Donor Dealings: The Impact of International Donor Aid On Sexual and Reproductive Health Services

By Susannah H. Mayhew

Susannah Mayhew is lecturer with the London School of Hygiene and Tropical Medicine and also works part-time for the Nuffield Institute for Health, University of Leeds, UK.

Since the Cairo International Conference on Population and Development (ICPD) in 1994, international donors to population and AIDS programs have been called on to respond to the ICPD goals for expanded and holistic reproductive health services. How have they met the call? Do donors really support post-Cairo sexual and reproductive health services, or do we need to look for new models of assistance? To explore these questions, I look first at the changing face of donors to sexual and reproductive health, the nature of their support and the inherent problems associated with their support. I then consider whether and how donors support the Cairo agenda, and discuss the opportunities presented by recent health systems changes.

DEFINING DONORS AND THEIR FUNDING

Traditionally, the donors associated with population and reproductive health activities have been the bilateral aid wings of wealthy Northern governments (notably the United States, Britain, Germany, Netherlands and the Scandinavian countries) and the major United Nations multilateral institutions, notably the UN Population Fund (UNFPA) and UNICEF. Over the last decade, however, North American and European donors have become increasingly reluctant to commit sufficient funds for sexual and reproductive health as detailed at ICPD.[1] Needs are increasingly being met, financially and in-kind, by Japan (although recent economic developments have limited its current contributions), development banks (such as the World Bank, and African and Asian development banks) and other quasi-private or private sources such as the Gates Foundation. In addition, notably in response to the AIDS crisis, pharmaceutical companies are offering support through donations of drugs. However, banks and private companies are not donors, although they are often referred to as such; banks require loan repayments with interest, and private companies often expect commercial benefits following donations.

Family planning, safe motherhood and HIV/AIDS continue to be the three main areas of donor funding. Accurate figures on donor financing remain extremely difficult to find, despite repeated calls for establishment of an international tracking system. UNFPA estimates from 1996 suggest that a total global budget of $10 billion was allocated for family planning. Of this, $1.4 billion was provided by international donors and $0.6 billion by the World Bank and other development banks. The remaining $8 billion was provided by developing country governments and private sources.[2] Safe motherhood programs are estimated to receive $1.3 billion from donors;[3] government contributions to these programs are probably several times that amount, as an estimated 4–17% of government expenditures on health go to maternal health programs.[4] Little information is available on funding for HIV/AIDS services, although funding by the World Bank and other development banks is reported to have almost tripled since 1990.[5] Funding for AIDS now appears to come predominantly from this nondonor source and, increasingly, from the private sector.[6]

In the current climate of resource shortages for sexual and reproductive health services, the rise in private-sector funding is welcome, but the financial burden could shift from donors to recipient countries, for example, through bank loan repayments and cost-recovery initiatives that impose fees for services. Such a shift could lead to health being regarded as a market commodity rather than a human right, with service provision aimed more at providing cheap, cost-effective services than at ensuring equal access to quality health care for the poorest countries and individuals.[7] Traditional donor support structures have a number of problems, but are they great enough to outweigh concerns about increasing nondonor funding of sexual and reproductive health?

DONOR SUPPORT IS POLITICAL

Donors (usually) are not neutral, philanthropic givers of gifts. Donors are subject to national and international political interests that can influence their decisions on program and service support to the detriment of local needs. This is currently the case in the United States. The anti-abortion stance of recent Republican administrations (starting with that of Ronald Reagan) has resulted in a policy (the so-called gag rule) that denies aid for family planning funding to any foreign nongovernmental organization (NGO) that uses its own money to provide abortions, engage in abortion counseling or referral or advocate changes in abortion laws, regardless of the needs of the population being served. In Nepal, the maternal mortality ratio (539 per 100,000 live births) is among the highest in Asia; more than half the country's maternal deaths are estimated to be due to unsafe abortions (abortion was officially illegal until mid-2002).[8] A number of local and international NGOs that provided reproductive health services were active in efforts to legalize abortion in Nepal. During the administration of Bill Clinton, who rescinded the gag rule, the U.S. Agency for International Development provided substantial support for the nonabortion-related services of these NGOs. When the gag rule was reimposed in 2000, several of

the NGOs refused to sign a commitment to cease their lobbying for legal abortion and consequently lost their funding. The loss of funding has impeded their ability to reduce maternal mortality by providing desperately needed family planning, safe (and now legal) abortion procedures and postabortion care.[9]

The issue of syndromic management (diagnosis and treatment of STIs based on symptoms in the absence of laboratory testing equipment) illustrates the international political contexts of donor decision-making. Originally developed in the 1970s as a technique to treat widespread STIs in resource-poor settings in Sub-Saharan Africa, syndromic management was intended to be a treatment strategy that would be responsive to local needs. In the 1980s, however, the World Health Organization simplified the approach and promoted it to donors and governments as a global policy guideline. In 1994, the ICPD commitment to STI treatment provided a further push for donor support for syndromic management. The emergence of the HIV/ AIDS pandemic focused attention on the need to prevent STIs, and donors were eager to be seen taking action. When, in 1995, results of a major international field trial in Mwanza (Tanzania) were published, showing a dramatic association between syndromic treatment of STIs and a decline in HIV transmission, donor support was consolidated. Thus, syndromic management of STIs became a key component of donors' post-Cairo reproductive health programs.

However, local epidemiological and demographic conditions vary, and problems have been experienced in context-specific implementation because of an inability to adapt the guidelines to local conditions or a lack of consultation with service providers. Moreover, in some cases, donors pressure national governments to adopt internationally sanctioned policies, even if those policies are not appropriate in a particular country.[10] These problems have resulted in donor programs and donor-influenced national policies that reflect an international research consensus but are locally inappropriate or ineffective.[11] In Ghana, for example, the use of condoms (which are not actively promoted by family planning programs) is relatively low, family planning services are predominantly used by married women, and men remain the most important transmitters of STIs and HIV. All these factors point to the inappropriateness of a policy focused on promoting STI/HIV management within woman-oriented family planning services, although it has formed an important part of many recent donor programs.

DONOR SUPPORT MAY IMPEDE SERVICE INTEGRATION

Another consideration is the nature of many donor support structures. In Sub-Saharan Africa, current donor support and funding structures are not geared to support of integrated or holistic service delivery.[12] Existing family planning and maternal and child health programs and institutional structures continue to have strong donor commitment, as they have often been supported and built up by donors over many years. These programs, however, still require vertical accountability, which tends to perpetuate program-specific flows of funding, management, commodities, logistics, reporting and so on. This vertical orientation is contrary to stated donor and government policy goals to provide integrated service delivery. In 1998, for example, Ghana, Kenya and Zambia each had separate donor-supported ministry units or councils for family planning, for AIDS and for maternal and child health. Each unit or institution, with the support of its own particular group of donors, had produced its own set of policy and program documents relating to (integrated) reproductive health. Service providers have found these hard to synthesize at the implementation level.[13] Another example comes from Uganda, where USAID produced manuals on reproductive health training for its own program that duplicated existing government manuals.[14]

Vertical or program-specific structures are not detrimental in themselves. Indeed, some components of sexual and reproductive health services, such as emergency obstetric care and treatment of AIDS patients, may require them. However, in situations where integrated or expanded sexual and reproductive health service delivery is the aim of government policy and donor support, some current donor support structures—notably those of USAID and the UN agencies—and the lack of donor coordination and streamlining of activities create problems. The impact of recent donor initiatives such as the Global Fund, which gives substantial funding to program-specific activities, will need close monitoring, because these efforts may also serve to reinforce vertical, disease-specific donor-support structures.

Donor support is changing. However, many key sexual and reproductive health donors still retain traditional support structures characterized by vertical and program-specific organization and frequent duplication of activities by donors. This impedes donors' stated goal of providing holistic sexual and reproductive health services in the spirit of ICPD.

TAKING CAIRO FORWARD

Given the constraints associated with donor support, can donors really advance the Cairo agenda? The ICPD program of action contains an inherent tension. The Cairo vision espouses a broader, multisectoral, participatory vision of sexual and reproductive health that encompasses notions of empowerment, equity and so on, which by definition require a qualitative understanding. However, donors who support and try to implement this program of action have accountability requirements that must be supported by quantitative data; they need to show their domestic constituents that aid flows are accountable, transparent and cost-effective. It is much harder to quantify empowerment than to quantify increased provision of STI management services at family planning clinics. Although accountability is absolutely necessary for provision of efficient and high-quality services, it requires both quantitative and qualitative indicators. The experience of service integration indicates that donors have not invested much in the development of broader, qualitative indicators. Rigid donor

accountability requirements have resulted in the development of inflexible structures and strategies that cannot encompass the broader ICPD vision of sexual and reproductive health services. A prime example is the major focus of post-Cairo donor activities on expanding existing woman-focused family planning and maternal and child health services by adding management of STIs and HIV. It would be far more appropriate to expand by addressing the issues of male sexuality and unequal gender relations.

To some extent, donors have sought to address the less tangible elements of ICPD by working with NGOs, which are considered more flexible and more able to address community-level, gender-relations and empowerment issues.[15] But even international NGOs have been slow to change their program indicators and activities to reflect the expanded Cairo agenda, because they too are driven by donor-accountability requirements. For example, a recent UNFPA-implemented initiative funded by the European Commission sought to support partnerships of international and local NGOs in Asia to further ICPD goals. Some headway was made, particularly with improving sexual and reproductive health services for adolescents and STI treatment services for men and women, and a number of local NGOs showed considerable innovation in their local context.[16] In general, however, international donors and NGOs provided disappointingly limited support for innovative ICPD components on reproductive rights and male sexual health, and many sexual and reproductive health programs still focus predominantly on woman-centered family planning services. The limitations were largely the result of a lack of visionary planning and a dearth of appropriate indicators to define objectives and measure progress for the innovative and rights-based components of ICPD.

Workable indicators (qualitative as well as quantitative) to monitor the progress and accountability of activities addressing the progressive elements of ICPD (rights issues and creative approaches to local sexual and reproductive health challenges) are urgently needed. Donors and governments will show how serious they are about promoting the Cairo program of action by whether they take up this challenge.

HEALTH SYSTEMS CHANGES

Many of the same donors who fund and support sexual and reproductive health services also fund wider systemic reforms that seek to restructure the financing, management and organizational structures of health systems to improve efficiency and quality of services. Many of these systemic changes offer opportunities for supporting a move away from constraining, traditional program-specific structures toward ICPD-focused comprehensive sexual and reproductive health services.[17]

For example, sectorwide approaches (SWAps) offer an opportunity for more coordinated and multisectoral service-delivery approaches for sexual and reproductive health. SWAps involve donors coming together to pool their funds rather than supporting separate programs. Donors and recipient governments jointly agree on targets and strategies for allocating the pooled funds and implementing defined priority projects. The SWAps approach is aimed at building local capacity and strengthening indigenous health systems to respond more efficiently to local service needs by requiring the government to take responsibility for decisions on local priority-setting and resource allocation (against the prenegotiated targets and strategies). SWAps require that donors give up some of their autonomy; they also encourage groups like NGOs to collaborate on the nationally agreed plans.[18]

Not all donors are committed to this approach, however, and tensions are evident when groups of donors remain outside the SWAp. In Ghana, for example, most European donors have pooled their funds into a SWAp, but key sexual and reproductive health donors—USAID and the UN agencies (notably UNFPA)—remain outside and continue to support and deliver separate sexual and reproductive health program activities. This can inhibit the effectiveness of the SWAp because national policymakers may not see any necessity for the holistic planning that the SWAp is designed to promote.[19] For example, the government in Ghana did not initially include a budget line for condoms (the mainstay of sexual and reproductive health programs) because USAID and UNFPA were continuing to fund condom supplies outside the SWAp. To keep sexual and reproductive health needs and requirements on the national agenda, sexual and reproductive health supporters must make the case for sufficient resources to national-level decision-makers. Early experiences in Uganda illustrate the potential difficulties of meeting this challenge. Weak leadership and lack of involvement of sexual and reproductive health advocates in the design of the SWAp led to sexual and reproductive health being left out of the SWAp targets and resource allocations altogether, although they were eventually reinstated by the central government.[20]

Allowing district managers to make their own district-specific decisions about resource allocation and collaboration with service providers outside the public health sector (i.e., through decentralization) could have a number of benefits. It would enable the provision of services tailored to local needs through the promotion of more community-based, participatory and accountable service delivery. Decentralization could also encourage district-level linkage with NGOs to expand and improve service delivery. One example is an initiative in Mali called Un Cercle une ONG (One district, one NGO). Under the decentralized AIDS Program, NGOs are contracted to adopt a district where they work with communities to develop local AIDS prevention activities.[21] If decentralization of decision-making and management powers occurs before the capacity at district level is actually in place, however, poor service implementation and human resource management may result.[22]

Thus, the challenge for sexual and reproductive health advocates—if they are to benefit from systemic reform and not be damaged by it—is to establish a dialogue with relevant policymakers and decision-makers. The challenge for

donors is to bring their own activities in sexual and reproductive health and health-systems development closer together.[23] Currently, the two areas are frequently run in parallel, with major donors like USAID and the UK Department for International Development having different leadership and groups working on each area.

CONCLUSIONS

Traditional donor aid to sexual and reproductive health services has been characterized by program-specific support for family planning, HIV/AIDS and safe-motherhood services. Donors have been slow to change to ways of providing support that would promote provision of the integrated and expanded reproductive health services envisaged at ICPD. In addition, the stringent accountability and transparency requirements of international donors have made it difficult for them to respond to the progressive but less tangible components of the Cairo agenda. Moreover, key donor policies on sexual and reproductive health are influenced by donors' broader political and economic interests and may not provide the most appropriate solution to context-specific needs.

However, the rise in private-sector, nondonor financing for sexual and reproductive health is a matter of greater concern because it is particularly prone to influence by commercial and market interests that may conflict with the sexual and reproductive health needs of recipient populations and with quality of care. Little is known about the impact of nondonor financing on sexual and reproductive health services; careful international monitoring and analysis will be needed to effectively harness these resources without compromising the ICPD goals.

Current changes in the way donors are structuring their support (e.g., through SWAps and decentralized structures) offer exciting opportunities for sexual and reproductive health advocates to further the ICPD vision at the policy and service levels. The achievement of this vision will depend on the ability of sexual and reproductive health advocates to engage with donors and policymakers involved with systemic change and the extent to which donors are prepared to streamline their own activities. It will also require the development of workable indicators against which to measure the more qualitative, innovative and comprehensive components of sexual and reproductive health.

All in all, international donors will remain an essential source of support for sexual and reproductive health. Changes in sources of aid and structures of support not only herald uncertainties for sexual and reproductive health services, but also are the keys to advancing the Cairo agenda: Donors must now take up the challenge.

REFERENCES

1. United Nations Fund for Population (UNFPA), *Final Report of the Hague Forum: Taking the ICPD Agenda Forward*: UNFPA, 1999; and Potts M et al., Paying for reproductive health care: what is needed and what is available? *International Family Planning Perspectives*, 2000, 25(Suppl.): S10–S16.

2. Potts M et al., 2000, op. cit. (see reference 1); and Population Action International (PAI), How are nations responding to the call for increased funding for reproductive health? Fact Sheet, Washington, DC: PAI, 1999.

3. Howard LM, *Supporting Safe Motherhood: A Review of Financial Trends*, Population and Human Resources Department Working Paper, Washington, DC: World Bank, 1990.

4. Potts M et al., 2000, op. cit. (see reference 1)

5. Ibid.

6. Ibid.; and Laws M, International funding of the global AIDS strategy: official development assistance, in: Mann JM and Tarantola DJ, eds., *AIDS in the World II: Global Dimensions, Social Roots and Responses*, New York: Oxford University Press, 1996.

7. World Bank, *World Development Report: Investing in Health*, Oxford: Oxford University Press, 1993; Shretta R et al., A political analysis of corporate drug donations: the example of Malarone in Kenya, *Health Policy and Planning,* 2001, 16(2):161–170; and Killick T, Gunatilaka R and Marr A, *Aid and the Political Economy of Policy Change*, New York: Routledge, 1998.

8. Center for Research on Environment, Health and Population Activities (CREHPA), Saving women's lives: building support for preventing unsafe abortions in Nepal, *Reproductive Health Research Policy Brief*, Kathmandu, Nepal: CREHPA, 2000; CREHPA, Saving women's lives: need to strengthen hospital resources for management of complications of abortions in Nepal, *Reproductive Health Research Policy Brief*, Kathmandu, Nepal: CREHPA, 2000; and CREHPA, Saving women's lives: women in prison in Nepal for abortion, *Reproductive Health Research Policy Brief*, Kathmandu, Nepal: CREHPA, 2000.

9. Mayhew SH and Ambegaokar MA, Donor support to the NGO sector: An analysis of the EC/UNFPA initiative for reproductive health in Asia, unpublished report, London: London School of Hygiene and Tropical Medicine, 2002.

10. Lush L, Walt G and Ogden J, Transferring policies for treating sexually transmitted infections: what's wrong with global guidelines? *Heatlh Policy and Planning,* 2003 (forthcoming); Mayhew S et al., Integrating component services for reproductive health: the problem of implementation, *Studies in Family Planning,* 2000, 31(2):151–162; and Philpott A, Twists in the Mwanza tale: did one HIV research study shift global policy? *Development Research Insights*, 1999, No. 32, pp. 2–3.

11. Lush L, Walt G and Ogden J, 2003, op. cit. (see reference 10); Grosskurth H et al., Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomised control trial, 1995, *Lancet*, 346:530–536; Philpott A, 1999, op. cit. (see reference 10); Mayhew S and Lush L, Donor double-speak on reproductive health: triumph of politics over science? *Development Research Insights*, 1999, No. 32, pp. 3–4; and Dehne KL, Snow R and O'Reilly KR, Integration of prevention and care of sexually transmitted infections with family planning services: what is the evidence for public health benefits? *Bulletin of the World Health Organization*, 2000, No. 78, pp. 628–639.

12. Mayhew S et al., Donor involvement in reproductive health: saying one thing and doing another? *International Journal of Health Services*, 2003 (forthcoming); Lush L et al., Integrating reproductive health: myth and ideology, *Bulletin of World Health Organization*, 1999, 77(9):771–777; and Mayhew S et al., 2000, op. cit. (see reference 10).

13. Mayhew S et al., 2003, op. cit. (see reference 12); Lush L et al., 1999, op. cit. (see reference 12); Mayhew S et al., 2000, op. cit. (see reference 10); Mayhew SH, Integration of STI services into FP/MCH services: health service and social contexts in rural Ghana, *Reproductive Health Matters,* 2000, 8(16):112–124; Njeru E and Njoka J, Barriers and opportunities for integration of STD/HIV and MCH/FP services in Kenya, unpublished report, London School of Hygiene and Tropical Medicine: London, 1997; Mutungwa CF and Nkwemu KC, Barriers and opportunities for integration of STD/HIV and MCH/FP services in Zambia, unpublished report, London School of Hygiene and Tropical Medicine: London, 1997; and Annan J and Dzukini H, Barriers and opportunities for integration of STD/HIV and MCH/FP services in Ghana, unpublished report, London School of Hygiene and Tropical Medicine: London, 1997.

14. Mirembe F, Ssengooba F and Lubanga R, *Uganda: Reproductive Healthin Policy and Practice*, Washington, DC: Population Reference Bureau, 1998.

15. Ambegaokar A, Donor support to NGOs in reproductive health: research issues in governance and policy, unpublished report, London School of Hygiene and Tropical Medicine: London, 2001.

16. Mayhew SH and Ambegaokar MA, 2002, op. cit. (see reference 9).

17. Lubben M et al., Reproductive health and health sector reform in developing countries: establishing a framework for dialogue, *Bulletin of the World Health Organization,* 2002, 80(8):667–674.

18. Salm AP, Promoting reproductive and sexual health in the era of sector-wide approaches (SWAPs), *Reproductive Health Matters,* 2000, 8(15):18–20; and Foster M, *The Status of Sector Wide Approaches*, London: Centre for Aid and Public Expenditure, Overseas Development Institute, 2000.

19. Personal communication, Sterling P, acting health adviser, DFID-Ghana, July 30, 2002; and personal communiocation, Dr. Agogo, regional director of health services, Upper East Region, Ghana, Aug. 1, 2002.

20. Krasovec K and Shaw R, *Reproductive Health and Health Sector Reform: Module 3 of Short Course on Population, Reproductive Health and Health Sector Reform*, Washington DC: World Bank, 1999.

21. Ministére de la Santé, Programme National de Lutte Contre le Sida, *Plan Stratégique National de Lutte Contre le VIH/SIDA 2001–2005*, Bamako, Mali: Ministère de la Santé, 2001.

22. Lubben M et al., 2002, op. cit. (see reference 17); and Center for Health and Gender Equity, *The Implications of Health Sector Reform on Reproductive Health and Rights. Report of Working Group on Reproductive Health and Family Planning*, Washington, DC: Center for Health and Gender Equity/Population Council, 1998.

23. Lubben M et al., 2002, op. cit. (see reference 17).

Author contact: *susannah.mayhew@lshtm.ac.uk*