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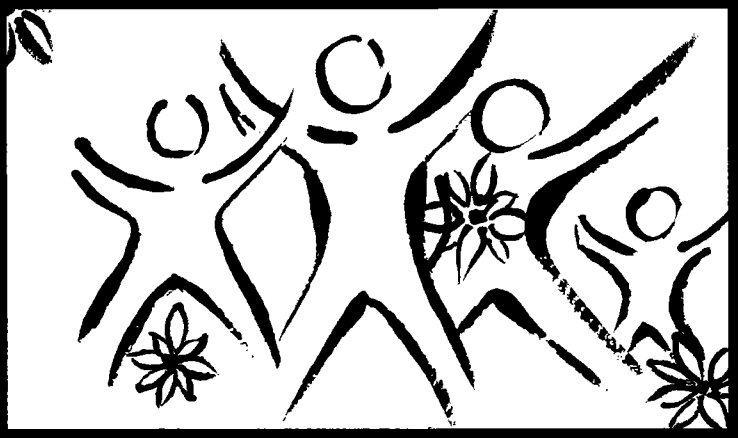

Statement by
Dr Gro Harlem Brundtland
Director-General

ICPD + 5 Forum, The Hague, 8-12 February 1999

World Health Organization
Geneva

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Reproductive Health: A Health Priority

Mr Chairman, excellencies, distinguished guests, friends and colleagues, ladies and gentlemen.

I am here today to pledge the commitment of the World Health Organization to reproductive health - a health priority into a new century.

I am here to lend our support to those committed women, men and constituencies who speak out for the right of all people to lead a healthy reproductive life.

I am here to share with you our impatience. Cairo was a crossroads. A lot has happened since 1994, but there is still a long way to go.

Today, a broader understanding of reproductive health is gaining ground. Reproductive health deals with intimate and highly valued aspects of our lives. It reflects health in childhood and adolescence. It sets the stage for health beyond the reproductive years for both men and women.

It is about relationships, with its positive dimensions - closeness, fulfilment, the opportunity to have a desired child. But there are the negative ones - disease, abuse, exploitation, unwanted pregnancy and even death.

Why did it take us so long to understand the full importance of reproductive health? Partly because these highly personal aspects of life are difficult to talk about openly. But also because there have been cultural taboos - and because women have been denied access to political, social and economic decision-shaping and decision-making.

Cairo was significant because it changed a lot of that. Our discussions there resonated around the world. Since Cairo, a more open debate has been possible on adolescent sexuality, on HIV/AIDS and on unsafe abortion.

Unless we can talk about the real challenges that we face - pandemics of sexually transmitted diseases, adolescent pregnancies, sexual abuse, rape, and pregnancy-related deaths and disabilities - we will never be able to address them, or to change the situation.

Let there be no doubt. We will need decades of continued advocacy and action. WHO for its part will speak out more strongly.

When we take stock of progress since 1994, there are positive changes - such as the paradigm shift from population control to reproductive health and rights. There are negative trends - such as a failing will to implement the Plan of Action and, not least, the tragic lack of resources. And there are still needs crying out for urgent attention - such as the challenge of adolescent sexuality and the tragedy of maternal mortality.

Let us consider the good things first. Cairo was a turning point because it placed sexual and reproductive health within an ethical framework.

I want to be clear about this. Failure to address people's reproductive health needs is a matter of human rights and social justice. People have a right to make free and informed decisions about their reproductive lives. They have a right to information and care that will enable them to protect their health and that of their loved ones. They have a right to benefit from scientific progress in health care.

We must never forget the right to equality and nondiscrimination on grounds such as sex, marital status, race, age and class. People have a right to privacy and to freedom from sexual violence and coercion. Defining reproductive ill-health as not only a health issue but as a matter of social justice provides a legal and political basis for governments to act.

We know what happens when they do not act - when people's sexual and reproductive rights are denied.

- Every year, at least 120 million women who do not want to become pregnant do not have the means to prevent it.
- Every year, 20 million women put their health and lives at risk because they seek unsafe abortions.
- Every year, there are more than 330 million new cases of curable sexually transmitted diseases and one in 20 adolescents become infected.
- Every year, the HIV virus infects 5.2 million people, over half of them young people below 24 years old.
- Every year, there are 450 000 new cases of cancer of the cervix.

Between 5% and 15% of the global burden of disease is associated with failures to address reproductive health needs. This burden hits people - particularly women - in the prime of life, it hits when their potential, responsibilities, and productivity are at their highest. Globally, among women of reproductive age, more than 20% of total years of healthy life lost are due to three main groups of reproductive health conditions - sexually transmitted diseases including HIV/AIDS, maternal mortality and morbidity, and reproductive tract cancers. A further 10% of healthy years of life are lost due to conditions affecting the newborn.

These figures are alarming in themselves - but they are still only the tip of the iceberg. The total burden remains inadequately documented and measured. Reproductive tract infections cause a huge toll of needless suffering. We are becoming aware of the importance of the mental and physical ill-health associated with violence, the harmful practice of female genital mutilation and sexual abuse.

Since Cairo, increasing attention has been given to these neglected issues, and let us pay a particular tribute to the NGO community for having pioneered effective efforts in these areas.

The Programme of Action from Cairo was not a blueprint. Countries have different needs and varying social and economic contexts, and will find different ways of fulfilling the agenda of Cairo.

Governments and civil society need to develop a public health approach to reproductive health that is cost-effective and has the maximum impact. There are lessons to be learned from 20 years of experience with Primary Health Care, looking beyond the customary boundaries of curative and preventive medicine and addressing the underlying social causes of poverty, hunger and ill-health.

It is not a job for the traditional health sector alone. The agenda is as much about social justice as it is about health care. We need to clarify concepts and to define the division of labour among sectors and professions.

Let me move on to the issue of declining real resources.

In Cairo we were aware of the growing problem of aid fatigue. Since then things have become worse. Developed countries have committed to contributing 0.7% of their GDP to development assistance. I know that is no small commitment, having fought the case as Prime Minister for Norway to have close to 1%. The sombre global average today is 0.2% and it is declining.

Global resources for public health interventions in reproductive health have also failed to keep up with increasing demand. As a result, there is a tendency to move away from the comprehensive definition of reproductive health that we developed at Cairo. We know who will pay the price. The most vulnerable - and above all millions of women and children.

We cannot bow our heads. We need to speak out with commitment and with convincing arguments.

Needless suffering and death are sufficient cause for action in themselves, but there are also significant social and economic considerations. Reproductive ill-health affects young people with family responsibilities, women and men in the prime of their lives.

Just imagine the costs, to the individual and to society, of the 600 000 women dying every year due to maternal causes, and the 7.6 million perinatal deaths. Not to mention the 2 million little girls subjected to female genital mutilation. Think of the costs of failing to ensure that young people - our common future - have the knowledge, skills and services they need to help them make healthy choices in their sexual and reproductive lives. Investment in reproductive health is an investment in future health and development. This message must be brought more convincingly to decision-makers. WHO will increase its gathering of evidence and its ability to bring it clearly across.

We know what needs to be done to reduce maternal mortality. We know how to prevent and treat many sexually transmitted diseases. We know how to increase people's choices regarding the number and spacing of their children. We know the kinds of interventions needed to promote breastfeeding.

We still have a lot to learn about how to prevent sexual abuse and violence, how to care for people with HIV infection, and how best to reach out to the

poor and most disadvantaged. We must continually seek to expand our knowledge of what works. We must anchor all our activities on a foundation of sound scientific evidence.

The evidence base is important because it enables us to assess what *needs* to be done, guides us in determining what *can* be done and permits us to evaluate what *has* been done in our health systems and health programmes. Evidence-based approaches help us to allocate and use our resources wisely. In WHO we have created a separate cluster on Evidence and Information for Policy. This too is a global public good - available for countries to access and learn from.

Looking ahead - five years after Cairo, I see two issues that demand our urgent and undivided attention. As the end of the twentieth century approaches, we must deal with the unfinished agenda in **maternal health** and we must address the **emerging challenge of adolescent sexual and reproductive health**.

Look at the tragedy of **maternal mortality**, an area where there has been little sign of progress. In parts of Africa, women face a one in 16 risk of death because they do not receive the care they need when they get pregnant. By contrast, in most of Europe and North America, such a tragedy will hit only one woman in 4000. No other indicator so starkly reflects the disparities between rich and poor, between the haves and have nots, between the developed and developing worlds.

Every death is a tragedy. The death of a young woman, who may have other children who depend on her, is a multiple tragedy. The inexcusable fact is that so many of these deaths are preventable. They are preventable with simple and cost-effective interventions. Pregnant women must have access to skilled care. They must be able to reach a functioning health care facility when complications arise.

These interventions are feasible, measurable and effective. Why have we not made more progress?

Part of the answer lies in piecemeal approaches. Health care providers have been trained, women have been informed about the risks of pregnancy and

childbirth, micronutrients have been distributed, antenatal care programmes have been established, family planning information and services have been made available. But not enough effort and resources have been directed into strengthening the health system.

WHO will address this challenge. We interpret the high levels of maternal mortality not only in terms of what they mean for women and children, not only in terms of their disease burden, but in terms of what they tell us about the failure of health systems, policies and programmes to address the essential needs of women.

We cannot address maternal mortality without a functioning health care system. A well-run health sector is designed to reduce inequity of access, focus on quality of health outcomes, both at clinical level and for public health programmes, and use scarce funds as effectively and efficiently as possible. It is responsive, and allows people a voice in setting priorities and in holding providers accountable for their performance.

The health sector cannot function without strong links to other parts of government, to the private sector and civil society. We will offer reliable and effective support to countries as they reform and restructure their health sector, making sure that people - particularly poor people - get a better deal from their health system.

At WHO we will give special priority to this - as we invite our Member States to join in a Partnership for Health Sector Development.

The second urgent issue that we must address is **adolescent sexual and reproductive health**.

There is often a deep-seated discomfort in dealing with adolescent sexuality. We need to change this. Adolescents - in developed and developing countries alike - are vulnerable - because of a variety of biological, psychological and social factors. Every year, one in 20 adolescents contracts a sexually transmitted disease and one in four unsafe abortions occurs in adolescence. We have an ethical duty to do what is necessary to prevent this suffering and devastation.

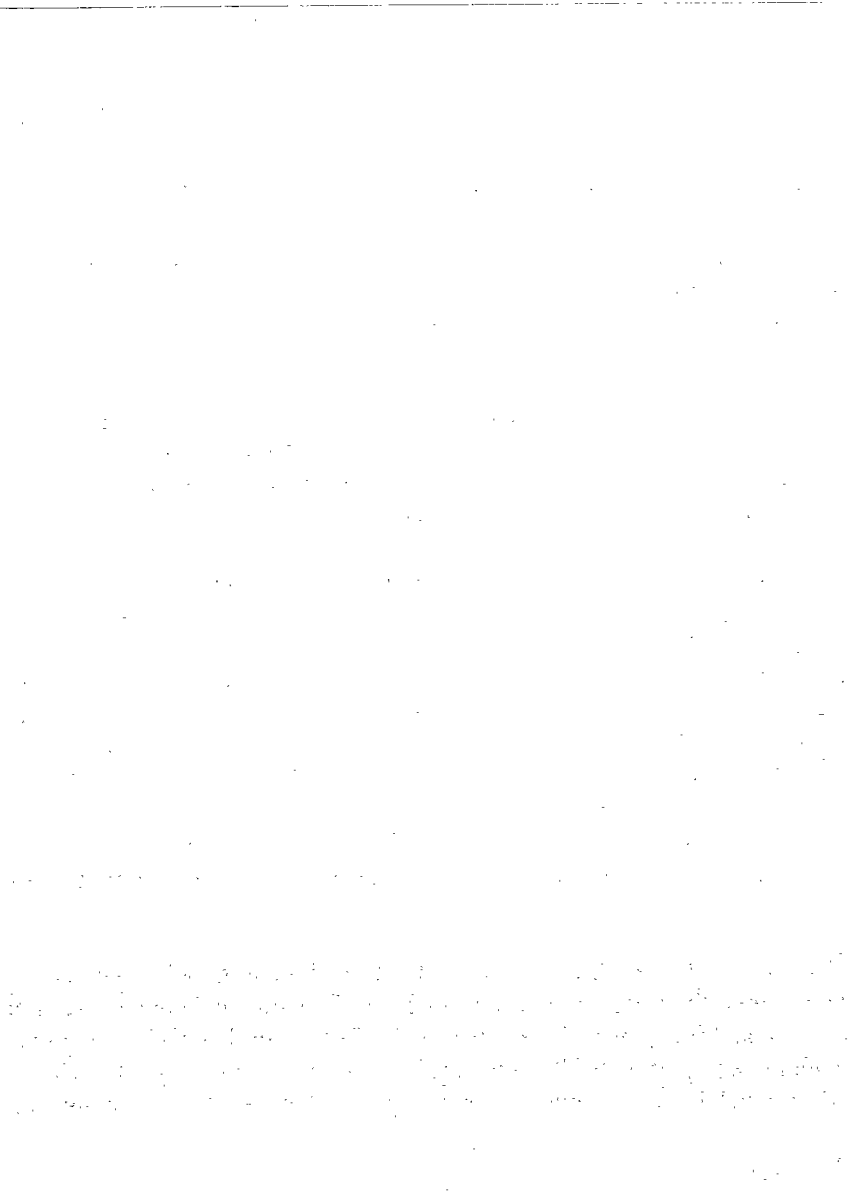
Young people need adult assistance to deal with the thoughts, feelings and experiences that accompany physical maturity. By providing this help, we are not encouraging irresponsible lifestyles. Evidence from around the world has clearly shown that providing information and building skills on human sexuality and human relationships helps avert health problems, and creates more mature and responsible attitudes.

Looking ahead, we need to make strategic alliances. The broad reproductive health agenda is too big and complex for any single agency. We can be more effective when we link with others, agree on a division of labour, and create real partnerships to achieve real outcomes.

This message goes to all those committed to international health and development. It is vital that we work together. We must not give mixed messages. We must avoid overlap and duplication. Let us share commitments as we look towards the next millennium. Let us work with countries, help them to mobilize their collective wisdom, knowledge and action and share experiences in carrying out reproductive health strategies. Let us pay more attention to reducing the disparity between the health outcomes of the poor and the better off. Let us promote increased access to a package of services that addresses people's needs in family planning, in prevention and management of sexually transmitted diseases and pregnancy care.

Cairo was a pledge for action. In the weeks and months leading up to July, let us renew the pledge. Let us generate and share our new knowledge. Let us build and strengthen a broad alliance for the key survival issues. WHO is committed to putting health at the core of the development agenda. That is where it belongs. Reproductive health is part and parcel of that commitment.

Thank you.



Statement by
Dr Gro Harlem Brundtland
Director-General

Plenary Session
ICPD + 5 Forum
The Hague, 9 February 1999

Mr Chairman, excellencies, distinguished guests, friends and colleagues, ladies and gentlemen,

Five years after Cairo we are getting together with a three-fold purpose:

- To maintain momentum where we have made progress
- To recreate momentum where we are lagging behind
- And to inspire each other to make an extra effort in the quest for the right of women, men and adolescents to lead a healthy reproductive life.

Let us thank the Government of the Netherlands, for giving us the opportunity to come together to review progress since that historic meeting in Cairo. And let us pay tribute to Dr Nafis Sadik, who has kept the vision of Cairo alive during these five years.

In Cairo we sent a new message: it is possible to achieve the stabilization of the world population while at the same time attending to people's health needs and respecting their rights in reproduction. We called for a shift in population policies and programmes. We went from an emphasis on demographic targets for reduced population growth to a focus on improving reproductive health. We advocated for measures that would enable people to make choices in a context of equity, human rights, mutual responsibilities and shared respect.

We sent a new message - an optimistic message. Progress and development can be reached by empowering people, especially women who for too long have been denied their fair access to political, social and economic decision-shaping and decision-making.

As Prime Minister of Norway, a country with a long interest in international health and development, I addressed the Cairo meeting. I emphasized then that visions are needed to bring about change. But I stressed that we must let visions and commitments materialize through allocation of resources. It was clear to me that the really hard work would begin when the ICPD was over.

Today, as Director-General of the World Health Organization, I see even more clearly the truth of what I chose to say five years ago.

Let us be clear about it. The Cairo commitments have not always been followed by the resources needed for commitments to be translated into improvements in people's lives. Many developing countries are responding to the challenge and allocate more resources to reproductive health - often with WHO's support and assistance. However, with some laudable exceptions, such as our host country, developed countries are not fulfilling their commitments.

In 1996, donor assistance represented no more than 35% of what was promised in Cairo. We have obligations to fulfill. Needless suffering and death are sufficient cause for action themselves but there are also significant social and economic considerations. Reproductive ill-health affects the young, people with family responsibilities, women and men at a period in their lives when they have the potential to be most productive for communities and societies.

In area after area of reproductive health we know what to do to change the course. And in most cases it is not costly. Not at all.

On this important occasion, I pledge WHO's commitment to the issues of population, development and reproductive health, a commitment that will be strengthened in the new organizational structure of the Organization. WHO will be more effective, more accountable, more transparent and more receptive to a changing world. We will establish stronger partnerships with Member States and we will be reaching out to the whole UN family, the international financial institutions, nongovernmental organizations and the private sector.

I would like to take this opportunity here at the Hague - as we start our preparations for the General Assembly in July - to focus on one specific issue that lies at the very heart of the Cairo consensus. I am talking about the tragedy of maternal mortality.

At the end of the twentieth century, it is unacceptable that women continue to suffer and die as a result of complications related to pregnancy and childbirth. The enormous disparities in levels of maternal mortality and morbidity between rich and poor are a continuing affront to all of us.

We have evidence of what works and what does not work to reduce maternal mortality. Women must have access to skilled assistance during pregnancy and childbirth; they must be able to reach a functioning health care facility when complications arise. We are not asking for the impossible; the interventions needed are well known. They are simple and cost-effective. We have no excuses for failing to act. As Director-General of WHO, I pledge maximum efforts to address maternal mortality.

Distinguished participants,

It is essential to maintain a long-term perspective regarding the implementation of the ICPD agenda. But we also need to be impatient. Despite many encouraging signs, we know that only limited progress has been made in actually implementing the Cairo Programme of Action. This should not surprise us. Despite the enormous conceptual advances that Cairo represented, much remains to be done about reproductive health. There are many barriers - political and cultural barriers - to its attainment. It takes time to turn institutions and thinking around, and even longer to be able to measure the impact of those changes.

We all need to mobilize to make a difference. WHO as the lead agency in health is ready to make a real contribution. Let us be impatient and enthusiastic. We can make a difference for the lives of millions.

Thank you.