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MEETING THE GOALS OF THE ICPD: CONSEQUENCES OF RESOURCE SHORTFALLS UP TO THE YEAR 2000

Report of the Executive Director

97-19074

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EXECUTIVE SUMMARY

1. UNFPA presented a conference room paper (DP/FPA/1997/ CRP.1) to the Executive Board at its annual session in May 1997. The Board discussed the paper with interest and requested that the analysis be refined and the data and methodology described in detail. The Board further requested that the revised report be submitted to the Board at its third regular session 1997 (decision 97/20). The present report responds to that request. The report is accompanied by an annex which explains the data, methodology and assumptions used in the report and contains tables on the consequences of resource shortfalls, the rates used for the estimates of these consequences, and possible patterns for donor assistance for the year 2000. It also provides a composite list of references used in the text, tables, figures and notes to the report.

2. The International Conference on Population and Development (ICPD) outlined a comprehensive agenda of activities for population and development including public, private and civic actions for reproductive health, mortality reduction, women's empowerment, poverty eradication and educational advancement. A new paradigm of population and development emerged from the Conference -- one that shifted population away from an exclusive focus on demographic concerns and targets to one that put the well-being of individual women and men at the centre of sustainable development. The ICPD's Programme of Action acknowledged the salience of demographic goals for macro-level development but underscored that such goals can best be accomplished by meeting the needs of individuals and increasing the role of all groups in civil society in achieving sustainable development.

3. The ICPD's Programme of Action constituted a 20-year plan, anchored in an overall human rights framework, for attaining a wide variety of goals: universal access to quality reproductive health services, including voluntary family planning, so that by the end of the 1995-2015 period all couples who so desired would have access to affordable and effective services; reductions in infant, child and maternal mortality; gender equity and equality and the empowerment of women; the widest possible access to secondary and higher levels of education for girls and women; and universal primary education. A basic package of integrated population and reproductive health programmes was accepted as central to this development plan.

4. The Programme of Action specified the financial resources (both domestic and donor funds) needed to implement the population and reproductive health package over the 20-year time span: $17 billion per annum in 2000 (and up to $21.7 billion in 2015). In 1994 and 1995, substantial resource increases were recorded, and in 1995 around $9.5 billion was mobilized. Some concern has been expressed, based on incomplete data, that this momentum has not been maintained after 1995.

5. This report examines the likely consequences of not meeting the goals of the ICPD Programme of Action due to resource shortfalls. It projects some readily quantifiable results of

such shortfalls, based on three plausible scenarios of future resource mobilization through 2000. These likely consequences include:

- An additional 44 million to 80 million individuals or couples not using any contraceptive method at all in the year 2000;
- An additional 130 million to 230 million unintended or unwanted pregnancies in the 1995-2000 period;
- An additional 50 million to 90 million induced abortions in the 1995-2000 period;
- An extra 59 million to 110 million unintended births between 1995 and 2000;
- An additional 300,000 to 540,000 maternal deaths during 1995-2000;
- An additional 4.9 million to 8.9 million infant and child deaths during 1995-2000.

I. INTRODUCTION

6. This report has as its main objective the illustration of specific population and reproductive health consequences that are likely to occur if the international community fails to implement the Programme of Action set out at the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in September 1994. The ICPD Programme of Action was designed, *inter alia,* to help developing countries and countries with economies in transition to meet future demand for reproductive health and family planning information and services, including the prevention of sexually transmitted diseases (STDs). The Programme of Action set out a schedule of financial targets for resource mobilization, on the part of both developed and developing countries, that would be required to meet this growing demand. These two parts of the Programme of Action are linked: a shortfall in resource mobilization will cause developing countries to miss achieving the Programme of Action's goals for reproductive choices and the reproductive outcomes. Quantifying the consequences of resource shortfalls on a selected set of indicators on reproductive outcomes, then, is the purpose of this report.

7. The Programme of Action, in paragraphs 13.15 and 14.11, laid out the international consensus on future global resource mobilization for the 1995-2015 period as follows (in billions of dollars per year):

	2000	2005	2010	2015
Domestic resources	$11.3	$12.4	$13.7	$14.5
Donor countries' assistance	$5.7	$6.1	$6.8	$7.2
Total resource requirement	$17.0	$18.5	$20.5	$21.7

The shares between donor and developing countries, one third and two thirds, respectively, was agreed in the Programme of Action (para. 13.16). At the same time, it was recognized that a great variation existed among countries in their ability to allocate domestic resources for implementing the Programme of Action. It was clearly foreseen, for instance, that in the least developed countries and other low-income countries, including many sub-Saharan African countries, a relatively larger part of the total needed resources would have to come from external sources on a concessional or grant basis.

8. The fact that a strong consensus emerged in Cairo, for both a focused programme on population and reproductive health and an agreed schedule of resource mobilization, produced a sense of optimism that global population and reproductive-health issues would be dealt with in a concerted way following a pragmatic 20-year plan. Indeed, a report on resource flows to the recent session of the Commission on Population and Development documented substantial and encouraging increases in official development assistance (ODA) and other international resources for population in both 1994 and 1995, reaching the $2.0 billion level in the latter year (document E/CN.9/1997/6). The report also analysed partial information on domestic financial flows in developing countries themselves. Preliminary, rough estimates of domestic flows for 1995 indicate that government allocations for population may have been in the order of $6.4 billion, with another $1.1 billion from domestic private sources. This results in a total resource level for both domestic and international sources of $9.5 billion in 1995.[1] If data collection efforts now under way confirm these figures, it would mean that recipient countries contributed around 78 per cent to total population resources in 1995 ($7.5 billion of the total $9.5 billion), a proportion greater than the 67 per cent agreed to in Cairo for the year 2000.

9. The Commission report, however, also noted indications of a slackening in external resource flows in 1996. This is reaffirmed by preliminary assessments for the resource situation for 1997, particularly as regards the donor community as a whole. At a meeting of donor countries convened by UNFPA in March 1997, several countries voiced their concern at this slow down in resource flows and the negative consequences that insufficient resource mobilization would have for population and development efforts -- one of the most successful and cost-effective areas of developmental assistance over the last 25 years. Many countries represented at that meeting asked UNFPA to prepare a quantitative analysis of the consequences

for the implementation of the ICPD of failure on the part of the donor community to meet its share of the ICPD's resource mobilization targets for the year 2000.

10. In response to this request, UNFPA presented a conference room paper (DP/FPA/1997/CRP.1) to the Executive Board at its annual session in May 1997. The Board's discussion showed that the paper's theme was viewed as an extremely important one. The Board requested that the analysis be refined, that the methodology used be made more explicit and that the data used be described in detail. The present report responds to that request of the Executive Board.

II. METHODOLOGY AND SCENARIOS

11. The methodology used to estimate the negative consequences of resource shortfalls to the year 2000 is based on the methodology used in preparations for the ICPD itself to estimate resource requirements (UNFPA, 1994b). Of the total requirement of $17 billion for the year 2000, four components were identified in the Programme of Action: (a) the family planning component, $10.2 billion; (b) basic reproductive health services, $5 billion; (c) specific programmes for the prevention of STDs, including HIV/AIDS, $1.3 billion; and (d) basic research, data and policy analysis, $500 million.[2] The first and largest component, on family planning, was estimated using a methodology grounded in a reproductive rights approach and based on the unmet needs for family planning services expressed by individuals and couples themselves. Using a regional level of analysis, unmet need for family planning by region was estimated. This was coupled with projected annual costs per contraceptive user by region to arrive at global estimates of annual resource requirements. A methodology developed at the World Bank was used to further project the future evolution of contraceptive prevalence and unmet need.

12. Data from demographic and health surveys, a key input into the costing methodology, show that unmet need for contraceptives, based on married women not practicing family planning, ranges from 14 per cent of married couples in countries such as Brazil, Colombia, Indonesia and Sri Lanka to more than 35 per cent in other countries such as Bolivia, Ghana, Kenya and Togo. These figures, as well as those based on the earlier World Fertility Survey, are usually considered to be underestimates because they do not include sexually active unmarried adults and adolescents. In many countries, the unmarried, adolescents and men in general do not have adequate access to family planning services. Statistics on abortion provide yet another strong indication of unmet need for family planning: women often resort to abortion because of a lack of available contraceptive services, a dissatisfaction with existing services, failure or ineffective use of a contraceptive, or insufficient support for their own reproductive desires.

13. Service cost per user is the other principal variable needed for estimating resources required for the family planning component of the Programme of Action. Studies of family planning expenditures per contraceptive user have, however, been conducted for various

countries and show that costs vary considerably from country to country. For example, in Ecuador, with 435,000 modern contraceptive users served, the average annual family planning expenditure per user for the period 1990-1994 was estimated at $14. In Bangladesh, with more than 5 million modern contraceptive users served, the annual expenditure per user came to around $13 in 1986-1990. Data for the Philippines show that in 1994, with an estimated 2.3 million modern contraceptive users served, the average annual cost per user was over $21. The annual family planning expenditure per user in Ghana, which had almost 260,000 modern contraceptive users, came to $27 in 1993. On the other hand, Cote d'Ivoire spent more than $50 per modern contraceptive user in 1994; the country reported just over 83,000 modern contraceptive users.[3]

14. Using this basic approach, the present report explores various consequences of shortfalls from estimates of total required resources. The methodology used to obtain quantitative estimates of consequences of resource shortfalls is explained in detail in the Annex to this report. The data sources used in the calculations are also fully referenced there. Assumptions that lie behind the computations are likewise discussed in the Annex. This methodology is based on, and closely mirrors, a methodology developed by the Alan Guttmacher Institute to examine reductions in international assistance for population by the United States of America.[4] As indicated in the Annex, the numerical estimates that this methodology produces are approximations: they should be interpreted as indicating the order of magnitude for each specific consequence of resource shortfalls.

15. Three scenarios depicting possible future courses of resource mobilization for the period 1995-2000 are illustrated in this report. As mentioned, in 1995 domestic financial flows for population amounted to around $7.5 billion (including estimated private flows) and ODA flows to about $2.0 billion, for a total of $9.5 billion from both domestic and international sources. Between 1990 and 1995, international assistance increased by approximately $1 billion, from $1.1 billion to $2.0 billion. The first scenario, called the **Constant Trend Growth Scenario**, assumes the observed rate of growth into the future up to the year 2000, at which time international assistance would have increased to $3.6 billion, some $2.1 billion below the ICPD target. This scenario additionally assumes that the domestic flows of recipient countries continue to grow and reach the ICPD target of $11.3 billion.

16. Given recent indications of a slackening in external resource flows, a second scenario, termed the **Intermediate Growth Scenario**, is also constructed. In this scenario, future external assistance is assumed to grow 20 per cent slower than in the first scenario, reaching only $2.8 billion in the year 2000. This scenario also assumes an on-target trend in the domestic flows of recipient countries, reaching $11.3 billion in 2000. Finally, a third scenario, the **Low Growth Scenario**, is included to explore the implications of slower growth of domestic financial flows for population, coupled with the slow growth in donor assistance depicted in the first scenario. An annual growth rate of only 5 per cent in domestic allocations (instead of 8.5 per cent, as in the

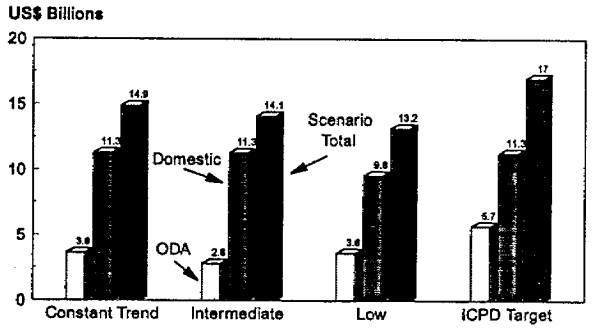
first two scenarios) is assumed for this scenario. The following table summarizes the three scenarios (see, also, Figure I):

Resource Mobilization in 2000 (billions of dollars)

Scenario	Donor Flows	Domestic Flows	Total Resources	Shortfall
1. Constant Trend Growth	$3.6	$11.3	$14.9	($2.1)
2. Intermediate Growth	$2.8	$11.3	$14.1	($2.9)
3. Low Growth	$3.6	$ 9.6	$13.2	($3.8)

17. The three scenarios presented in this report are based on three different sets of assumptions about possible levels of resource mobilization for implementing the ICPD agenda. The report makes no conclusions about which of the possible scenarios is more likely to take place. However, it does show that the consequences associated with under-achievement of the ICPD goals will vary greatly depending on the extent to which global resource mobilization falls short of agreed targets.

Figure I. Levels of Resource Mobilization: Three Scenarios for Year 2000



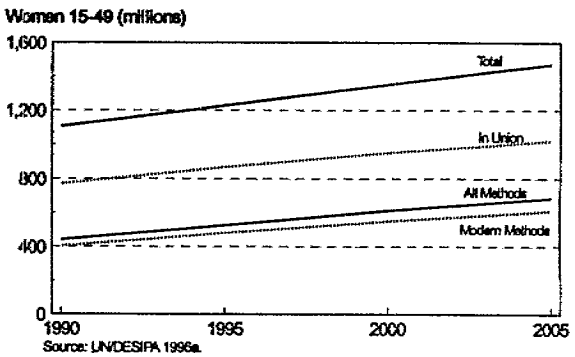
III. CONSEQUENCES OF RESOURCE SHORTFALLS

18. This section presents the main analytical findings concerning the implications of shortfalls in resource mobilization below the targets agreed to at the ICPD. Lower levels of resources would necessarily mean that the ICPD agenda would not be fully implemented, thus slowing progress towards achieving ICPD goals and worsening various reproductive outcomes. This report focuses on a number of implications of a less-than-full implementation of the ICPD, including reductions in potential users of family planning services and increases in traditional contraceptive use as well as in non-use of contraception; increases in the number of unintended pregnancies; additions to the number of induced abortions; increases in the number of unintended childbirths; additional maternal morbidity and mortality; and increased infant and child mortality. (See tables 1 and 2 in the Annex for, respectively, a composite of these consequences and a summary of the rates used to estimate these consequences.) All these consequences flow from expected changes in the number of individuals and/or couples using

various methods of contraception. Another consequence, the lower quality of reproductive health services, would have additional consequences. These effects are more difficult to quantify, however. The Fund is beginning to undertake in-depth analyses of them, recognizing that high-quality comprehensive reproductive health services are a necessary and important component of any basic health-care package.

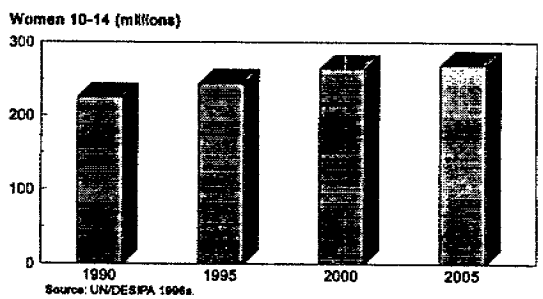
19. Figure IIa shows the basic data on the number of women aged 15-49 in developing countries and countries with economies in transition from 1990 to 2005. By the year 2000, there will be 1.35 billion women in the reproductive ages, 950 million of whom will be married or in a stable consensual union. Over the 15-year period depicted in Figure IIa, the number of married women in reproductive ages in developing countries and countries in transition will increase by about one third. The lines in the lower part of Figure IIa show the expected growth in the number of individuals or couples who will be practising family planning. In 1995 there were an estimated 470 million contraceptive users in developing countries and 60 million in countries in transition. The upward trends in total contraceptors and contraceptors using modern methods is predicated on the successful implementation of the ICPD's 20-year plan to make quality reproductive health and family planning services accessible to all couples and individuals by the year 2015. Thus, it is forecast that, in 2000, between 610 million and 640 million couples in developing countries and countries in transition will be using contraceptives if the resources agreed to by the ICPD are in fact mobilized from domestic and international sources and made available for the implementation of the Programme of Action.

Figure IIa. Estimated and Projected Number of Women Aged 15-49



20. Figure IIb shows how the numbers of adolescent women aged 10-14 will likewise increase over the period 1990-2005. The extent to which the Programme of Action is fully implemented to include the needs of this growing cohort of young women will determine in large part how successful the ICPD will ultimately prove to be. Equal access to education, elimination of gender bias, as well as appropriate counseling and communication on sexual concerns and reproductive health for

Figure IIb. Estimated and Projected Number of Adolescent Women Aged 10-14

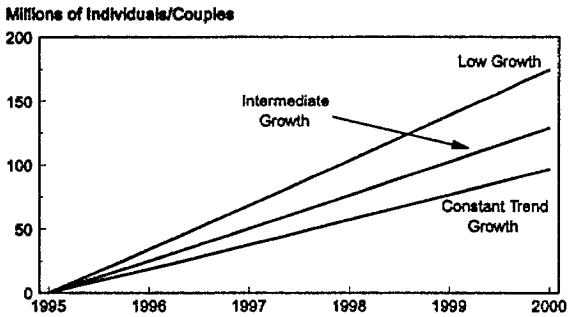


adolescents are parts of an integrated programme to make reproductive health a long-term and lasting achievement of the ICPD.

Reductions in potential users of family planning services

21. Reducing the level of resource mobilization below that envisaged by the Programme of Action would have dramatic consequences by the year 2000, as demonstrated in Figure III.[5] This figure shows net reductions in potential contraceptors: individuals or couples who would have chosen to use a contraceptive method for planning their childbearing, but will not be able to do so due to the decreased availability of and access to reproductive health and family planning services, in turn caused by resource shortfalls. In the year 2000, the reduced financial resource levels embodied in the Constant Trend Growth scenario (a $2.1 billion shortfall) would adversely affect about 97 million couples in this way. If donor resources for population activities were to be even more constrained, as in the Intermediate Growth scenario (a $2.9 billion shortfall), the effect on reproductive choice in developing countries would be starker still: around 130 million women and couples would find themselves without access to family planning services by the year 2000. Finally, under the Low Growth scenario, a net reduction of 170 million potential users would result.

Figure III. Additional Individuals/Couples Not Contracepting Due to Resource Shortfalls



22. These numbers represent substantial proportions of the total number of couples projected to be using family planning services in the year 2000 under the ICPD scenario. Even if the least grave (Constant Trend Growth) of the three scenarios were to occur, the number of couples having access to and using reproductive health and family planning services would drop by 16 per cent. The Intermediate Growth scenario would deprive 21 per cent of couples of access, and, in the worst-case scenario presented here (Low Growth), the potential number of contraceptive users would decrease by nearly 30 per cent.

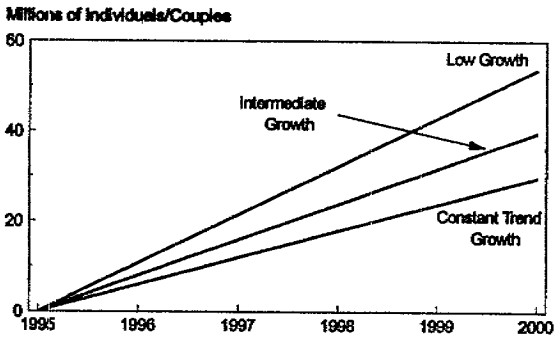
Increases in couples using traditional methods

23. Not all individuals or couples deprived of access to family planning services and to the range of modern methods will remain non-users. Even if these services are unavailable, a proportion of people will, on their own, use traditional methods such as periodic abstinence or withdrawal. Projecting users of traditional methods is important because such couples have much higher "method failure" rates than do users of modern methods. One study of this proportion,

using data from 36 countries, estimates the proportion of individuals/couples opting for use of a traditional method, rather than non-use, at 20 per cent. In this report, however, this proportion has been doubled to 40 per cent to assure that the assessment of negative consequences is on the conservative side (since users of traditional methods are better protected from the risk of becoming pregnant than are non-users).

24. Figure IV illustrates how the number of users of traditional methods will escalate under the three scenarios. Even under the most optimistic of the scenarios (Constant Trend Growth), the number of couples using traditional contraceptive methods, instead of more effective methods, would increase by 30 million couples, by the year 2000. Under the least favourable scenario, the additional number of users of traditional methods would reach 51 million. In effect, these couples would, because of circumstances of lower accessibility to affordable modern family planning services, be unwillingly adopting a less-than-ideal solution to their reproductive needs and risking unwanted reproductive outcomes.

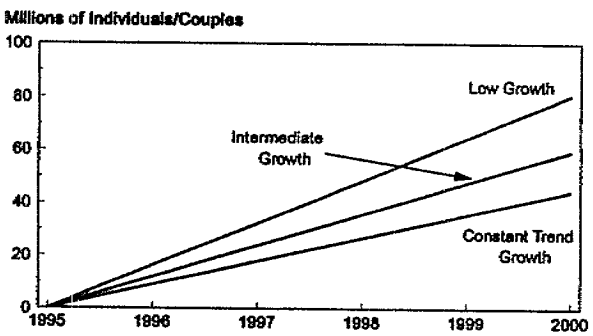
Figure IV. Additional Couples Using Traditional Methods of Contraception



Increases in non-contraceptors

25. The remainder of the millions of couples affected by decreased availability of services -- those who choose not to use a traditional method -- will remain as non-contraceptors. These are the individuals and couples who would have obtained reproductive health information and would have decided to exercise their reproductive right to plan the spacing and size of their family had reproductive health services been available. The additional non-contraceptors that result from applying the three scenarios of future ICPD implementation are shown in Figure V. By the year 2000, their numbers range from 44 million (Constant Trend Growth) to 80 million (Low Growth) and form a group at particularly high risk of unintended and/or unwanted pregnancies. These additional

Figure V. Additional Couples Using No Method of Contraception

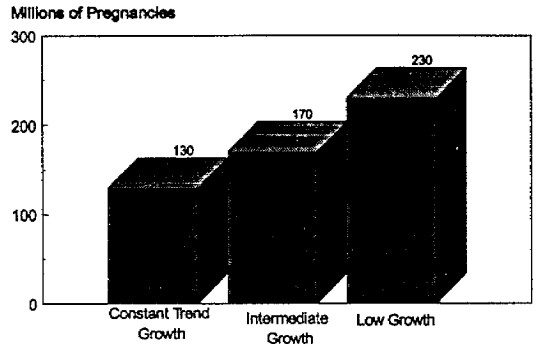


non-users may be compared to the roughly 340 million individuals/couples who are projected to not be using family-planning methods in 2000, even if the Programme of Action were fully implemented.

Increases in unintended pregnancies

26. As a result of not using any form of contraception whatsoever, or using traditional methods, millions of couples in the developing world will experience unintended and/or unwanted pregnancies. The cumulative number[6] of additional unintended pregnancies during the period 1995-2000 is shown in Figure VI for each of the three scenarios. The numbers are sobering, ranging from around 130 million unintended pregnancies under the best-case scenario to 230 million under the worst.

Figure VI. Additional Number of Unintended Pregnancies (1995-2000)

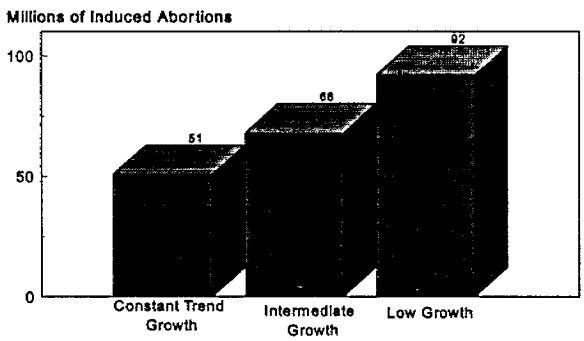


27. Even without contemplating the direct outcomes of these additional pregnancies (see below), the costs implied by these numbers, in terms of increased demand for antenatal health services and the additional opportunity costs from lost work time and other social contributions of the women who become pregnant, must be counted as substantial adverse developmental consequences of the large number of additional unintended pregnancies.

Increases in induced abortions of unwanted pregnancies

28. A major consequence of lack of access to family planning services is an increase in the number of induced abortions of unwanted pregnancies. As can be seen in Figure VII, the cumulative totals over the period 1995-2000 range from just over 50 million to more than 90 million, depending on the scenario.[7] Besides being a tragedy in its own right, the costs to the women undergoing the abortions -- as well as to the countries' health systems -- are enormous. Unsafe abortion is a major public health problem and a major cause of maternal deaths. Complications from unsafe abortions are usually among the leading causes of hospitalization of women in the prime reproductive age group.[8]

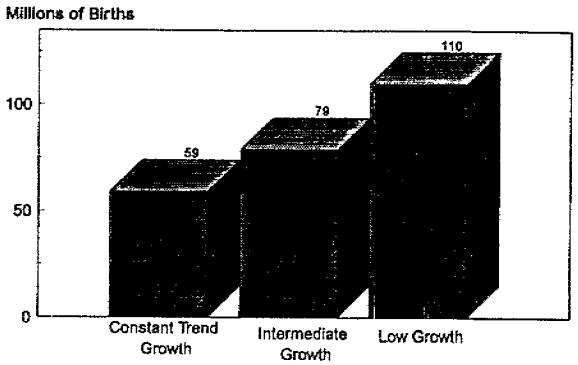
Figure VII. Additional Number of Abortions of Unintended Pregnancies (1995-2000)



Increases in unintended births

29. Cumulative totals for unintended and often unwanted births resulting from the large increase in unintended pregnancies are shown in Figure VIII for the three scenarios. As the figure indicates, cumulatively over the 1995-2000 period, 59 million to 110 million additional unintended births will occur depending on the degree to which ICPD implementation suffers from under-budgeting.[9] These extra births imply significant extra burdens in terms of health risks to the mother at time of delivery, extra demands on health care services, and a general dilution of resources available to the family which can be dedicated to investing in the human capital of the offspring. This is true at the micro-level, where families must spread their incomes over more family members, as well as at the macro-level, as public-sector budgetary allocations for social infrastructure become more strained.

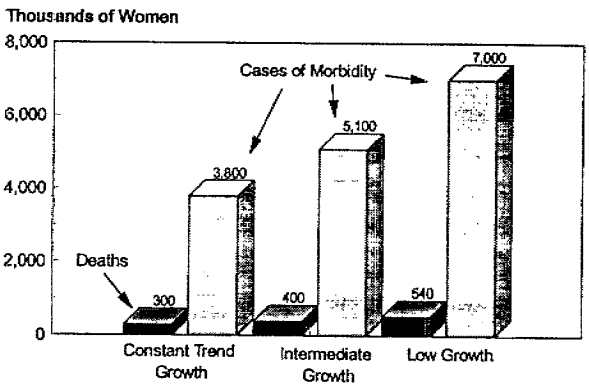
Figure VIII. Additional Number of Unintended Births (1995-2000)



Increased maternal mortality and morbidity

30. Another consequence of a lower rate of ICPD implementation, as depicted in the three scenarios, would be the additional toll on mothers who would die or suffer life-threatening ailments from causes related to pregnancy and childbirth (Figure IX). Again, cumulative estimates over the five-year period are shown -- 300,000 to 540,000 additional deaths. Additional maternal deaths would be a grave implication of lower-than-planned implementation of the ICPD Programme. In the year 2000 alone, additional maternal deaths may range from 99,000 to 180,000 deaths[10], a sizable proportion of the latest WHO global estimate of annual maternal deaths (585,000), implying a substantial rise in the global total for that year. In addition to the maternal deaths related to the increased number of unintended pregnancies, lack of resources would also make it more difficult to address high levels of maternal mortality through direct measures such as

Figure IX. Additional Maternal Morbidity and Mortality (1995-2000)



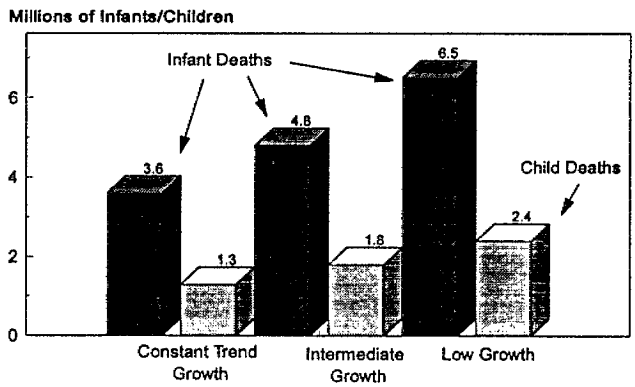
improved emergency obstetric care, better antenatal care and higher proportion of births attended by a health professional.

31. The incidence of maternal morbidity, although not well studied and difficult to measure, is known to be many times that of actual maternal mortality. The results of the analysis conducted for this report indicate that resource shortfalls could lead to between 3.8 million and 7 million additional cases of life-threatening maternal morbidity, depending on the scenario, over the five-year period.[11] In 2000 alone, the increased number of women affected would range from 1.3 million to 2.3 million, depending on the magnitude of funding shortfalls.

Increased infant and child mortality

32. Annually, around 125 million children are born in developing countries and countries with economies in transition. Of these, more than 7.5 million die before reaching their first birthday, and another 3.2 million die before reaching five years of age; over the five-year period, 1995-2000, this amounts to almost 38 million infant deaths and around 16 million child deaths. Figure X shows the additional deaths of infants and children (defined as ages 1-4) that would be added to these totals from a failure to meet the ICPD targets for implementation of the Programme of Action. Even under the most optimistic of the resource scenarios (Constant Trend Growth), an additional 3.6 million infants and 1.3 million children would be expected to die over the 1995-2000 projection period.[12] This figure rises to 6.4 million infant and child deaths in the Intermediate Growth scenario and to almost 9 million deaths in the Low Growth scenario. These additional deaths would be a direct consequence of the large number of additional unintended births noted above.

Figure X. Additional Infant and Child Mortality (1995-2000)



Consequences for the basic reproductive health component of the Programme of Action

33. To this point, the analysis has focused on implications of resource shortfalls for the family planning component of the ICPD Programme of Action. The second component of the ICPD "package" is concerned with basic reproductive health services and is estimated to cost around $5 billion in the year 2000. Since the Cairo conference, much work has been done on operationalizing this component, including work on the development of measures and indicators for monitoring reproductive health services. Nonetheless, the newness of this field is such that

little appropriate data exist, and some of the definitional issues are as yet unresolved in some operational areas.[13] It is thus not possible at this stage to quantify the effects of failure to fully implement the Programme of Action as was done above for the family-planning component. Consequences of under-funding this component will, therefore, be described mainly from a qualitative viewpoint.

34. In general, it is expected that resource shortfalls would constrain efforts to improve the quality of services, since funds available would likely to continue to be directed to maintaining existing services and standards. Lack of adequate funding will adversely affect the range of contraceptive methods available, technical competence of staff, provider-client information exchange and client-provider relations. Resource shortfalls will also tend to delay the introduction of new or improved contraceptive methods. Family planning clinics that do not offer a mix of contraceptive methods or that experience periodic stockouts of contraceptives will not be able to adequately service existing clientele, to direct interested users to methods appropriate to their needs and desires, or to attract new clients.

35. Situational analyses show that resource shortages have indeed affected quality of service of many programmes, particularly family-planning programmes which have been most widely studied. In many countries, a large percentage of service delivery points (SDPs) lack adequate infrastructure, basic equipment, contraceptive supplies, or educational materials for providing quality services. Many SDPs are not adequately staffed with competent service providers trained in the latest methods and techniques.

36. In the United Republic of Tanzania, for example, a large percentage of service delivery points throughout the country lacked basic equipment for providing quality services in 1992. More than three-quarters of health centres and hospitals did not have a speculum, nearly one-third lacked disposable gloves and 22 per cent and 15 per cent, respectively, did not have a stethoscope. The lack of such basic equipment is a major barrier to the expansion of services in the country and to the provision of quality reproductive health services, including family planning. Other quality problems affecting most service delivery points included lack of a well-ordered and usable client card system, infrequent supervisory visits and stockouts of specific materials. To lesser degrees, similar problems affected the quality of service delivery in Botswana and Kenya. Similar difficulties have been documented in Asia and Latin America as well.[14]

37. Information given to clients at clinics is an important issue in quality of care. Resource constraints in this area may result in under-staffed clinics and under-trained service providers, and, in turn, result in rushed visits, insufficient client/provider communication and poorer overall quality of service. Situation analyses in Ghana, Nigeria and the United Republic of Tanzania have shown many deficiencies in client/provider exchanges. These can result in clients not being able to exercise choice in their selection of contraceptive methods and in a lack of awareness of possible side-effects. A 1993 situation analysis in Pakistan found that although 94 per cent of

clients had discussed with their service providers how the contraceptive method worked and 62 per cent had discussed how to use the method, less than half of the service providers described possible side-effects and just over one third inquired about client questions. Similar practices have been observed elsewhere in Asia and in Latin America.

38. Recent research shows that service providers need to interact more dynamically with clients -- learn their needs and practices, address their questions, explore a wider range of reproductive health concerns, explain alternative treatments and methods, teach appropriate responses to possible side-effects and follow up on results. Yet the same situation analyses show that many staff have not received training in over five years and that periodic upgrading of skills is not routinely provided. Improvements in how health-care providers impart information and offer counseling to clients is crucial, and this will require greater training of the providers. The costs of such training will account for much of the total costs of improving services.[15]

39. Integrating family planning programmes with comprehensive reproductive health programmes is a major ICPD goal. Significant improvements in many dimensions of "programme effort" have been observed in previously weak and strong programmes over the past decade and a half. An analysis of the period 1989-1994, however, showed that management capacity suffered in mid-level programmes as they strained to keep up with increasing demand. Even strong programmes, on average, showed a decline in field and media outreach efforts (Bulatao, 1996). Resource shortfalls would only exacerbate these trends.

Consequences for prevention of STDs and HIV/AIDS

40. The third major component of the ICPD-costed population package includes the prevention of STDs, including HIV/AIDS. It includes mass media and in-school education programmes, promotion of voluntary abstinence and responsible sexual behaviour, and expanded distribution of condoms. This prevention programme was estimated by the WHO Global Programme on AIDS to cost $1.3 billion in the year 2000.

41. Estimating current expenditures for the prevention of STDs and HIV/AIDS, especially on a global level, has presented major difficulties. Besides the lack of data in many countries, or the inadequacy of reporting procedures, one of the most important difficulties lies in the fact that in many countries, accounting systems for health services are still not able to isolate total HIV/AIDS expenditures. UNAIDS has not, so far, attempted to estimate global spending on HIV/AIDS prevention programmes.

Economic impact of AIDS

42. The potential global economic impact of AIDS is not fully understood because of the multiple dimensions in which AIDS will affect economies. Besides the cost of unexpected loss of labour productivity resulting from AIDS-related morbidity and mortality, and of the treatment of

AIDS patients, AIDS education and research, and blood screening, there are other problems, such as an increase in the number of orphans, the breakdown of family support systems for the elderly and young, decrease in private savings, and potential real national population losses that will have serious economic impacts on individual countries, many of which already find themselves in dire economic situations.

43. A number of studies have been conducted to estimate the economic impact of AIDS. Basic economic models were used to show the likely effects of AIDS on the ratio of capital to labour and output per capita in the United Republic of Tanzania and Thailand. Results from both countries show that the spread of AIDS will have a serious, direct economic impact on development. The rise in morbidity associated with the AIDS epidemic will have the immediate effect of reducing labour productivity and increasing health-care spending. The Tanzanian study shows that without decisive policy action, AIDS may reduce the country's gross domestic product (GDP) in the year 2010 by 15 to 25 per cent, while per capita income levels are expected to decrease from anywhere between 0 to 10 per cent. Studies of the economic impact of AIDS in Thailand, one of South-East Asia's hardest hit countries, also portray severe problems for continuing the rapid economic growth that the country has experienced. In Thailand, it has been estimated that just in terms of the effects on worker productivity, savings loss and medical costs alone, the country will spend up to $8.7 billion by the year 2000. A simulation model for Thailand shows that the country's overall economic size would be between 15 and 20 per cent smaller than the no-AIDS projection and that GDP growth rates would be 15 to 23 per cent smaller than the no-AIDS projection (Nelson, 1996).

Population and development strategies

44. Failure to fully implement the ICPD Programme of Action would hinder necessary improvements in information systems for monitoring programmes and for devising appropriate population and reproductive health policies. In order for developing countries to develop appropriate policies, they need to improve the coverage and use of service statistics, client reports, socio-medical data on the prevalence and causes of reproductive health problems, demographic and health surveys, censuses, registration systems, sociocultural research and community studies. Knowledge, attitudes and practice surveys of reproductive health issues (including, *inter alia,* family planning, safe motherhood, STDs and HIV/AIDS, and adolescent sexuality) are required. The role of gender relationships needs further research. Understanding the content and context of interaction concerning reproductive health issues in communities and families is also an urgent topic for research. If the goals of the ICPD are to be met, research in all of these areas is essential. Shortfalls in financing for the ICPD Programme of Action will also inevitably impose constraints on these data collection and research activities.

Advocacy and education efforts

45. The ICPD's agenda sees advocacy and educational efforts as an important tool for meeting the reproductive health needs of the world's women and men. One important area is the promotion of gender equity and equality and the empowerment of women. The ICPD realized that these are important development goals in themselves and that, moreover, none of the other goals are attainable unless women have the possibility of realizing their own reproductive choices. This is to be carried out by a number of means, including, in the words of the Programme of Action, "achiev[ing] universal access to quality education ... and eliminat[ing] gender disparities in access to, retention in, and support for, education." (para. 11.5) These goals require further resources, beyond those costed by the ICPD for the basic package of integrated population and reproductive health.

46. Moreover, the ICPD establishes a firm groundwork for advocacy activities that would work to empower women as well as to meet the other goals of the Programme of Action. If resources are not available to carry out these advocacy activities, it will be harder for millions of girl children and women to realize their rights and opportunities and enjoy equal access to nutrition, education and health. Many more girls than need be will suffer the consequences of harmful traditional practices, including female genital mutilation. Many more women will never realize their potential because, constrained by their reproductive roles, they will be unable to avail themselves of educational and employment opportunities. Many people, especially girls and women, will be denied their human rights, including their reproductive rights.

Developmental consequences

47. The consequences presented in this section have dealt directly with the costed ICPD "package" that focuses on reproductive health, family planning, STDs and population policy. Beyond the specific and direct consequences that have been demonstrated here, however, there are wider, developmental consequences associated with higher population growth rates -- and population distributions more highly skewed towards young ages -- that would also flow from additional unintended pregnancies. Although not included in the present analysis, these negative consequences on the environment, on human development, on women's empowerment and on poverty are real and will undoubtedly affect the development potential and performance of countries.

IV. THE NEXT FOUR YEARS

48. Section III of this report highlighted several important consequences that would likely follow from the failure to increase global allocations of resources to the level needed to reach the resource targets set out in the ICPD Programme of Action. This section briefly explores future actions on the part of donor countries -- countries in the Development Assistance Committee of

the Organisation for Economic Cooperation and Development -- to strengthen their commitment to the full implementation of the Cairo agenda.

49. Annex table 3 presents actual (1995) levels of assistance for population as well as possible outcomes for the year 2000. The level of external funding for that year, as set out in the Programme of Action, should reach $5.67 billion. International assistance for population activities, however, is made up of several components, only the largest of which is that supplied directly by donor countries. (The other components are provided by development banks, multilateral organizations, foundations and other private institutions.) Using the observed 1994-1995 distributions of assistance as a baseline, it is estimated that donor countries as a group should directly contribute around $3.57 billion in the year 2000 towards realizing the Programme of Action.[16]

50. As can be seen from the first column of Annex table 3, in 1995 donor countries directly contributed around $1.37 billion for population activities. (Another $672 million was provided indirectly by donor countries through their contributions to international financial institutions and other multilateral institutions.) The increases in donor assistance from 1993 to 1994 (25 per cent) and from 1994 to 1995 (30 per cent) were very encouraging.

51. Since the Cairo Conference a number of donor countries have pledged to increase their support. These include, in particular, the United States, Germany, Japan, United Kingdom, Netherlands, Denmark, Switzerland and Australia as well as the European Union. In 1994, for instance, the Japanese Government announced a new Global Issue Initiative on Population and AIDS through which $3 billion will be allocated, from 1994 to 2000, to address global population problems and prevent the spread of HIV/AIDS. The German Government has committed itself to spend more than $2 billion over the period 1995-2000 on population programmes and has become the second largest donor of population assistance after the United States. After the ICPD, the United Kingdom pledged to increase its assistance for population and reproductive health by approximately 65 per cent, for a total of about $160 million over the following two years.

52. Further examples include Denmark which, in 1996, increased its contribution to UNFPA to $47 million, of which $8.6 million is earmarked for additional ICPD activities in sub-Saharan Africa. Following the urging of the Parliament of the Netherlands to increase population funding as a proportion of the overseas development budget, Dutch policy now encompasses a 4 per cent target for population assistance. This will bring the Netherlands funding level for international population assistance to about $125 million by the year 1998. The Government of Australia is in the middle of a four-year initiative through 1998 to earmark $130 million to population and family-planning programmes in developing countries. After the severe economic recession in the early 1990s, Finland has gradually been restoring the level of its population assistance to earlier levels. Finally, the European Commission has set a policy target of approximately $375 million on programming in the area of population and reproductive health by the year 2000. An

agreement for more than $31 million between the European Commission and UNFPA was recently reached on an important initiative involving population programmes in several Asian countries.

53. Donor support, however, remains uneven: while donors such as Denmark, Finland, Netherlands, Norway, Sweden, United Kingdom, United States and other countries mentioned above have maintained or increased their commitment to the ICPD agenda, other donor countries have provided little funding compared either to the size of their economies or to their total ODA. Overall, donor support for population activities would have been almost $1 billion higher in 1995 if all donors had allocated 4 per cent or more of ODA to population programmes (a level reached only by Finland and the United States).

54. To reach the ICPD resource targets in 2000, the distributional pattern among donor countries could be either maintained as it was in 1995 or move towards a fairer distribution of responsibilities. For example, the distribution of assistance among donor countries could be related to countries' capacity to pay, as reflected by the relative size of the gross domestic product (GDP) of each donor country.

55. A hypothetical distribution of population assistance for 2000 -- when the first resource goals agreed at the ICPD are to be met -- could thus be based on the proportionate size of each country's GDP.[17] The amounts shown in column two of Annex table 3 are based on this hypothetical distribution. These hypothetical contributions of donor countries for population assistance in 2000 vary according to the size of their economies. The third column of the table shows the annual rates of growth in population assistance that would be needed over the period 1995-2000 to meet the hypothetical amounts shown in column two. As can be seen, several countries (Norway, Denmark, the Netherlands, Sweden and Finland) already contribute a relatively high proportion of their GDP towards population programmes. Australia, the United Kingdom and the United States would have to roughly double their population assistance over 1995 levels to reach the targets implied in column two of the table. Countries that have so far contributed relatively little to population relative to the size of their economies would obviously have to greatly increase their funding levels in order to reach these year-2000 targets.

56. As has been seen, domestic flows from developing countries and countries with economies in transition (including estimates for the private sector) are currently estimated to amount to about 78 per cent of total resources available for population programmes. To keep on track to meet the resource targets of the Programme of Action, domestic financial flows will have to grow by around 8.5 per cent annually through the year 2000. This will certainly be difficult, if not impossible, to achieve, particularly in certain regions, including many countries of sub-Saharan Africa. However, given the mix of public and private resources that make up this component of the global domestic resource picture and the strong commitment to balancing population growth and socio-economic development at all levels of society, there is reason to expect that this level of growth is sustainable at an aggregate level.

57. At the same time, however, wide variation exists among developing countries in both their commitment towards ICPD resource mobilization as well as in their capacity to domestically finance population activities. In fact, the overall percentage of 78 per cent is considerably skewed by a few large developing countries, such as China, India and Indonesia, whose population programmes are to a great extent self-financed: this means that there are many other developing countries where a much lower proportion of programme financing is from domestic resources. This is particularly the case in sub-Saharan Africa and other low-income sub-regions where external resources will have to fill the gap if the implementation of the ICPD is to proceed as agreed in Cairo.

UNFPA's future resource level

58. If the ICPD targets through 2000 are to be met, growth in size and capacity would be required from the three principal channels for donor funding -- bilateral programmes, multilateral programmes and NGO-executed programmes. In recent years, around 27 per cent of donor assistance for population has been channeled through UNFPA. In the short term, to the year 2000, this proportion may be assumed to stay constant since the other channels of assistance will be hard pressed to expand their capacity under conditions of high growth in demand. This implies that by 2000 the Fund's resources would reach about $960 million a year.

59. An increase in UNFPA resources is likely to include growth in both core and multi-bilateral resources. The potential for growth in the multi-bilateral field is particularly strong. From a level of $12 million-$15 million per year in the early 1990s, multi-bilateral arrangements are estimated to currently total about $25 million. With the recent agreement with the European Commission on a regional programme in several Asian countries, UNFPA's multi-bilateral channel could well expand further. Moreover, in 41 country programmes, either recently approved by the Executive Board or that are now being prepared for submission to the Board, the multi-bilateral components incorporated in the programmes total more than $132 million. The possibilities for expanding cooperation at the country level between UNFPA and bilateral donors are great.

60. Debt-swap agreements are another potentially large source of additional resources that could also be managed through the Fund but which, so far, have not been tapped. Approximately $2 trillion is owed by countries where UNFPA operates. Of that amount, over $800 billion is owed bilaterally (i.e., government-to-government debt). UNFPA would like to encourage agreements between lenders and debtors to forgive a portion of debt in exchange for the use of local resources by debtor countries for their population and reproductive-health programmes as well as for other social development programmes. So far, debt-swap agreements have been managed by multilateral organizations and NGOs. In order to further the implementation of the ICPD Programme of Action, UNFPA could help broker agreements by assessing the priority areas of population programmes that most need local financing.

61. UNFPA's growing leadership in procurement of contraceptives and primary health-care supplies is shown by the efforts of the Global Initiative on Contraceptive Requirements and Logistics Management Needs and the Global Contraceptive Commodity Programme to help countries better cope with emergency procurement needs. Contraceptive procurement by UNFPA has quadrupled over the last five years. UNFPA has also taken on the commitment to provide emergency procurement of contraceptives and other reproductive-health supplies in emergency humanitarian relief situations. To facilitate prompt response to such emergency requests and to avoid disruption to national contraceptive provision programmes UNFPA has now established limited stockholdings of essential contraceptives. Such efforts point to another avenue by which UNFPA participation in channeling international population assistance to developing countries may be enlarged.

V. CONCLUSION

62. This report has examined the consequences of resource shortfalls in terms of meeting the goals expressed in the ICPD Programme of Action over the period 1995-2000. It is meant to provide the Executive Board with some quantitative estimates of reproductive-health consequences if the implementation of the Programme of Action were not to be fully achieved. The earlier conference room paper which is the foundation for this report has been re-examined and strengthened by bringing to bear all pertinent empirical information that is available, and the methodology used is fully described in the Annex to this report. Although all projections into the future are in a sense hypothetical, demographic prognoses in general benefit from extensive bases of empirical data and in practice have proven to be quite robust. Even though the analysis presented in this report is based on a great deal of empirical data, all quantitative estimates should be read as orders of magnitude, not mathematical certainties.

63. The magnitude of the negative effects of failing to fully implement the ICPD Programme of Action, described in Section III of this paper (and Annex table 1), should be sobering to all who are committed to the goals of the ICPD. If the implementation of the Programme of Action were to fall short of the agreed targets and goals, many reproductive-health outcomes would suffer incrementally. Millions of individuals or couples who would have used family-planning services would not be able to do so because fewer services will be available or accessible. Many millions more unintended pregnancies would thus result over this period and millions of these additional pregnancies would end in abortions. Hundreds of thousands more women would die than otherwise, either in childbirth or while undergoing unsafe abortions. Several times that number of mothers would suffer life-threatening morbidities. Millions of unwanted children, born from these unintended pregnancies, would die in their infancy or early childhood. While the exact estimates may change when more data become available, the order of magnitude of these grave -- yet avoidable -- consequences will not change.

VI. ELEMENTS FOR A DECISION

64. The Executive Board may wish to:

(a) Take note of the report on the consequences of resource shortfalls in meeting the goals of the ICPD up to the year 2000 and the comments made thereon by the Executive Board;

(b) Reiterate the need for the continued commitment on the part of all countries of the world to make sufficient resources available for the successful implementation of the Programme of Action of the International Conference on Population and Development.

NOTES

1. These estimates of domestic flows need to be treated with some caution as they are based on incomplete data. UNFPA has signed an agreement with the Netherlands Interdisciplinary Demographic Institute (NIDI) to collaborate on a system of data collection and analysis for both domestic and ODA resource flows, aimed at improving knowledge on the global resource situation for population.

2. In the incorporation of these estimates in the Programme of Action it was explicitly recognized that a large portion of the joint costs of family planning and other reproductive health services are included in the family planning portion of the estimates and that further analyses would be needed to clarify the allocation of joint inputs.

3. All expenditure estimates include the cost of external technical assistance. Note, also, that economies of scale play an important part in determining average costs per users. (See United States Agency for International Development, Evaluation Project, "Family Planning Expenditure/Cost Study", internal documents.) Economies of scale were explicitly built into the analysis of costs per user in the estimation of resource requirements for ICPD (UNFPA, 1994a).

4. The methodology used in this report, in terms of additional traditional users, pregnancy rates, abortion rates, birth rates, and spontaneous abortion rates, follows that developed by the Alan Guttmacher Institute in association with The Futures Group, Population Action International, Population Reference Bureau and The Population Council (AGI, 1996). See the Annex for a description of the methodology.

5. Resource shortfalls have intensifying and cumulative implications for future years. This analysis presents only short-term implications.

6. Cumulative totals are the sums of all events (in this case unintended pregnancies) occurring in the years 1996, 1997, 1998, 1999 and 2000. Note that around one third of the cumulative effects occur in the last year of the projection period since resource shortfalls are assumed to be zero in 1995 and increase linearly through the year 2000.

7. The number of additional abortions may be over-estimated to the degree that motivation for fertility limitation may not be high among non-contraceptors. In regions where recourse to abortion is rare, this over-estimation may be significant; however, where abortion levels are already high, the parameter used (see Annex) might even under-estimate the number of abortions.

8. In the year 2000 alone, the final year of the projection exercise, 17 million-31 million additional abortions would have been resorted to depending on the scenario.

9. Additionally, spontaneous abortions and stillbirths will increase as a result of a lower level of available reproductive health services. For the Constant Trend Growth scenario, an additional 16 million such outcomes can be expected, 22 million for the Intermediate Growth scenario, and 30 million for the Low Growth scenario.

10. A simple computational error made in the conference room paper (DP/FPA/1997/ CRP.1) produced much lower estimates of maternal events.

11. It is assumed that there are 13 cases of life-threatening maternal morbidity for every maternal death (see UNFPA, *State of World Population Report 1997*). See the Annex for further discussion concerning the measurement of maternal mortality and morbidity.

12. In the case of children aged 1-4, the cumulation of deaths is over a longer period since children born in the year 2000, for example, would still be at risk of child mortality until the year 2004. All such children, however, would have been born during the period under study (1995-2000).

13. It is also difficult to disentangle costs for the two components because, as stated in the Programme of Action, delivery-system costs (e.g., infrastructure costs) are included under the family-planning component. As methodology and measurement improve it may be easier to separate the costs under each component or more precisely identify joint costs.

14. Examples are taken from the findings of The Population Council's situation analyses conducted in various countries: Bruce, 1996; Miller, 1996; and Population Council, 1991.

15. These points are emphasized in a forthcoming National Research Council report (Tsui, Wasserheit and Haaga, 1997).

16. The amounts referred to in this section are donors' primary funds, i.e., funds specifically earmarked for population activities, and do not include other ODA contributions that donors make to development banks, multilateral organizations (other than UNFPA), or other organizations -- some of which may ultimately be destined for population activities.

17. GDP estimates for 1995 were used for a constant reference point for the hypothetical distributions. (Source: World Bank, 1997, *World Development Indicators, 1997.*) No assumptions are made or implied about future GDP growth.
