year 2000 and to decrease by 22 million in the following twenty-five years. At present, the United States population is still growing, due to both the momentum of the post-World War II "baby boom" and to immigration. As birth and death rates come closer, future population growth or decline will depend mainly on immigration. In contrast, many developing countries can expect to see their populations double, and in some cases triple, over the next few decades.

The rapid growth in the world's population has resulted in a massive increase in the numbers of people living in poverty, with women and children bearing the largest share of the burden. By the year 2000, 42 percent of the world's population will be twenty-five years old or under. Increasing numbers of children will stretch the capacity of families and societies as a whole to provide food, clothing, shelter, education, and health care. Young adults will struggle to find work in societies where jobs will be scarce.[2] Even the minority who claim that population growth in the long run is beneficial to economic growth accept that in the short run–from thirty to eighty years–there can be serious difficulties in balancing population growth and available resources.

In the 1950s and 1960s, in response to rising concern over the increase in absolute numbers of people in the world, private foundations supported research and the development of policies and services aimed at reducing population growth rates. These efforts were joined by the governments of developed and a few developing countries, notably India. By the 1970s the United Nations and additional developing countries had begun to act on these concerns, and by the end of the 1980s practically all governments had adopted population policies, in most cases with a commitment to reducing population growth.

Initial population policies were based on the "demographic transition" that followed the industrial revolution in Europe and the United States. In this transition, socioeconomic improvement was followed by a gradual decrease in death rates, and soon after by declining birth rates. The industrializing countries experienced only a modest increase in total population size as declining death rates were offset by large-scale out-migration and by people deciding to limit their fertility. They did so by using the few options available to them, mainly delayed marriage, *coitus interruptus*, and abortion. This demographic transition in industrialized countries was achieved with neither modern contraceptives nor national policies or programs to alter fertility patterns.

As the dramatic doubling of the world's population was documented in the late 1950s, the population issue was transformed from an academic discussion into a topic of public, and frequently heated, debate that was not always based on full understanding of the factors involved. The developing countries faced population growth rates and increases in absolute numbers of people well beyond those experienced in Europe. Further, developing countries had increasingly limited options for migration. In response to these developments, some researchers and policy makers began to seek ways to better understand demographic changes and to improve population data collection and interpretation. At the same time, those concerned with the consequences of rapid population growth sought ways to hasten the adoption of smaller family norms in countries with high fertility.

By the early 1960s the first modern contraceptives–"the pill" and intrauterine devices (IUDs)–had been developed. They were considered to be safer and much more effective than traditional contraceptive methods. Since the industrialized countries had achieved smaller family size without modern contraceptives, it was assumed that increasing the supply of new medical methods would accelerate the demographic transition in developing countries. Thus began a long-term effort to develop more and better contraceptives and to make them available throughout the world.

Population Data

The paucity of demographic data and analysis, particularly in developing countries, led the Ford Foundation, and subsequently other donors, to provide substantial funds to establish centers for graduate studies in demography, first in the United States and shortly thereafter in developing countries.[3] As a result of this long-term commitment, demography has become a respected discipline within the social sciences, and the research centers have developed into a worldwide network of prestigious institutions whose research has had an important influence on governments' actions and on public opinion.

Improved understanding of both the causes and consequences of rapid population growth has been critical to developing broad consensus on the need to reduce such growth. Demographic research at the national level also contributed to recognition that "overpopulation" is not universal and that different countries face different demographic problems and priorities. In many countries it is the rate of growth or an inability to cope with greater absolute numbers of people that poses problems. In a few countries there is a need to increase population. Countries facing similar problems of rapid growth require policies that are specific to their social, economic, and cultural conditions. Even within a country, particular regions or population groups may require different approaches.

One of the most important contributions of demographic research has been in revealing the social inequities related to unplanned reproductive behavior and their implications for public policies.[4] As the discipline of demography developed, its research evolved from the study of large-scale trends to a greater focus on community, family, and individual factors. For example, combined demographic and epidemiological studies have shown the importance of timing and spacing pregnancies for the health of the mother, her children, and the rest of the family. Research also established that adolescents under the age of fifteen are five to seven times more likely to die in pregnancy and childbirth than women in their early twenties.

Another major contribution has been in documenting the magnitude of maternal morbidity and mortality and the effects of unsafe abortions on maternal health. In many developing countries estimates of maternal mortality range from 300 to 800 deaths per 100,000 live births, and figures as high as 1,500 deaths per 100,000 live births have been recorded in some areas. Consequently, a woman's chance of dying in childbirth is from one in fifteen to one in seventy in some developing countries, while in industrialized countries the risk of dying in childbirth is between one in 3,000 to one in

10,000.[5] In industrialized countries better health and nutrition and access to prenatal care and legal abortion all contribute to a greatly reduced maternal mortality rate, which is estimated at about 10 deaths per 100,000 live births. In addition, women in these countries have fewer children and thus face the risks associated with pregnancy less often.

The extent of disability related to pregnancy is difficult to measure and has not received much study. Information on abortion and its consequences is hard to obtain, especially in countries where abortion is illegal. Studies conducted to date, however, estimate that from 30 percent to 50 percent of all maternal deaths in developing countries are due to complications from unsafe abortions. As a result of such findings, fertility regulation is now recognized not only as a population issue but also as a major public health concern.

Contraceptive Research

At the same time that the discipline of demography was developing, contraceptive research was making considerable advances. Here, too, the Ford Foundation played a leading role in promoting research and attracting other donors to the field.

Encouraged by the development of the pill and IUDs in the 1960s, researchers and donors concentrated on finding new, improved contraceptive methods. As a result, there are more and much safer contraceptives available today than there were twenty-five years ago. The choice of methods now includes low-dose combined hormonal oral and injectable contraceptives, long-acting subdermal implants, improved intrauterine devices, simplified sterilization procedures, and better methods of natural family planning. Research to improve existing methods is continuing and some new and possibly better methods for men and women are being developed.[6]

This progress has occurred despite a series of complex and interrelated constraints, including insufficient funding, worries about liability by producers and testers of contraceptives, some unjustified regulatory requirements, and misconceptions in public opinion resulting from inadequate communication between the scientific community and the public, especially women's groups.[7] All contraceptive methods have some intrinsic limitations, and differences of opinion about risks involved in their use continue. These differences of opinion are compounded by heated public debates in which ideological, religious, political, and commercial considerations further complicate the issues.

Some constraints have increased over time with the result that most

large pharmaceutical companies have withdrawn from contraceptive research. Moreover, progress in improving contraceptive methods has been and will continue to be slow and costly. It may take twenty-five to thirty years and $50 million to $100 million to develop a new contraceptive. This long process starts with the testing of a new idea and continues through assessing its safety and efficacy, first in animals and then in carefully controlled clinical trials. After the method is ready for use, substantial effort is required before it can be introduced in a manner sensitive to various conditions and cultural values. With new and widely used methods, the process continues for many more years and includes the collection of epidemiological data to provide solid assessment of long-term risks and benefits. As a result, we are still far from having an ideal spectrum of safe and effective contraceptives that are both medically and culturally acceptable and affordable to all women and men who choose to practice contraception.[8]

Furthermore, at present women bear the major part of the responsibility for family planning. Due to biological and social factors, females have a wider choice among effective contraceptives than do males. It is easier to interfere with one ovum produced monthly than with millions of spermatozoa being produced constantly. Also, scientists have shown greater interest in studying pregnancy than reproduction. A striking example of gender bias in contraceptive development and practice is that female sterilization is much more widely performed than male sterilization, even though the surgical procedure for women carries considerably greater risk, requires much more technical expertise, and is many times more expensive than sterilization for men.

Family-Planning Services

While demographic research and contraceptive development was proceeding in academic institutions and research laboratories, there was a concurrent effort to provide family-planning services, particularly to women, in developing countries. Over the past forty years, most population-related investment, particularly from the public sector, has gone to providing contraceptive supplies and information through family-planning programs.

These programs differ in structure and practice from country to country, and the results have been mixed and are often difficult to interpret. On the one hand, the use of contraceptives has increased, if unevenly, throughout the world. In the early 1960s it was estimated that only 9 percent of all women of reproductive age in the developing world were using contraceptives; present estimates are about 50 percent, indicating the considerable success of many family-planning efforts. On the other hand, there remain marked

differences by region. In some Asian countries, like China, Hong Kong, Singapore, South Korea, Sri Lanka, Taiwan, and Thailand, as well as in some Latin American countries, like Argentina, Brazil, Colombia, Costa Rica, Chile, and Uruguay, contraceptive use is estimated to be 60 percent or higher. Most developing countries, however, have considerably lower prevalence rates. In many African, Arab, and a few Asian countries–Afghanistan, Cambodia, Iran, Laos, Myanmar, Pakistan, and Papua New Guinea–programs are weak or nonexistent and contraceptive use is under 15 percent.

These contraceptive use rates correlate with changing fertility patterns. From the 1950s to the mid-1960s fertility statistics show little change in developing countries. By the late 1980s, following several decades of family-planning efforts, increased contraceptive use, and social and economic changes, most Latin American and Asian countries have experienced a 25 percent decrease in fertility. By contrast, sub-Saharan Africa and Arab countries, with lower contraceptive use rates and less success in their general development, continue to show little fertility change.

In analyzing the contribution of family-planning programs to fertility declines in developing countries it is difficult to separate the effect of an increased supply of contraceptives from a number of social and economic changes that occurred simultaneously. For example, infant mortality has been cut by half, life expectancy has increased by seventeen years, adult literacy has increased by 19 percentage points (female literacy by 16 points), and primary and secondary education enrollment by 21 percentage points (female enrollment by 25 points). These figures do not include China, where improvements have been even greater.[9] Although these changes are impressive, the data tend to mask the increasing numbers of people living in poverty without access to basic health, education, or an acceptable standard of living. Recently the rate of improvement in many of these indicators seems to have become static, if not declining, due to the economic crises experienced in many developing countries.

Improvements in the quality of life, even at the modest levels described here, are thought to have an independent influence on the adoption of family-planning methods. An attempt to quantify the relative effect of socioeconomic gains and family-planning programs on fertility declines found that almost 60 percent is associated with changes in socioeconomic variables, and a little more than 40 percent with family planning.[10] Although such results may be used to support those who argue that "development is the best contraceptive," most people recognize that 40 percent is a significant achievement. Furthermore, according to an article on the demographic impact of family planning, "investment in socioeconomic development and

family planning programs have much more than simply additive effects on fertility . . . they operate synergistically, with one reinforcing the other."[11]

It has been questioned, however, whether relying solely on contraceptive supply and narrowly defined family-planning efforts can create sustained increases in contraceptive use. In many countries such use has leveled off at rates that will allow for continued rapid population growth; also, many people do not choose to limit their family size, even when contraceptives are available. In addition, high rates of contraceptive use do not always reflect high-quality reproductive health care. For example, in Brazil, where 70 percent of women with partners use some method of contraception, recent studies show that from one-third to almost one-half of those using the pill were at moderate or severe risk for pill use because they were smokers, were over thirty-five years of age, suffered from high blood pressure or heart problems, or had some other condition that put them at risk.[12]

These statistics underscore the need to improve existing family-planning services. In addition, programs must recognize the interplay between family planning and socioeconomic development and provide services that are more responsive to women's changing self-image, opportunities, and needs.

CONCERN FOR THE QUALITY OF LIFE

The last couple of decades have witnessed a rise in women's movements and a greater concern in society as a whole for what is often called the "quality of life." This concern focuses on reducing inequity and discrimination and, quite prominently, on promoting observance of ethics and human rights. It has also influenced the study of reproductive health and population by highlighting the inequity of concentrating on numbers of births and deaths without paying equal attention to the well-being of people, and by revealing the clear discrimination against women when their status depends on their capacity to bear children. By the 1980s a deeper understanding of the complexities of reproductive decision making and of the consequences of those decisions for the whole family began to change the framework within which population policies were discussed.

Concern about the quality of life has also begun to alter contraceptive research and the delivery of family-planning services. Infertility counseling and referral are starting to be included in some family-planning programs. Increasing attention is given to such issues as how to provide contraceptive methods that are both medically and culturally appropriate, along with adequate information to allow for a free and informed choice, as opposed to concentrating on numbers of new contraceptors. In contraceptive research, new methods are being developed that may better respond to women's needs, and the development of methods for men is receiving increasing attention. There is a growing recognition that research must address the social, cultural, economic, and political factors affecting reproductive health as well as the biomedical aspects. However, changes in established programs and approaches are slow to occur.

The Status of Women

Recognition of the longstanding discrimination against women in many aspects of their lives has led to a broader understanding that women's status is a key factor in their ability and desire to control their fertility. In much of the world, women are more likely than men to be malnourished, poor, and

illiterate; they have fewer opportunities to earn income and less access to health care and education. Although there have been large gains in female education and literacy, in most developing countries women still lag far behind males in literacy and school enrollment. In Africa, for example, 36 percent of women are literate as compared with 57 percent of men. In developing countries overall, women account for more than half the food produced, and many rural women work up to eighteen hours a day. Women are increasingly entering the paid labor force, but most remain in highly segregated, low-paid jobs.[13] These factors influence women's sense of personal security and consequently affect their reproductive decisions.

Large families often are seen as providing economic and social security. In areas with high infant mortality rates, having many children is seen as a way to ensure that some will survive beyond childhood to contribute toward the family upkeep and to help support parents as they grow older. For women, more children, particularly girls, may mean more hands to help with paid and unpaid work. In cultures where the family line passes through males there is strong impetus to have several children to ensure that at least one son, and preferably more, will survive to adulthood.

In many societies, however, changes in social and economic conditions and improved opportunities for women counter traditional incentives for larger families. Although it is difficult to isolate the effects of increased education, better income-earning opportunities, and improved health for women, all of these factors are associated with declining fertility rates. The most constant correlation is between women's education and smaller family size. The exact causes of this relationship are not well understood, but it is thought that improved education for women and girls contributes to their ability to make decisions about their own lives, improves their status within the family, delays age at marriage, and in many cases motivates a desire for smaller family size as other opportunities become available. Furthermore, increasing women's education improves the chances for survival and development of their children, and implies greater social and economic opportunities for their daughters.

These findings highlight the fact that improved reproductive health is closely interrelated with women's status. As a paper on population policies and women's health put it: "Women must be able to achieve social status and dignity, to manage their own health and sexuality, and to exercise their basic rights in society and in partnership with men."[14] Clearly, however, many women are prevented from achieving this status by legal, social, and cultural norms. In some societies the low status of females is reflected in their unequal access to food and medical care, which leads to malnutrition,

deficient growth and development, and increased sickness and death in childhood. Girls who survive tend to have smaller pelvic bones, so if they get pregnant they face a greater risk of obstructed labor and of their own and the baby's death. The risk is compounded by early marriage, which is the social norm in many developing countries.

In some areas, women's lack of control over their sex lives leads to early sexual initiation and greater exposure to sexually transmitted diseases (STDs). STDs result in a high incidence of infertility and, in the case of acquired immune deficiency syndrome (AIDS), in death.

Poor-quality health and family-planning services discourage people from using them, particularly if providers do not treat clients with respect, supplies are lacking, or access for teenagers is limited. The poor especially may then suffer pregnancy complications, unsafe abortions, sepsis, severe bleeding, and death. Adolescent pregnancy also contributes to lower child survival, shorter pregnancy intervals, a larger average number of children, lower educational achievement, and fewer opportunities to earn income. Thus the same factors affect fertility, female morbidity, maternal mortality, child survival, abortion, and even poverty. A women-centered approach that takes into account these larger social factors is essential for improved reproductive health.

Understanding the full context of women's lives and the complexity of decisions about reproductive health also requires recognition of the influence of men on reproductive health. Little research and hardly any programs have centered on men largely because of the heavy emphasis on increasing the number of contraceptive users and the variety of effective contraceptives for women. If the influence of males is considered negative and unchangeable, we are implicitly accepting that discrimination against women will always exist.

Addressing these problems involves such sensitive issues as early sexual education and changes in women's roles and status in society, topics that many governments and health providers prefer to avoid. Nevertheless, at the national and international policy level, there has been growing formal recognition that longstanding discrimination against women has placed an unequal burden on them in all aspects of their lives, including health. The Convention on the Elimination of All Forms of Discrimination Against Women, adopted in 1979 and now ratified by over 100 nations, says:

> States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.[15]

In November 1989 the "International Forum on Population in the Twenty-First Century," convened in Amsterdam by the United Nations Population Fund, attracted senior government officials from seventy-nine countries. The forum's concluding document, called the "Amsterdam Declaration," states that "to be effective, a development strategy must reflect population concerns among its primary objectives. Similarly a population strategy must reflect development concerns. It must link population programs to those on health, education, housing and employment, among others. Indeed it is only through such linkages that sustained and sustainable development can be achieved." The declaration also stated:

> Population, resources and environment are inextricably linked.... Women are at the center of the development process and...the improvement of their status and the extent to which they are free to make decisions affecting their lives and that of their families will be crucial in determining future population growth rates.... The principal aim of social, economic and cultural development, of which population policies and programs are integral parts, is to improve the quality of life of the people.[16]

Human Rights, Ethics, and Law

In 1968 the International Conference on Human Rights in Teheran recognized that "parents have a basic right to decide freely and responsibly on the number and spacing of their children."[17] The World Population Plan of Action agreed to at the Bucharest Conference of 1974 reaffirmed that right and expanded on it, stating: "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so...."[18] The document also states that governments should "respect and ensure, regardless of their over-all demographic goals, the right of persons to determine in a free, informed and responsible manner, the number and spacing of their children." This affirmed a distinction between family planning and population control, recognizing the problems associated with rapid population growth but condemning coercion and insisting on education, information, and freedom for couples to decide the size family they want. Research and action to promote women's rights and equity have also contributed to the definition and advancement of reproductive rights.

Reproductive decisions made by individuals and by societies also involve moral judgments and ethical values. The parameters within which these decisions are made are increasingly being challenged by new technolo-

gies as well as socioeconomic changes. The communications revolution and large-scale migrations of poor people throughout the world are bringing together diverse cultures, religions, ideologies, and moral values that often conflict. This is particularly true in discussions of reproductive choice and freedom, which are concerned not only with individual decisions but also with the social effects of dramatic changes in reproductive behavior. There is therefore a need for greater exploration by individuals and associations–whether religious, social, political, or scientific–of the moral and ethical dimensions of reproduction. The recent emergence of bioethics, in which reproductive issues play a considerable role, is one response to the need for ethical reflection in these areas. The diversity of views and the increasing intensity of public discussions on reproductive issues highlight the need for greater respect for pluralism.

Although the public debate is characterized by conflict over religious and moral considerations, legislation on reproductive matters appears increasingly secularized. Contraceptives are now legally available almost everywhere and governments are giving legislative approval to modern methods of "assisted procreation," with varying restrictions. Moreover, there is a tendency in legislation to liberalize the indications for abortion while restricting them to early pregnancy.[19] These changes may signal a tendency to respect the moral standards of different groups, leaving it to individuals to decide which moral guidelines and religious injunctions to follow. Prominent examples are a number of European countries with strong Catholic traditions, such as Belgium, Italy, and Spain, which have recently legalized abortion. This may also reflect recognition that a forced morality is never a solid one. Experience shows that individuals make their reproductive decisions according to their personal moral values and use the methods to which they have access, be they legal or illegal, safe or unsafe.[20]

Bringing an ethical perspective to discussion about reproductive behavior and population concerns has enriched debate but also increased its complexity. For example, the tension between "individual good" and "common good" is strikingly apparent in discussions of optimal family size. Furthermore, though virtually all would agree that it is beneficial for the health of both the mother and her children to space pregnancies, questions about which contraceptive methods accord with particular religious and moral perspectives abound, as do questions about the ethics and the appropriateness of different kinds of government interventions. It is important, therefore, that the legal and ethical dimensions of reproductive health and population policies be included in public debates and considered in the formulation, implementation, and evaluation of programs.

Multiplicity of Health Programs

In response to the need for a more holistic approach to reproductive issues, governments and intergovernmental and nongovernmental organizations have established a number of health-oriented programs along with conventional family-planning services. These programs deal with child survival and, more recently, safe motherhood and services related to sexually transmitted diseases (STDs), AIDS in particular. Problems related to other STDs, to such traditional practices as female circumcision, to infertility, and to the special needs of adolescents are still largely neglected.

The advantages of a more holistic approach have been recognized since the Alma Ata Declaration on Primary Health Care, issued at the International Conference on Primary Health Care in Alma Ata, Kazakh, the Soviet Union, in 1978. In practical terms, however, progress has been limited. This has been due, in large part, to the proliferation and success of "categorical" or "vertical" programs, such as family planning, child survival, and safe motherhood, which evolved out of bureaucratic distinctions within donor agencies and governments rather than as a response to the health needs of women and men and their children.

In September 1989 India's former Prime Minister Rajiv Gandhi opened the General Conference of the International Union for the Scientific Study of Population with a remarkable analysis of the shortcomings of his country's family-planning program. His comments could be applied to most of the Third World, and the same critique could be made of all vertical programs:

> For developing countries, the lesson to be learned is that there has to be a holistic perception of the development process, of which population policy constitutes but one component, albeit a significant component.... The [Indian] family planning program remains essentially an official, government-sponsored program, and not a people's program.... Government agencies can, at best, contribute to raising awareness, creating an ethos and making available the required supplies, but the success of the program depends upon the personal and private decisions of myriad individual human beings...[which are determined by] each couple's perception, especially the woman's perception of the desired family size. This perception is mostly influenced by the values and ethos of the local community or neighborhood....
>
> Programs thus must be decentralized to allow them to be devised and determined at the grass-roots.... At present a host of different official agencies, operating independently of each other, despite their inevitable interlinkages, are approaching the same target group of women and children with little cooperation and coordination among themselves. The net

> result is that delivery costs eat up a vast proportion of program resources, and the absence of a holistic approach sharply reduces the impact of these programs.... I would hazard the prophecy that a delivery system run and supervised by the poor, deprived and largely illiterate people of India will prove far more effective than the paternalistic model of planning, administration and implementation that we have relied upon so far....[21]

Poorly coordinated vertical programs not only cost more to deliver but also cost more to receive. Though they provide many needed services, these overlapping programs often add to the burdens of the poor, and poor women in particular, by fragmenting into separate delivery systems services that are really essential parts of primary health care. More importantly, such programs continue to view women only from the perspective of producing and caring for their children, rather than recognizing the full range of women's needs.

PAST PROGRAMS OF THE FORD FOUNDATION

As noted earlier, the Ford Foundation has played a leading role in promoting research, policy discussion, and services since population issues first came to the fore in the late 1950s. Initially, the main themes in the Foundation's work were:

- research and training in social sciences related to population issues, particularly demography and (later) management and communications in family-planning programs;
- research in the reproductive sciences, contraceptive development and safety, and building research capacity within developing countries; and
- support for family-planning programs in developing countries.

From 1952 to the early 1980s, the Foundation allocated $260 million to these activities, of which $60 million (24 percent) was for the social sciences, mainly demography, and $150 million (58 percent) for biomedical concerns, mainly for research aimed at greater understanding of human reproduction. During the 1950s allocations were less than $1 million a year, rapidly increasing to a peak of over $20 million annually in the mid-1960s, and declining to about $7 million a year in the 1970s.

After twenty-five years of experience, the Foundation saw a need for a more comprehensive approach to population. During the 1980s four interrelated lines of work evolved:

- Activities to improve women's economic opportunities, education, and health in order to advance women's status and to encourage fertility reduction. At the community level, helping women organize to meet their own needs, in income-generating projects, for example, often resulted in their seeking improvements in other aspects of their lives, including more accessible, higher-quality reproductive health services.
- An emphasis on high-risk mothers and children through the Foundation's Child Survival/Fair Start for Children program, which supported research and community-based health services.
- Support for the development of effective population policies in developing countries by "building the capacity of local social scientists to

analyze national problems within the context of their national culture."[22]

- Efforts to cope with the problem of increasing flows of refugees and migrants throughout the world.

From 1982 to 1989, $69 million was allocated for the latter three activities. Of this, $44.8 million (65 percent) went for Child Survival/Fair Start for Children projects, a substantial part of which were biomedical projects. The rest was allocated to population policies, social science research on population, family planning, and, more recently, to the integration of reproductive health concerns with programs aimed at advancing women's status. Refugee and migrant concerns remained a small part of the overall budget, amounting to $4 million (6 percent).

At the same time, the Foundation was engaged in an overall increase in grants on behalf of women. In 1980 the Foundation's Trustees approved a special appropriation of $19.3 million, which more than doubled such grants between 1980 and 1983. The Urban Poverty, Rural Poverty, and Education and Culture programs focused on such issues as improving women's income and employment opportunities; fostering women's studies programs and policy research related to women; improving girls' and women's access to all levels of education; alleviating the problems faced by teenage parents; and strengthening women's participation in a variety of fields, from the military to the arts. In the Human Rights and Governance program, grant making has sought to advance women's status through legal and policy changes as well as through activities to safeguard women's reproductive choices, including improving access to safe abortion services.

In one portion of the Foundation's 1987 mid-decade review, "Women and Children in Poverty: Reproductive Health and Child Survival," consultants urged the Foundation to focus on women-centered, community-based approaches to reproductive issues. The report recommended that emphasis be placed on the following themes:

- enabling women to become more active as health providers for their families;
- advancing knowledge of the social and cultural context of health programs so as to bridge or reduce the social gap between providers of health services and their users;
- promoting policy discussions and systematic planning (with both governments and donors) to help develop appropriate health and population policies; and
- building capacity in research, advocacy, and management information.

In addition, a Trustee appropriation of $4.5 million in 1988 made it possible to begin funding activities related to the AIDS pandemic. Programming in this area focuses on:

- preventive education and innovative services for people who have AIDS or test positive for the human immunodeficiency virus (HIV), which causes AIDS;
- analysis and dissemination of current data on the demographic, social, and economic consequences of HIV/AIDS in order to inform policy makers of the legal and ethical implications of the AIDS crisis and to encourage due regard for both the rights of HIV positive individuals and public safety; and
- social science research that might contribute to better understanding of disease transmission and of ways to organize effective prevention campaigns.

Encouraged by the mid-decade review and a renewed national concern with issues related to population and reproductive health, the Foundation has developed a new reproductive health and population policy for the 1990s. The strategy proposed in the following pages is the result of a collaborative process with Foundation staff in New York and field offices and with colleagues in the reproductive health field.

THE CURRENT CHALLENGE

The current challenge is to obtain greater government and public commitment to improving reproductive health, which should be understood to mean that

- people have the ability to reproduce as well as to regulate their fertility;
- women are able to go through pregnancy and childbirth safely;
- the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; and
- couples are able to have sexual relationships free of the fear of unwanted pregnancy and of contracting disease.[23]

Improving reproductive health will have an influence on population policies and programs, but is also an important challenge and need in its own right, whether the size of the population is growing, decreasing, or stable.

In responding to this challenge, the Foundation can combine its long experience in the population field, its commitment to improving the lives of disadvantaged women, and its staff's experience in the social sciences. The Foundation hopes to demonstrate that it is possible to be concerned about population growth, women's rights, and equity at the same time. This will require a new conceptualization of reproductive health in its sociocultural context and then demonstrating that programs based on this new thinking are feasible. Although the Foundation is convinced that the fairest and most effective way to approach population questions is through a focus on women, it is also aware that women should not be seen as a means to an end, but rather as individuals whose reproductive rights and decisions must be respected in their own right.

Until now, family planning and other reproductive health services have been largely the responsibility of the medical profession, which often approaches fertility reduction as an issue of compliance with medical recommendations–women should follow doctors' orders. There has been insufficient concern for the needs of ordinary people, particularly disadvantaged women, and the way these needs affect their decisions about health and reproduction. Communities, and women in particular, have been too little involved in decision making and in the design of programs. Health in

general, but reproductive health in particular, could greatly benefit from a change in this situation.

Women should be encouraged to share their own experiences, to recognize common problems, and to develop confidence in their individual and collective ability to change their health conditions.[24] Community activities must explicitly focus on the role of women and poor households since they are often excluded from traditional forms of community organization.

It must also be recognized, however, that in many cultures social and religious status confer important decision-making powers on elders, family heads, and community and religious leaders. Therefore, efforts to raise awareness of the problems and to broaden participation in reproductive health care should include outreach to such people as village chiefs and elders, religious leaders, schoolteachers, parents and extended family, traditional healers, and birth attendants. In particular, programs must involve males in efforts to improve reproductive health. If women are to act as equal partners with men, men must be encouraged to recognize their responsibilities toward the health of the family and to respect their partners' concerns. To increase men's involvement and to counter the sometimes negative influence of their behavior, further research is needed to answer such questions as: What proportion of reproductive decisions are taken by women independently of their partners and under what circumstances? What influence have partners on women's contraceptive use and what motivates the men's attitudes? When men are not involved (or concerned), how much of this is the result of culture, and how much of ignorance?

Improving reproductive health also requires attention to the quality of services provided. Most health programs in developing countries do not properly address the concerns of women, and there are few opportunities for women to contribute to the development of such programs. In addition, many program staff are poorly trained and lack motivation. They have minimal or no supervision, low salaries, and ambiguous objectives, and receive no feedback on the results of their work. This leads to routinization of the work and poor quality of care. In addition, services in high demand frequently are not offered or clients may wait many hours to receive poor assistance. Women are often not given a chance to make an informed choice about which contraceptive would best suit them because few methods are available and counseling is poor. Because of the unequal power relations between clients and health-care providers, clients may fail to raise pressing concerns or if they do their questions may not be answered, particularly if related to women's sexual lives. The impersonal, indifferent, even negative attitudes of staff constitute a strong deterrent to full utilization of services. In the few cases where people in a community have organized to discuss their

problems with basic health-care providers the quality of services has significantly improved.

Sociocultural factors, including the status of women in society and client-provider interaction, play a role at least as important as technology and clinical capacity in the success of reproductive health programs. Yet many governments have failed to consider these factors, in part because it has not been clear how to develop comprehensive, women-oriented programs. The constraints include: limited knowledge of the factors influencing reproductive behavior; inadequate allocation of resources and insufficient decentralization of decision-making power; negative social and cultural attitudes; and limited national capacities. As a result, there are few models of a national reproductive health policy rooted in a concern for equity and women's rights.

A Reproductive Health Approach

The Foundation proposes an approach that will focus on the social, economic, and cultural factors that influence reproductive health as defined earlier. This definition includes safe motherhood, family planning, child survival and development, and control of sexually transmitted diseases. It recognizes that individuals do not perceive their health needs in isolated categories, but rather as part of the circumstances of their whole lives.

Foundation programming will bring a social science perspective to bear on questions that have been largely the domain of the medical profession. It will focus on women and take advantage of the synergistic effects of collaboration with complementary Ford Foundation activities. This program will give special attention to the needs of women throughout their reproductive life cycle. It will include projects targeted to the specific needs of adolescents, both female and male; and it will promote discussion and education about human sexuality, which, though fundamental to all aspects of reproductive health, remains largely ignored. This approach cannot fail to acknowledge the need to provide for safe abortions.

Placing disadvantaged women at the center of reproductive health programs requires a commitment to understanding women and their lives. This can only be achieved by involving them in creating and evaluating programs and through careful social science research. To date, the social sciences' contribution to reproductive health has been limited, in contrast to their contribution to population policies. In general, applied social sciences have lacked academic prestige. Postgraduate training and research in social sciences and health are rare in social science institutions throughout the

world and particularly in developing countries. As mentioned earlier, demography has made an independent and important contribution to knowledge about certain aspects of health. Nevertheless, demographic methodologies, even at the micro level, provide information on correlations among events or characteristics but rarely include explanations of why certain trends exist or how people's decisions are made.

An understanding of the social issues affecting reproductive health depends in part on a number of social science disciplines, particularly anthropology, sociology, and economics. Each of these has a sub-discipline, such as medical anthropology, medical sociology, and health economics, devoted to the study of health issues. These sub-disciplines are relatively new fields in the United States and Europe and still in their infancy in the developing world.

These sub-disciplines tend to follow one of two orientations. The first, found mainly in social science departments of major universities, is theoretically oriented and rarely linked to medically defined problems. For example, data might be collected on the remedies women use to protect their health and subsequent analysis might treat the women's actions as metaphor for other aspects of their lives. In other words, bodily problems are used as a way of making statements about women's social relations or position. The value of this approach is its ability to see a health issue from a lay perspective and within a wider theoretical framework. Its main deficiency, however, is its purely sociological orientation, emphasizing theoretical disciplines and lacking implications for action. Rarely is a comparison made between what women see as threats to their health and threats defined by the medical profession.

The second orientation is more applied and directed to the concerns of the medical profession. Social scientists who are attached to medical schools or schools of public health often espouse this approach. Unfortunately, these social scientists tend to work in an auxiliary capacity rather than as partners in research. They add a social science perspective to medically defined problems, such as discontinuation of contraceptive use, diarrhea, respiratory infections, or maternal mortality. Medical anthropologists, for example, have conducted substantial research on diarrheal disease in children in developing countries: how mothers understand it, what they call it, how they treat it, what they think of the recommended oral rehydration therapy. This sort of information is useful to managers of health programs but should not be seen as the only way social scientists can contribute to improving reproductive health. Starting from the perspective of disease will rarely generate fresh insights into the relationship between how women and

children live and their health, particularly because social scientists working in medical institutions usually have little interaction with their colleagues in social science institutions.

A new kind of social science interest in health is required that combines the strengths of the theoretical and applied orientations. It must be able to provide an understanding of the multifaceted problems of disadvantaged women and their children, and how health figures among them. It must draw on theories about poverty, ethnicity, and gender and will require the development of new methodologies. It should be multidisciplinary and linked to the biological realities of health and disease.

For example, researchers might want to understand why some children in a uniformly poor community are undernourished and others are not. The research might start with a nutritional assessment of the children in the community, ranking them from best to worst. The families of the best- and worst-off children could then be studied sociologically to learn about economic resources, social support, autonomy of members, demands on time, and personal attitudes. Such knowledge could help formulate new hypotheses about the determinants of malnutrition and suggest interventions, including non-medical ones.

In such studies, epidemiology and the other biomedical sciences must contribute to research led by social scientists, not the other way around. This research would create a new body of knowledge in the social sciences capable of collaboration on equal terms with the biomedical sciences. A genuine partnership should have a major effect on the improvement of health in general and reproductive health in particular, especially if the research is fed back to the families as they become involved in both understanding its meaning and in acting on its implications.

Such an approach is now possible because social scientists are becoming more aware of the contribution they can make in illuminating the social determinants of ill health, even as they recognize the limitations of a sociological perspective. Increasing numbers of social scientists and social science departments realize the value of their own research on health as complementary to the insights offered by epidemiology, nutrition, and other aspects of public health. Medical anthropology is undergoing a major renewal that includes the incorporation of quantitative methodologies. In addition, the distinctions between sociology and anthropology are becoming less clear, and health economics is developing as a discipline that is looking increasingly at micro issues.

The reproductive health approach follows the evolution of Foundation programming in the population field, from its successful efforts to establish

demography as an independent discipline and its support for contraceptive research, to its concern with child survival and early childhood development, to support for a range of women's programs. It seems timely now for the Foundation to reorient its programming into a holistic concern for reproductive health and rights, as many governments and organizations around the world are beginning to question past approaches and are seeking new ways to achieve more effective and more just population and health programs.

The Ford Foundation Advantage

The Foundation has traditionally worked with disadvantaged communities and peoples to develop an understanding of and solutions to problems from a societal rather than a technical perspective. The Foundation's experience with small-scale farmers and irrigation illustrates the advantages of bringing a social science perspective to bear on what had been generally considered a technical field. Irrigation specialists had tended to regard farmers as a disruptive element in the technical management of irrigation systems and had sought ways to circumvent or control their behavior. Social scientists, in contrast, viewed farmers as an important resource for irrigation development and management and sought ways to enhance their roles. Over the past fifteen years, the social science perspective has gradually gained prominence in the national programs of a substantial number of countries in Asia and in the irrigation policies of major donors. Farmer participation in the design and construction of irrigation systems, once a heresy among engineers, has become commonplace. Recognition that farmer organizations can manage entire irrigation systems has become widespread, and a number of countries have initiated national programs to turn over the management of government irrigation systems to farmers. Foundation support has played a critical role in developing and maintaining these ideas so that they have become part of the "received wisdom." A similar transformation is needed in the reproductive health field.

Of particular importance is the Foundation's ability to work on sensitive issues that other donors may be unable or unwilling to fund. Questions of human sexuality, fertility, and women's role in society involve issues that are frequently avoided.

Another comparative advantage lies in the Foundation staff now engaged in related work. Among the fourteen Foundation staff members working full- or part-time on reproductive health and population, twelve are social scientists. Through its field offices, where ten of the staff are based,

the Foundation is able to ensure that programs are sensitive to local conditions and are responding to locally identified problems and priorities. This ability to respond to local needs is enhanced by the Foundation's freedom to choose grantees and the subject and content of grants. The field offices are able to provide direct financial support to appropriate local institutions, and staff there can provide professional expertise, drawing upon an extensive knowledge of the local context that is often lacking in programs run from a developed country.

Among funders concerned with reproductive health and population, the Foundation is one of the few with extensive programming in other areas that influence reproductive health, including poverty, human rights and governance, and women's education and income-earning opportunities. Thus, field staff will be able to link reproductive health activities with work in other areas related to women's status. The Foundation's tradition of working with academic social science institutions and with women's organizations and their networks could form the basis for much of its reproductive health work.

Objectives

The general purpose of the Foundation's program in reproductive health is to enhance the capacity of developing countries to develop solutions to their reproductive health and population problems. Activities will focus on the social, cultural, and economic factors that influence reproductive health and population trends, concentrating on the problems of disadvantaged women in both urban and rural areas.

Three specific objectives for the Foundation's work on reproductive health are proposed:

- Develop a comprehensive socioeconomic, legal, and biomedical framework for reproductive health by strengthening social science research and its utilization in policy formulation and the design of services.
- Empower women to better understand their own reproductive health needs and to articulate and act on these needs in the family and at the community and policy levels.
- Promote public dialogue and advance public awareness about reproductive health and population issues, including the development of ethical and legal frameworks in different societies, in order to improve policies and services.

Successful national reproductive health policies and programs require meeting all of these objectives, although there may be different emphases in programming from one field office to another depending on difficulties and opportunities in each country. In order to achieve the objectives listed above, the Foundation proposes strategies discussed in the following chapters. Like the objectives, the strategies are complementary and interrelated.

STRATEGIES

The following strategies have been developed to cover a ten-year period, with Foundation funding estimated at $12.5 million per year. Most of the funds will be spent in direct response to developing countries' needs; more than two-thirds will be allocated to developing social science research on reproductive health and to enabling women to achieve a stronger voice in reproductive health matters. About 10 percent will support grants to help develop ethical and legal frameworks for improving reproductive health. The remaining funds will be allocated from New York. Half of these funds will complement field office activities; the other half will support United States and global activities that influence reproductive health programs and policies around the world.

Social Science Research

In order to develop a more comprehensive framework to address the reproductive health needs of developing countries, the Foundation proposes to strengthen the capacity of the social sciences to deal with these problems so that social scientists may collaborate on equal terms with the biomedical professions. Social science research, by its very nature, is specific to particular sociocultural settings and is best carried out by local investigators most familiar with the indigenous culture and social systems. The following two strategies are proposed.

Building Institutional Capacity

It is proposed that the Foundation support the development of about one dozen multidisciplinary research and training sites in the social sciences and health, with a special focus on reproductive health. These research and training sites would build on existing institutional arrangements and would provide a focal point for groups of social scientists representing different disciplines working collaboratively for research and training purposes. Such groups may be located within a single research institute or university or may comprise individuals from different institutions working under a coordinating administrative mechanism. Like the Foundation's work in developing demographic centers throughout the world, this new effort will require several things: flexibility in the choice of

institutions; support for approaches suited to various local capacities, circumstances, and interests; and, most importantly, a long-term commitment of Foundation funds, with the understanding that within a specified period local institutions will progressively assume responsibility for all recurrent costs.

The research and training sites to be developed with Foundation support will be located in developing countries and should have, or plan to have, a strong representation from such social science disciplines as anthropology, sociology, and health economics. They should be part of, or have strong links to, one or more social science institutions, and they should have a good working relationship with a local school of medicine or public health. Some may be located within universities, but governmental and nongovernmental research institutes would also be eligible for support. They should pay special attention to the diversity of their staff in terms of gender and representation of the country's population. Capacity building may include graduate training, travel and study awards, research support, establishment of libraries, and seminars. The goal is to have, in ten years, three or four strong research and training sites each in Africa, Asia, and Latin America. They should be capable of providing training based on research experience in the field, technical support to other researchers, leadership in theoretical analysis, and resources for public debate and contributions to policy and community-based activities. These institutions and the researchers in them would be working in partnership with biomedical institutions in improving reproductive health.

The research and training sites will be expected to contribute to the achievement of the other objectives listed in this paper. In addition to providing opportunities for training and skills development, they will support and help evaluate the activities of community organizations. They should also encourage a wider concept of research in which gathering information and knowledge is part of the process of empowering women. They should involve local organizations and women's associations in improving services; include policy makers and service providers in research and training programs; and, by providing data and participating in public discussions, inform programs and policies to improve reproductive health and further recognition of reproductive rights.

Research on Poor Women and Children

Research is a component of all the strategies in the Foundation's new reproductive health program. For example, the testing of affordable and replicable models for reproductive health care requires operational research, including studies of cost effectiveness and quality of services. Similarly, all

advocacy work, whether at the community or national level, must be based on a thorough understanding of the cultural, social, economic, and legal contexts of reproductive health.

Support of research projects by social scientists based in developing countries should also help develop a social science research community by promoting peer review and the setting of high standards. This may be achieved by establishing research networks and research competitions through national or regional mechanisms, similar to those in the Foundation's successful Middle East and Africa Awards program. Social scientists from all types of institutions would be eligible to apply, including those working in Foundation-supported research and training sites.

It is worth noting that two different kinds of research may be supported within this strategy. The first, applied research, is tied to practical program needs and is already part of many Foundation-funded projects. Applied research answers such questions as: What do women think about the services available and why do they use or not use them? What are the obstacles faced by individuals seeking reproductive health care? How is the legal status of abortion interpreted by women and their health providers? Since such project-relevant research may require collaboration between action organizations and academic institutions, grants should be structured to encourage such working relations. When research results are meant to inform policy, the Foundation will help ensure that policy makers are involved in the research from its inception.

The second research perspective addresses more general issues, questioning commonly held assumptions about reproductive health and generating new hypotheses about the relation between the lives of disadvantaged women and children and their health. It would follow a new approach to social research in the field of health, linking the biological with social concerns. Social scientists, such as anthropologists, sociologists, or economists, would take the lead in defining the kinds of research needed. Their research, in turn, would be strengthened by contributions from those working in public health.

Following are examples of the kinds of questions that might be raised in this approach: Who are the disadvantaged in a given society and how does the way they live affect their reproductive health? Why is infant mortality so unusually high in West Java, compared with the rest of the island? Why do Egyptian women not use contraceptives even when they say they want no more children? What are the constraints limiting behavior change among persons at risk of AIDS in Thailand? Research on the situation of poor women and children living in rural or urban areas should also address problems of social and economic changes and their effect on reproductive health. For

example, how have structural adjustments programs affected household economics and reproductive health? Even though this type of research may not be tied to action-specific projects, care would be taken to link such research projects to action programs, policy makers, and advocacy groups in order to increase the impact of the research findings.

By bringing both theoretical and applied social science to any discussion of women's and children's health, the Foundation's reproductive health program presents a unique opportunity to reconceptualize health and illness—not just as biological states but as a process related to the way people live. Since virtually no funds exist for this sort of research in developing countries, Foundation support would fill a major gap. This reconceptualization underlies all the other strategies described below.

Empowering Women

To meet this objective, three strategies are proposed: support for community-based activities involving reproductive health and rights; development of women-centered models of reproductive health care; and support for education on reproductive health and rights. These strategies seek to empower women, women's organizations, and their communities to better understand and participate more actively in the promotion and care of their reproductive health. Two essential goals are to enable women to participate as equal partners with men in the decision-making process, within their families and in their communities; and to seek ways to overcome barriers to improved reproductive health, both through better health services and through changes in cultural, social, and economic factors.

Community-Based Activities

The specific form of projects funded under this strategy will vary according to the particular groups concerned—for example, urban or rural communities, poor households, women's organizations, or other types of associations—and according to the conditions prevalent and the services available in various communities. Grants might build on existing community activities related to health or other services, or to projects that promote public discussion or consciousness raising.

The Foundation is already supporting activities of this type in several countries. In Nigeria, for example, concern about a specific health problem, obstetrical fistulae, has led to broader programming to improve women's lives and to mobilize the community. Obstetrical fistulae, openings between the genital, urinary, and digestive tracts with resulting fecal and/or urinary incontinence, are caused by unattended, obstructed labor and are wide-

spread among women in some regions. Many of these women become marginal members of society with few or no resources. In response to this situation, Foundation grants have supported specialized care, including inservice training for Nigerian physicians. Health education, skills development, and income-generating components to provide social and economic security for these women have also been supported. Other grants have supported community education and a campaign to urge community and religious leaders as well as national policy makers to consider the ways in which early marriage and harmful birth practices make obstetrical fistulae more likely.

The Self-Employed Women's Association (SEWA) in India started as a union of street vendors, providing small loans to its members. When the members of SEWA conducted an evaluation of the program, they found that virtually all the women who had not repaid their loans had died or were severely debilitated from pregnancy-related complications. This led SEWA to expand its activities to include reproductive health. Members are now trained to provide health care at the grass-roots level and to develop links with the existing health-care system. A major thrust of SEWA has been to empower women as providers and users of health services.

In an income-generating project in Bangladesh, women's groups decided to develop a small-scale health program. The women collected information on the health problems in their communities and fed this information back into the training curriculum of a newly established health-education program targeted to poor, women-headed households. The women also were trained to take over responsibility for securing and refrigerating vaccines, and for ensuring regular vaccination of the children in their villages. This project now includes a men's group with similar objectives.

Comprehensive community-based projects like these offer the opportunity for collaboration and, in some cases, integration with other Foundation activities to improve women's status.

Women-Centered Care

The Foundation is currently supporting a variety of experimental service models aimed at improving the quality of care so as to be more responsive to women's needs. These and other models should be expanded, replicated, and carefully analyzed to draw generally applicable lessons. In many countries, government programs are the main source of services for the most disadvantaged groups. The Foundation must therefore consider how community-based experimental models can contribute to the reorientation of public programs in reproductive health. Cost effectiveness, financ-

ing, and sustainability both at the community and the national levels also must be taken into account.

Activities will focus on primary health care at the community level and on the quality of services. Models of primary health care should include appropriate referral systems, particularly for reproductive health services where obstetric emergencies require timely, specialized technical assistance to reduce the chances of maternal and infant death. Other essential elements of quality services include information suited to the needs of users and the linking of services related to all aspects of reproductive health. Priority also should be given to improving accountability.

In many areas, where services are lacking or are of poor quality, women will continue to rely on traditional birth attendants (TBAS) and other traditional health practitioners. Since their importance should be recognized, the Foundation will support programs to encourage beneficial traditional health practices and change harmful ones. One such program in India teaches technical skills to TBAS, most of whom are from lower castes, and their new skills help enhance their self-esteem. This is important because TBA effectiveness depends not only on technical skills but also on the respect they are given by the community and the health profession.

In West Africa, the Foundation is helping strengthen the skills of health professionals to provide women with quality primary health care. For example, the Foundation is supporting efforts by fourteen Nigerian medical students' associations to design and implement both community-based and mass-media campaigns on family-planning information. Grants also have been made to the National Association of Nigeria Nurses and Midwives to develop the skills of their members in community assessment and organization and to enhance their partnership with community leaders. Support also has been provided for a program to train nurses and midwives in the training and supervision of traditional midwives.

Education

A third strategy to empower women to act on their reproductive health needs is support for educational activities that enable women to make informed choices and encourage them to raise questions important to them with their health providers and within their communities. Specific projects will be targeted to men's and women's groups so as to raise awareness of the extent and consequences of reproductive health problems. Educational efforts will include support for print and electronic media but will also build on more traditional channels of communication such as theater, music, community meetings, and other means likely to reach the audiences

intended. Such efforts are already being supported in a few places. For example, a grant to the Cairo Women's Health Book Collective is supporting a book of educational materials on women's reproductive health. It is based on local research and discussions with women, public health specialists, and service providers.

In Nigeria the Foundation is supporting a community-based health education and counseling project dealing with sexually transmitted diseases (STDs) and AIDS prevention. Part of the project, based in two bus depots, is targeted to long-distance truck drivers, frequent travelers, and others who may have multiple sexual partners and therefore may be at high risk of contracting and spreading STDs. The project is also training union officials to educate their fellow union leaders about the risks of STDs. The project uses research to develop educational materials for its various target audiences.

Policy, Ethics, and Law

Two strategies are proposed to meet this objective: support for the promotion of informed public discussions and for the dissemination of information in order to define areas of consensus about reproductive health policies and practices, raise public awareness, and contribute to policy changes.

Dialogue and Coalition Building

Knowledge and understanding of the complexities of issues related to reproductive health and their interaction with individual and social values require an informed and respectful discussion at all levels of society. Such discussion can make an important contribution to regulation and legislation that are based on the broadest consensus possible and that respect different views where no consensus exists.

Because women's views on health services have been largely missing from policy debates and in decisions about the design and content of services, the Foundation will give special attention to programs that strengthen women's ability to participate in discussions in their own communities and at all levels of public debate.

An example of work already being done in this area is the collaboration between the Foundation and the Institute of Social Studies and Action in the Philippines. The institute monitors legal and policy issues that relate to women's reproductive health and informs women's groups about them. It also convenes meetings that bring together women's groups, legislators, and government policy makers to discuss such issues. In India the Foundation has supported the National Planning Commission to stimulate discussion

on the Women and Development chapter of the nation's eighth Five-Year Plan. State and regional meetings were held with activists, scholars, and representatives of nongovernmental organizations, which provided a forum for diverse perspectives on problems facing women in India, including health, education, employment, and legal rights.

Ethical and legal values are basic components of any debate on reproductive health, and participation of specialists on these matters is essential to a respectful and properly informed discussion in any society. Seminars, workshops, and conferences bringing together participants from various pertinent backgrounds are other areas of possible Foundation support. At the 1988 Tietze Symposium, organized by the International Women's Health Coalition in Rio de Janeiro and partially funded by the Foundation, feminist leaders, ethicists, physicians, sociologists, and lawyers met for a comprehensive discussion of abortion. Foundation funds also supported the participation of people from developing countries in a symposium at the University of Iowa on medical, ethical, and legal issues related to the beginning of human life. The meeting was attended by physicians, lawyers, social scientists, theologians, and ethicists.

Many aspects of both customary and statutory laws, ranging from the legal age for marriage to criminal penalties for abortion, have a direct bearing on women's reproductive health. Child marriage, forced sexual intercourse, seclusion of women, denial of access to safe maternity care, and female circumcision are all examples of the denial or neglect of women's fundamental rights. Acknowledgment of and respect for these rights is a long-term aim of the Foundation's proposed work in reproductive health. To bring that about requires better documentation of the consequences for women's lives of such practices and laws, as has been done on the results of too-early and too-frequent pregnancies and septic abortions. By increasing awareness and discussion among key constituencies, sound documentation can lay the foundation for changes in laws and practices. Pursuing this approach requires great sensitivity to the circumstances of each country or region and a willingness by local health professionals, women's groups, and human rights lawyers to take up these issues.

Other grants might support legal research to develop a framework for reproductive health based on national and international laws and norms; development of a law school curriculum to inform students about reproductive rights and the health consequences of current laws; and collaboration between family-planning agencies and legal advocates.

Grant making in this area will be closely linked to the Foundation's activities related to women's rights.

Dissemination of Information

Gathering and disseminating information about certain reproductive health problems and their relation to current law is necessary to raise awareness, influence public opinion, and ultimately to change national policies and laws. In implementing this strategy, the expertise of the epidemiology networks developed during the 1980s with Foundation support can be used to supply knowledge necessary to achieve the new objectives.

Studies of the prevalence of illegal and unsafe abortions in a given country and of the demands they place on the country's health services will provide the country-specific information essential for an informed debate and the subsequent development of health and legal reforms. Such data should be the background against which the moral values involved are discussed. Another study might document the effects of laws prohibiting sterilization. In Brazil, for example, where sterilization is illegal, a large proportion of pregnant women deliver by Caesarean section so that a tubal ligation can be simultaneously (though unofficially) performed, at considerably greater risk to the mother and child.

In many cases such research and the dissemination of results will be closely linked to the Foundation's community initiatives. In Nigeria, a multidisciplinary research program on sexual behavior and STDs, including AIDS, is providing much-needed community data in this area. The research findings are being used to develop health education materials, to design a training program for primary health-care workers, and to bring public attention to STDs, a devastating but only reluctantly acknowledged reproductive health problem. Dissemination of such policy research to key groups of lawyers, women's organizations, religious leaders, and policy makers, as well as health professionals, is essential to a better informed public debate.

COORDINATION OF ACTIVITIES

The coordination of Foundation grant making and the exchange of experiences between field offices and New York should ensure a consistent, well-focused program with the potential for significant effect. Periodic international and regional meetings will take place as well as individual visits among staff of the different offices.

Programming emanating from New York will complement or provide backup to field-office initiatives. New York staff will also promote an informed dialogue on reproductive health issues in the United States and at the international level. This will include bringing developing-country perspectives to policy debates that may have an effect on reproductive health in developing countries. In keeping with Foundation efforts to integrate its U.S. and developing-country programs, staff will also explore possible areas of collaboration with other programs both within and outside the Foundation and encourage the sharing of lessons learned from efforts to develop comprehensive approaches to the problems of poverty, discrimination, and reproductive health.

Although the Foundation emphasizes funding local institutions directly, it recognizes that international institutions or those based in developed countries can also provide valuable contributions. The Foundation has a long history of working with such intermediaries and can draw upon their technical expertise to assist activities promoting a women-centered approach to reproductive health. When support for intermediaries is provided, it is important to ensure that such funding is used to fill gaps that cannot be met by the developing countries themselves. Clear outlines of the proposed activities of the international intermediary will be established, and staff of the field office, New York, and the grantee will cooperate closely on the terms of the grant. One of the elements of such grants will be to strengthen the capacity of local institutions to further programs in reproductive health.

The magnitude of the proposed objectives will also require linking the Foundation's efforts with those of other donors. Both private foundations and international agencies have shown a growing interest in supporting activities that include the social aspects of reproductive health, and many are exploring ways to support more comprehensive, women-centered approaches to these issues. Discussions are under way with several founda-

tions and international agencies. In particular, partnerships are being sought to strengthen social science work on reproductive health.

Evaluation

Periodic evaluation of specific projects and of the new program overall will be essential to sustain improvements in reproductive health. These evaluations will be important both to assess the success of particular projects and to help build a common body of knowledge in an area that is still little understood. The results of evaluations will be disseminated both within the Foundation and to colleagues in the field.

Evaluation will be included as an integral part of grants whenever possible, and support for independent evaluations will be provided as well. The lessons learned could contribute to more informed public debate and to improvements in policies. Systematic evaluation could also contribute to the development of innovations that are affordable and useful on a wide scale. In such evaluations, priority will be given to the participation of researchers from the social science research and training centers the Foundation intends to support. Including scholars from the centers will increase their research experience and enhance their training.

Every five years the Foundation will support a review of its efforts in reproductive health. The first five-year evaluation will focus on the progress and achievements made. The second evaluation will include a major reappraisal of the objectives and the strategies in light of achievements and changing circumstances. In addition to the overarching objectives of the program, evaluators should keep in mind that some specific aims of the program are:

- to reconceptualize reproductive health in a holistic perspective in which both social and biomedical factors are recognized;
- to develop multidisciplinary social science research and training centers capable of working in partnership with medical professionals in the field of reproductive health;
- to promote reproductive health policies and programs that are sensitive to the needs of women;
- to promote models of women-centered health care that can be adopted by public institutions;
- to change the atmosphere in which reproductive health and population are discussed and policy decisions made; and
- to have a positive effect on the status of women, on public health indicators of reproductive health, and on demographic indices.

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