PROMOTING REPRODUCTIVE HEALTH

Investing in Health for Development

EDITED BY
Shepard Forman and Romita Ghosh

Center on International Cooperation
Studies in Multilateralism

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—The Editors

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1

Introduction

Shepard Forman & Romita Ghosh

THE NATURE OF INTERNATIONAL COOPERATION IN SUPPORT OF sustainable development has evolved over time. Development cooperation and the flow of aid between developed and developing countries in the 1950s and 1960s were strongly influenced by the politics of the Cold War and emphasized the quantitative aspects of growth through investments in large-scale infrastructural projects and scientific advancements, which were thought to be the driving engines of modernization. Theorists and practitioners alike have since recognized that, in addition to capital growth and technological advancements, social, political, and cultural progress are essential to development. The 1970s and 1980s, therefore, saw a shift toward the qualitative aspects of growth, including investments in education, health care, clean water, and sanitation, in addition to microenterprise credits and human rights. The increasing role of civil society in setting standards for effective development cooperation and collaborating in its implementation accompanied these changes, resulting, in the 1990s and into the next century, in a renewed emphasis on partnerships between and among private and public sectors, both nationally and internationally.

Several additional trends parallel these changes, including an increasing role for multilateral agencies, such as the United Nations Development Programme and other UN special agencies, the World Bank, and collaborative bilateral donor forums, such as the Development Assistance Committee of the Organization for Economic Cooperation and Development. As private-capital flows sharply outpaced bilateral and multilateral development assistance, poverty reduction replaced economic growth as the rationale for development assistance, and the needs and demands of individual clients became established as the driving force for all development activities.

The UN-sponsored international conferences of the 1990s reflect and have helped to reinforce this evolution in development thinking. Through

such conferences, UN member states—often pushed by nongovernmental organizations—have sought to create consensus around development goals and promote cooperation on a range of global issues. They include the well-being of children (1990), a clean, healthy, and sustainable environment (1992), universality of human rights (1993), reproductive health and population (1994), social development (1995), women's rights (1995), safe and productive habitats (1996), and food security (1996).[1] Together, they constitute a platform for sustainable development in the century to come.

The UN's 1994 International Conference on Population and Development (ICPD), held in Cairo, Egypt, was a landmark in the field of population and development. The Programme of Action, which was agreed to by 180 countries represented at the conference, reaffirmed the importance of slowing population growth for social and economic development, but it also called for a significant shift in strategies to achieve this goal. Rather than continuing a supply-side and quantitative approach to achieving demographic targets, the ICPD endorsed a client-driven approach to meet reproductive health needs of individual women, men, and their families. Rejecting the concept of "population control," the Cairo conference recognized that smaller families and slower population growth can be achieved through free choice and by ensuring the conditions that encourage such choice.

The reproductive health approach embodied in the ICPD Programme of Action emphasizes the interrelationships between population, human rights, and sustainable development. It stresses the importance of advancing gender equality, equity, and the empowerment of women, and emphasizes women's ability to control their own fertility. It promotes women's involvement in the planning, management, implementation, and evaluation of reproductive health programs, and emphasizes the role of men as active partners in family planning and family life. The ICPD Programme of Action also calls for an approach to reproductive health that is comprehensive, client-centered, and dependant on quality health care. To satisfy the reproductive health needs of individuals, couples, and families during all stages of the life cycle, it recommends that primary health care systems in all countries provide a range of reproductive health information and services, including but not limited to family planning.

The ICPD built on the outcomes of previous international population conferences in Bucharest in 1974 and Mexico City in 1984, the Earth Summit in Rio de Janeiro in 1992, the Vienna World Conference on Human Rights in 1993, and decades of research and experience. In addition, the ICPD consensus exemplified years of work by women's rights advocates and health professionals to put women's needs and concerns at the center of population and development efforts, and to recognize the central role healthy and educated women can play in alleviating poverty and promoting

sustainable development. Additionally, the devastation caused by HIV/AIDS lent a sense of urgency for a reproductive health agenda that would place increased attention on sexually transmitted diseases (STDs) and on risk-free sexual behavior.

Importantly, each of the UN conferences went beyond the interstate actions of most other international agreements to include representatives of nongovernmental organizations (NGOs) and other sectors of civil society in the run up to their deliberations. Indeed, it would not be going too far to declare that the conference outcomes were strongly influenced by research and advocacy carried out by such NGOs during the past several decades. In most cases the conferences also called for a strong role for independent actors in promoting and monitoring compliance with the commitments governments have made. It is in this spirit that the Center on International Cooperation (CIC) at New York University initiated a project to review progress made by developing and developed (donor) countries in advancing the reproductive health agenda endorsed at the 1994 ICPD.

This volume contains case studies of six developing countries: Bangladesh, Egypt, Indonesia, Mexico, South Africa, and Tanzania; as well as two developed (donor) countries: the United Kingdom and the United States. The case studies were authored by an international team of experts working collaboratively with professionals at the CIC. The studies review progress made in advancing the reproductive health agenda of the ICPD Programme of Action, focusing on how each country acted on the endorsement of different elements of the reproductive health approach for which cost estimates are given in the Programme of Action: elements including family planning, reproductive health services, STD/HIV/AIDS prevention, and research, data collection, policy analysis, and formulation. Each author was asked to examine the state of policy and program development and financing related to the implementation and sustainability of the reproductive health approach. In addition, a CIC policy report, *Paying for Essentials: The Reproductive Health Approach to Population and Development,* synthesizes major findings of the studies presented here and provides recommendations on key issues affecting financing, implementation, and sustainability of the reproductive health approach advanced at the ICPD.

The authors reviewed existing literature and data from government and nongovernmental sources,, and interviewed many individuals, including government officials, representatives of NGOs and international donor agencies, academics, and, in the case of the developing-country studies, health care providers and users of services. Although the studies were conducted within a common framework and methodology, CIC encouraged the authors to develop their research around sets of questions that were most appropriate to each case. The studies, therefore, exhibit a rich diversity of

data, analysis, and perspectives. At the same time, they evidence many common themes.

The reproductive health approach endorsed at the ICPD has permeated policies and programs to varying degrees in each of the countries studied here. Although the language of reproductive health has entered population and family planning discourse everywhere, in some countries it is still contested terrain, as overriding concerns with population growth continue to dominate population and family planning policy. In others, the integration of family planning and reproductive health envisioned in Cairo is slowly taking shape, though constrained by established patterns of funding, bureaucratic prerogatives, organizational barriers, lack of popular understanding of the reproductive health approach, and limited training opportunities for health service providers. In several cases, reproductive health inroads into the family planning agenda are due to the impetus of donor funding.

Although formidable obstacles to the identification and tracking of financial components stand in the way of thorough analysis, two patterns in financing the ICPD Programme of Action seem to have emerged. First, despite an initial spike immediately following the ICPD, support from international donors has declined, making it virtually impossible to meet the financial goals set at the ICPD. Second, health-sector financing within the six developing countries studied here raises serious concerns about sustainability. In some countries health spending has been negatively impacted by economic conditions; in all of the countries studied, health and population spending represents a small portion of total public-sector expenditures.

Current donor funding patterns suggest that even the modest, near-term financial targets set for implementing the Programme of Action will not be met. In 1995, twenty bilateral donors contributed nearly $1.4 billion to population assistance, some $3.6 billion short of the total bilateral and multilateral targets projected for ICPD implementation by 2000. Furthermore, 73 percent of the bilateral funding was from just four countries: the United States, Germany, the United Kingdom, and Japan.[2] Although the United States continues to lead in the disbursement of funds for reproductive health and population, its actual dollar commitment has declined due to congressional cuts in the aid budget. For its part, the United Kingdom has significantly increased its contributions as part of a generalized overseas poverty reduction program. However, unless there is a major recommitment of funds by current donors or an increase in the number of donor countries, it is highly unlikely that the 2015 target of $21.7 billion (international and national) envisioned in the Programme of Action will be available over the next twenty years. Although international donors will continue to play an essential role, sustaining the reproductive health approach will depend in large part on political will and resource mobilization efforts within each country.

In particular, the donor country studies underscore the importance of consistent and long-term commitment of political leadership to the reproductive health agenda, the need to base international funding firmly on the local needs and priorities of developing countries, the importance of donor coordination and partnerships in maximizing programmatic and regional coverage of programs and financial needs, and the need for careful monitoring and evaluation of efforts to integrate the reproductive health approach into development and poverty reduction programs.

The developing country case studies reveal important advances in policy formulation, financing, and delivery of services in the health and population sectors. However, they underscore that more needs to be accomplished, especially in improving the reproductive health care of women, men, and adolescents, as well as improving access to information and quality health care services. In addition, the studies reveal important lessons about the way in which international assistance works and how it can be improved. Local ownership of the design and implementation of programs is a prerequisite to success. Many of the reproductive health programs initiated in developing countries have been strongly influenced by donors. To ensure long-lasting benefits, donor assistance should be supportive of local priorities and programs.

The Programme of Action was not intended to be a one-size-fits-all solution; national plans of action were expected to develop policies and programs according to local needs and capabilities, consistent with the principles and goals of the ICPD. The will and capacity to implement and sustain policies and programs depends in large part on their appropriateness to local needs and aspirations. A complex set of internal and external factors affects that will and capacity. At the national level, dominant ideologies and prevailing economic conditions play a critical role. Where entrenched population programs are in place and there is little room for citizen action, little progress can be expected. Overriding debt burden and alternative claims on scarce resources for social programs and poverty alleviation also limit the scope for implementation. The financial crises now affecting Asia and threatening Latin America raise serious questions about the ability of countries in those regions to promote reproductive health and increase health-sector budgets in the short term.

Several of the developing country case studies make clear that the prevailing financial crises, structural adjustment demands, and vagaries of external funding threaten the sustainability of the reproductive health approach. Everywhere, the long-term success of investments in reproductive health is embedded in the process of health-sector reform and decentralization currently under way in many developing countries, significantly affecting how health services are prioritized and delivered. These changes in the health sector overall affect the extent to which reproductive health care

is implemented and how effectively considerations of cost reduction and organizational efficiency are balanced with those promoting quality and equity.

Highlights of Case Studies

Simeen Mahmud and Wahiduddin Mahmud's assessment of the situation in Bangladesh (Chapter 2) is cautiously optimistic. During the decade preceding the ICPD there were visible improvements in both the demographic and health conditions of the Bangladeshi population; however, the status of women's reproductive health remains compromised, despite the fact that women's childbearing burden has been halved. The authors contend that although public expenditures to expand health facilities during the 1990s appeared impressive, the figures fail to reveal either the quality or the equity aspects of such expenditures, which largely remain dismal. Access to a range of reproductive health services, including prenatal care, clean and safe delivery, and essential obstetric care, remains inadequate.

One distinctive feature of the existing health and family planning program in Bangladesh is the low utilization of most public health facilities at the community level, largely due to the widespread but unofficial collection of user fees. The family planning program's excessive reliance on external funds, and the artificial division of labor and authority between the health and family planning personnel, have also affected service utilization and the care-seeking behavior of the population. Most important, donor dependence has prevented program efforts at self-reliance in terms of resource mobilization, cost recovery, participation, ownership, and accountability and has reduced the potential for financial sustainability over the long term.

Following the ICPD, Bangladesh adopted a national reproductive health strategy designed to integrate, for the first time, services for women's health and family planning under a single programmatic approach while recognizing such an approach would require wide-ranging reforms in the health and population sectors. The Health and Population Sector Programme, initiated in 1998 to implement these reforms and address the issue of financial sustainability over time, seeks to implement the reproductive health agenda of the ICPD and introduce program equity, cost-effectiveness, and improvements in service quality. The authors caution that the realization of these objectives will depend on significant increases in public spending in the health and population sectors given scarce resources and continued dependence on external donors. It will also require improved administrative effectiveness and reorganization of the service delivery system, which is part of the much broader problem of

"good governance" challenging development efforts in Bangladesh. The authors recommend that priority areas for donor action include the training of service providers for a comprehensive reproductive health approach to services, improving the quality of care at public facilities, and improving management information systems for monitoring program performance. Public- and private-sector collaboration is encouraged, the authors suggesting that the private sector could play a crucial role in nonmedical services, social marketing of health and family planning commodities, and media awareness.

In Chapter 3, Hind Khattab, Lamia El-Fattal, and Nadine Shorbagi point out that even though Egypt's concern with population growth goes back to the 1950s, population policy has oscillated between emphasis on family planning and the importance of socioeconomic development. Hosting the ICPD provided Egypt with the impetus to critically evaluate past policies and programs, enhance national awareness of women's problems, and encourage the government and private sector to strategize in a more cooperative and comprehensive manner. Although the government's family planning program has achieved commendable levels of contraceptive use, the quality of health care requires significant upgrading. Poor quality has often resulted in high discontinuation of contraceptive use, incorrect use of methods, high rates of medical complications, and women's unnecessary exposure to unwanted pregnancies and unsafe abortions.

Overall, the Egyptian government has reacted favorably to many ICPD issues, and recent policies and programs reflect a commitment to integrating family planning and reproductive health services and to making services more gender-sensitive. As a result of the post-ICPD strategy, NGO cooperation with the government has also improved. At the governmental level, the Ministry of Health and Population was created in 1996 to centralize, upgrade, and integrate all population, family planning, and reproductive health services and activities. Following the ICPD, the government consciously developed a modified population and health strategy that placed greater emphasis on providing universal health coverage and reproductive health services of high quality, part of an overall effort to improve women's health and status, especially in poorer regions.

However, the authors note that despite concerted efforts to implement the ICPD reproductive health agenda, important obstacles stand in the way. First, the government and donors appear to be concerned that reproductive health will replace family planning, with grave consequences for rates of population growth and overall development. The basis of such fear is predominantly an incomplete understanding of the concept of the reproductive health approach itself. Consequently, the implementation of reproductive health programs has been haphazard and lacking in direction. Second, since Egypt is in the process of structural adjustment and health

reform policy development, it is not clear how and whether the perceived extra costs of reproductive health will be covered. National resource mobilization is still in its infancy. Public spending in the health and population sectors has increased since 1995 but remains low, and international donors contribute a significant portion of related costs.

In Chapter 4, Terence Hull and Meiwita Iskandar report on the 1997 financial crisis that led to fears that two decades of progress in providing family planning services and reducing fertility could be reversed by economic depression and government upheaval. However, they assert that anxiety about the fate of the family planning program betrays a lack of concern over the broader program of action of reproductive health and social development formulated at the ICPD. The authors point out that serious policy discussions on the control of STDs is virtually nonexistent; that abortion continues to be a subject of acrimonious debate; that calls for male participation lack any practical content with regard to the use of contraceptives and the control of STDs; that adolescent sexuality issues are almost taboo; that opposition to sex education, counseling, and contraceptive services for unmarried people is widespread; and that even family planning programs have long been criticized on issues of quality of care, appropriateness of technologies, and failure to meet the needs of adolescents, men, and women experiencing side effects or contraceptive failure.

The authors conclude that although Indonesia's reproductive health program was undoubtedly in serious trouble in 1998 its problems are rooted in factors that long predated the economic crisis. The division between the National Family Planning Coordinating Board and the Department of Health, the lack of systematic improvement of quality of services, and problems of health care financing are examples of structural and policy issues that need immediate resolution. The political and economic reforms called for by the newly activated public may lead to long-term improvements in the quality of health and family planning services, but there is no guarantee that they will foster efforts to seriously address the ICPD agenda.

Yolanda Palma and José Luis Palma point out in Chapter 5 that Mexico, the country that hosted the aforementioned 1984 international population conference, had begun to incorporate aspects of reproductive health into family planning programs well before the 1994 ICPD. Since the ICPD, a new Reproductive Health and Family Planning Program, which incorporates most of the elements of the reproductive health agenda, has been adopted. Laws and standards were created or modified to implement that program, and the 1997 Health Law incorporated, for the first time, the concept of reproductive health. Running parallel to the health and family planning program is the national population program, a program to improve the status of women, and health-sector reform. The reform process

is designed to improve the financial management of the health insurance system, improve efficiency, expand coverage, ensure greater transparency and accountability among service providers, improve service delivery through decentralization, and introduce a "basic" package of services to address family planning, maternal health, and cervical cancer.

The study reveals that implementation of the reproductive health agenda has only just begun and that questions remain over how best to integrate reproductive health services at the operative level; how best to train health personnel in the reproductive health approach to service delivery; and how to strengthen state-level capacities to implement programs, a problem that is especially relevant to the ongoing process of decentralization. According to the authors, an anticipated risk in the implementation of the concept of reproductive health is the adoption of an interpretation that weakens the links between reproductive health and population policies and programs, thus attaching to the former a predominantly "medical approach" that fails to realize the full integration of social and demographic components of policies.

The involvement of NGOs in official reproductive health activities has increased since the ICPD, yet the potential of NGOs to collaborate as effective partners with the government in implementing specific programs has not been sufficiently tapped. The authors conclude that Mexico's reproductive health program is largely sustainable through the mobilization of national resources; however, program areas substantially supported by international donors, such as the testing of innovative strategies, personnel training, program evaluation, information, education, communications, and mass-media campaigns, may suffer due to the decline in donor funds to Mexico.

Barbara Klugman, Marion Stevens, and Alex van den Heever's review of South Africa in Chapter 6 shows how the overall political context shaped the development of a human rights and equity orientation toward population policy as well as health services. The key component of the new government policy in 1994 was the creation of a single health system, with equitable distribution of resources and provincial implementation seeking to bring primary health care services as close to the people as possible. Sexual and reproductive health care is integrated into primary health care, so that most clinics provide maternal health care, contraception, and STD services. Abortion services are slowly being introduced; cervical screening is on the agenda; counseling training is taking place, mostly initiated through the AIDS program; and there seems to be sufficient commitment to public education programs on health and human rights.

The authors recognize that the primary challenge to providing sexual and reproductive health services relates to the weaknesses of South Africa's health systems. This arises partly from the process of integrating

different health authorities and restructuring the system—from an urban-centered system in which most funds went into tertiary care into a decentralized system with equitable distribution of resources across all regions—and partly from the lack of management capacity at the provincial level. The completion of the restructuring process and improvements in management are prerequisites for efficient delivery of services and for cost-saving that will facilitate better use of resources.

The authors estimate that there is a substantial gap between financial resources required to provide a basic package of sexual and reproductive health services and those available nationally, yet they are optimistic that the current process of decentralization and shifting priorities toward primary health care will bring more resources to such services over time. Moreover, the government's approach to eschew international donor funds, despite immediate financial shortages, must be seen as positive in the long run. Donor assistance, however, continues to be critically needed for NGO activities supporting public health system development, community education and outreach services, policy advocacy, and monitoring and evaluation of government performance.

In Chapter 7, Margaret Bangser questions the likelihood of implementing the ICPD's reproductive health agenda in Tanzania given several factors. They include the existing constraints posed by the tremendous burden of debt service that undermines the health sector and social sectors in general; extreme poverty; a deteriorating primary health care system; limited local capacities; and minimal commitment on the part of political leadership to invest in social services. The launching of the 1998 Reproductive Health and Child Survival Strategy, influenced by the principles of the ICPD, represented a new approach in a field that traditionally focused on family planning. It also legitimized the claims of health advocates seeking a more comprehensive, gender-oriented approach to reproductive health. However, Bangser is concerned that Tanzania's almost total reliance on international donor funds makes this strategy vulnerable to donor biases, changing donor priorities, and budgets, and raises questions about the extent to which Tanzanians can determine the agenda and sustainability of reproductive health programs. Although reproductive health is a growing priority on the donor agenda, it is only one among many priorities that vie for limited national resources. Moreover, it is not clear how the ongoing process of health-sector reform and decentralization will affect implementation of the reproductive health agenda.

The author recommends that donors involved in reproductive health conditions in Tanzania must address the problem of international financial systems that compromise implementation of the health services; assist to strengthen the primary health care system; attempt to strengthen local ownership of the health sector through the current evolution of sectorwide

approaches to funding; and be more transparent and responsive to community needs and priorities; and the author underscores the need for highly accountable systems of tracking health financing for program and policy formulation, implementation, monitoring, and evaluation.

Chris Allison's assessment of policy, program, and financial responses to the ICPD in the United Kingdom (Chapter 8) describes progress made by the Department for International Development (DFID) in aligning policy formulation, program design, appraisal, and monitoring with the ICPD agenda. He notes that the series of UN-sponsored international conferences in the 1990s prompted the British government to increase attention to the social sectors in development assistance, including health and population.

The Children by Choice initiative was launched by the government in 1991 in preparation for the UN's 1992 conference in Rio de Janeiro. In May 1997, following the election of the Labor government, there was a move to modify both domestic and foreign policies. This process culminated in the publication of a 1997 white paper that reaffirms the importance of the reproductive health approach as envisaged in the ICPD and the need to build effective partnerships. DFID policy and program documents emphasize the importance of reproductive health goals, including reproductive rights, principles of choice, equity, and equality, which DFID recognizes as "common causes" to be shared with all of DFID's partners. DFID's 1997 maternal health strategy aims to reduce the dangers of pregnancy in poor societies and focuses on four essential areas: ensuring that women have sufficient information to make sound decisions about health; ensuring that quality services are provided and accessible at all times; ensuring that women receive emergency care; and ensuring that safe motherhood efforts are properly monitored at all levels.

In general, DFID has increased expenditures on reproductive and sexual health and population activities and also has increased its health personnel at headquarters and at field offices. However, it remains to be seen how far such strategies and principles are effectively addressed and achieved in the health-sector reform processes that DFID is promoting in developing countries. The author recommends increased emphasis on partnership building; greater efforts to monitor and demonstrate the cost-effectiveness of DFID assistance for reproductive health; and strengthening of the process of accountability among program partners, which should ideally extend to "outward" accountability to the public of both developed and developing countries.

In Chapter 9, a study of policy, program, and financial commitments to the ICPD in the United States, Judith Jacobsen demonstrates in her study that implementation of the commitments has been dominated by contrasts between the actions of the administrative and legislative branches of the U.S. government. A Democratic administration helped shape the