ACTING FOR REPRODUCTIVE HEALTH
in global reform contexts

MAKING THE LINK BETWEEN SEXUAL & REPRODUCTIVE HEALTH AND HEALTH SYSTEMS DEVELOPMENT
Leeds, UK, September 9 – 11th 2003.

Proceedings of an international conference

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Introduction

This conference was held in Leeds between 9th – 11th September 2003. It was organised by the London School of Hygiene and Tropical Medicine and the Nuffield Institute for Health, University of Leeds. These two institutions, together with an organising committee and a broader advisory committee, set the structure and agenda for the meeting. JSI (UK) provided technical support, managing logistical and financial aspects.

The **aims** of the conference were:

- To further international debate and knowledge on the implications of health systems development (HSD) for sexual and reproductive health (SRH) policies, programmes and services.
- To identify priorities for health systems to respond to the needs of sexual and reproductive health services and appropriate approaches for addressing these.
- To develop recommendations for promoting dialogue and collaboration between SRH and HSD actors.

The **objectives** of the conference were to:

- Further international understanding of the issues of SRH-HSD linkage which could inform future policy and programme decisions
- Identification of gaps in knowledge and of future research priorities
- Identification of health systems priorities and procedures for responding to SRH needs
- Strategies and recommendations for promoting policy dialogue and advocacy between health systems development and sexual-reproductive health actors
- Fostering of new collaborations/partnerships at the conference itself
- Dissemination of the insights and recommendations of the conference in a variety of ways to a variety of actors, including publication of papers in a Supplement of Health Policy and Planning & an action point document for stakeholders.

Funding and participation

The conference received funding from DFID, UNFPA and LSHTM. Additionally, participants from Western institutions funded their own participation, either fully or in part. Participants comprised researchers from UK and developing country academic institutions; representatives from international institutions; ministries of health; and NGOs.

Over 100 participants were brought together from reproductive health and health systems development expertise from over 20 countries.

Outputs & follow-up

- All presentations and key note speeches are now available on the conference website:

  www.lshtm.ac.uk/cps/events/link
  www.nuffield.leeds.ac.uk/content/research/international_development/conf03.asp

- Discussion points from working group sessions will be available on the website shortly.

- Selected papers will be published in a special Supplement of the international journal Health Policy and Planning scheduled for September 2004.

- It is hoped that a summary document of Action Points for sexual-reproductive health and health systems stakeholders will be launched in 2004 to coincide with ICPD+10 events.

In particular, four overarching messages that came out during the conference were:

- The need for SRH advocates to network and organise themselves to **advocate**
- Effective advocacy for SRH will involve **learning the 'language'** of health system development and macro global reforms (economic and political)
- There is a need for research to document **evidence** of the impact of reforms on SRH
- Current **indicators & measures** for policy and programme development (e.g. DALYs, Burden of Disease) are not adequate to reflect SRH benefits and therefore need to be (re)developed and (re)defined.

It is hoped that the summary document and networks/collaboration resulting from the conference will help to pursue action on each of these points.

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List of Acronyms

CSO	Civil Society Organisation
DALY	Disability Adjusted Life Year
HIPC	Highly Indebted Poor Country Initiative
HSD	Health Systems Development
MDGs	Millennium Development Goals
NGO	Non Government Organisation
PPPs	Public Private Partnerships
PRSPs	Poverty Reduction Strategy Papers
SRH	Sexual and Reproductive Health

Over-arching Key Points for Action

The following is not a consensus document; it represents a synthesis by the conference committee, of summary points arising from the conference.

The conference recognised that:

- Both health systems and reproductive health are diverse and complex involving a multiplicity of stakeholders; contextualisation is therefore important.
- Sexual & reproductive health and health systems stakeholders have not been good at talking each other's language & therefore do not well understand each other's needs and concerns.
- Both sexual & reproductive health and health systems development are inextricably linked to macro-international aid and development initiatives and mechanisms including PRSPs, HIPC, MDGs, debt and world-trade rules; both need to be kept on the policy agenda at national and international levels.
- Government and donors at all levels need awareness of SRH and its importance for alleviating poverty reduction and achieving development goals; capacity building takes time.
- A stronger evidence base is needed of the effects (positive or negative) of HSD and macro political-economic mechanisms on SRH.
- Resources are critical to make sexual & reproductive health a reality; costs and spending need to be monitored.
- Polarisation of stakeholders and lack of co-ordination has a negative effect on sexual & reproductive health promotion.
- The political context of SRH is highly charged, in particular the impact of the Global Gag Rule and highly contentious issues in abortion, abortion care, adolescent sexuality and so on.

Key action points for stakeholders:

- Both SRH and HSD advocates at national and international levels should make a commitment to establish regular contact with each other, and with international aid and development actors, through formal and/or informal mechanisms.
- Develop a strong evidence base & appropriate indicators/measures for SRH to maintaining its visibility and placement within different reform regimes and macro-economic & development instruments.

Sexual & Reproductive Health stakeholders

- Invigorate and expand SRH alliances & networks (include media) and encourage them to become conversant in the language of reform and macro political-economic frameworks.
- Develop networking and advocacy strategies to promote a holistic understanding of SRH, involvement of SRH advocates in policy development and inclusion of SRH indicators and measures in PRSPs, MDGs, and other international aid and development initiatives.
- Demand involvement in systems and policy design processes if not invited; advocate for legislative change if necessary.
- Acknowledge that although user needs are paramount, system wide improvements are essential for SRH.
- Advocate to governments and donors on importance of SRH issues & need to strengthen support for SRH and mitigate negative effects of health systems developments and macro-international aid and development mechanisms.
- Develop partnerships with international agencies and research institutions to generate a strong evidence-base to reflect sexual and reproductive health needs for local and international advocacy.

Health systems development stakeholders

- Define (negotiate) which part of the bureaucracy 'owns' SRH programmes and what is included/understood by SRH.
- Health systems planning, design and implementation should involve a range of SRH stakeholders at national and local levels.
- HSD specialists should be prepared to meet with and understand the language of technical SRH specialists to foster dialogue and common ground.
- Systems design should incorporate inter-sector coordination mechanisms with equally important areas such as education and transport.
- Explore means of addressing rights of the poor/marginalise as well as cost-effectiveness as system priorities.

Research institutions

- Generate an extensive evidence base on the benefits & challenges of health systems development and macro-economic and development initiatives on different sexual and reproductive health services.
- Generate evidence base for links between SRH and poverty impact.
- Collaborate with international agencies, such as WHO, to conduct further research to adapt current Burden of Disease, DALY, cost-effectiveness and other similar priority setting tools to better reflect the SRH needs of the poorest.
- Collaborate with international agencies to develop SRH-sensitive indicators and measures, and associated data collection tools, for inclusion in national health sector planning, MDG, PRSP monitoring and reporting.
- Document and learn from successful experiences in influencing sector, national and international policy/strategy development from the inside.
- Development of new, and sharing of existing, methodologies for analysing and measuring impact, implementation etc.

Donors and governments

- Donors should promote development of inclusive formal and informal consultation links between SRH specialists and reform managers and policy makers.
- Donors should support national governments need to become more proactive vis-à-vis donors in designing health systems improvements.
- Donors should honour commitments to SRH and continue to safeguard SRH funding if necessary within reforming systems and aid packages.
- UNFPA could (and should) play a leading role in SRH advocacy and monitoring.
- Beware the silver bullet, the technical fix.
- Recognise, & aim to avoid, the negative impact of stakeholder polarisation and lack of co-ordination among donors.
- Sector ministries should have incentives to work to poverty linked objectives.
- Develop transparent accountability mechanisms and explore the role of outside agencies in promoting accountability in authoritarian political settings.
- Keep improvement of health systems and sexual and reproductive health needs reflected in the indicators for PRSPs as well as sector-wide and budget support financing initiatives.
- Technical, policy and financial support is needed at the local level for SRH advocacy.
- Capacity building for groups at opening up processes for engagement particularly for marginalised people, using both demanded and invited space.
- Reform and policy processes should promote inclusive consultations and negotiations through institutional mechanisms such as a legal framework; key SRH stakeholders include professional bodies (midwives and nurses as well as doctors) NGOs, consumer organisations, trade unions and judiciary.

Sexual and Reproductive Health and Health Systems Development: Inter-linkages and dialogue

An overview of key issues

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Executive Summary

At the ICPD in 1994, a broad concept of reproductive health emerged, based on a vision of reproductive health as a human right, with key principles including a broad multi-sectoral approach, client-centredness and democratisation of power. An agenda for structural and systems reform, led in the 90s by the World Bank, has resulted in significant changes in the organisation, financing and resource management of the health sector in many countries. Both areas have attracted considered resources and interest of development agencies. However, the two policy areas have developed separately, with apparently little explicit overlap and dialogue. Indeed, Health System Development (HSD) policies may be developed without a clear realisation of their implications for sexual and reproductive health (SRH) programmes.

The programmatic implications for SRH of HSD policies are extensive. The paper outlines the major elements of SRH programmes, and reviews the research to describe the effects of HSD changes on them. What emerges is evidence of the potential for both beneficial and negative effects of any systems changes, depending on various factors, although large gaps in evidence are acknowledged.

In the implementation of HSD processes and SRH programmes, dialogue is needed between the policy actors to reduce negative effects and maximise benefits of HSD for SRH programmes. SRH actors need to understand reform objectives, learn its language, and explain their system requirements for their programmes to reach HSD and SRH goals. HSD actors, in turn, must be willing to engage with SRH actors and respond to their requirements. The role of health ministries in managing policy networks and instituting the major changes implied by HSD within their own organisation is critical, through dialogue processes such as consultation, capacity-building, conflict management and communication strategies.

Development partners have a clear role in improving the interplay between these two policy areas, through their expertise and experience in various countries, the resources they bring to both HSD and SRH programmes, and their policy leverage. They can build the capacity within national and sub-national levels of governments to ensure that HSD changes act to the advantage of SRH programmes, through support to such processes as planning and priority-setting, stakeholder identification, consultation and communication, incorporation of gender expertise, and the involvement of NGOs and inter-sectoral agencies of government. Within the development partner agencies themselves, linkages are needed between HSD and SRH expertise, and the associated development and research programmes, to support these processes in low-income countries. In their support to international initiatives, such as global public-private partnerships and follow-up to ICPD, development partners can advance the agenda of the interconnections between SRH and HSD. They also are critical to support the development of evidence for policy making of the interplay between HSD and SRH, as well as the development of practical tools for policy planning and implementation.

Introduction

This paper is aimed primarily at audiences who are interested in improving sexual and reproductive health (SRH) within reform contexts. It starts by reviewing the major elements of SRH programmes and discusses the potential effects on them of different aspects of the reform agenda.[1] A basic assumption is made that dialogue between the two "factions" of SRH and health systems development (HSD) can improve the potential for reforms to benefit SRH programmes, and the paper then goes on to discuss ways in which such dialogue can be initiated and maintained. It concludes by describing the implications of these issues for development partners such as DFID.

1 Programmatic implications of health systems development policies for sexual-reproductive health stakeholders

Programmes are made up of a number of general components (inputs and processes) needed to make them functional. For reproductive health programmes these components can be defined as:

- Programme policy and guidelines
- Organisational structure, including referral systems
- Planning and Management, including priority setting/accountability
- Financing mechanisms
- Drug and resource flows
- Human resource management and supervision
- Monitoring/evaluation mechanisms.

In addition, post-Cairo programmes have tried to incorporate a number of principles (Lubben et al., 2000) viz.:

- Programme integration;
- Community involvement;
- Multi-agency collaboration (especially with NGOs).

Reproductive health programmes (like all programmes) seek to achieve a number of performance criteria that are necessary if improved reproductive health outcomes are to be achieved. Four key criteria are widely used by international agencies and development institutions as standard 'indicators' of programme 'success': Equity; Access; Quality; Accountability (Krasovec and Shaw, 2000). These performance indicators underpin both the ICPD and other reform agendas; the similarity of WHO goals for health systems (effectiveness, fairness of financing, and responsiveness) reflects this.

Health sector reforms may have an impact on the components of technical programmes such as SRH, and this in turn will have implications for the above performance indicators. Analysing and measuring the impact of reforms on SRH programmes is difficult, partly because one cannot directly attribute any observed influence to the reform process alone, since reforms do not work in isolation. Nevertheless, a systematic framework for analysis can be developed, as Lubben et al. (2002) exemplify in previous work done at the Nuffield Institute for Health.

[1] Most of the literature reviewed examines this issue from the perspective of the effects of aspects of HSD (decentralisation, privatisation etc.) on technical programmes. This paper starts with the perspective of a technical programme, specifically SRH, as it is written for SRH programme managers who need to engage with HSD policy makers. This has led to a certain amount of repetition, which we regard as inevitable, considering the overall need to review systematically all elements of SRH programmes.

From the extant literature, one can say that whether health sector reforms (HSRs) have a beneficial effect on SRH programmes, or a detrimental effect, will depend in great part on the local context and particular reform 'mix'. What is beneficial to SRH programmes in one setting may impede them in another. For example, in Brazil health services operating in a devolved system performed very differently in different states because of local contextual differences although the reform policy was the same (Atkinson et al., 2000).

The remainder of this section reviews the evidence from available literature - both published and 'grey' - to consider each SRH programme element in turn and discuss the implications of different HSR components.

1.1 SRH Programme organisation and structure

1.1.1 Private-partnerships and separation of financing and provision

Weak public sector services has resulted in growing dominance of the private and quasi-private sectors. In the SRH area, for example, this includes private clinics and social franchises to deliver contraceptives and related FP services in Latin America, Asia and parts of Africa (Berman and Rose, 1994; Montagu 2002) and services such as maternity care in India, Cambodia and other parts of South and South East Asia (Bhatia and Cleland, 2001; Huff-Rouselle and Pickering, 2001). The Ghana MOH, like many others, contracts an NGO to run a contraceptive social marketing programme that is highly successful, particularly in marketing condoms which are not actively promoted by the public sector family planning or by SRH services (Mayhew, 2002a). While FP or VCT for HIV have been successfully franchised, not all RH services (such as maternal health care or holistic youth services) are suitable for such 'branding'. Moreover private facilities are driven more by markets than 'need', as in Tanzania where the private sector has not improved equity of access and coverage (Benson, 2001).

This privatisation and separation of financing and service provision (such as contraceptive social marketing or contracting of maternal health services) in health may expand access to SRH services. The second generation of SWAps (e.g. in Ghana and Bangladesh) has included explicit linkage with private sector in recognition of its importance as a service provider and to try to bring it within a national framework (Austen, 2001). Where services such as maternity care are being provided in the private sector, however, issues of regulation have yet to be resolved and large variations in quality are reported (Ranson and John, 2001; Nandraj et al., 2001).

1.1.2 Autonomous hospitals and market competition

Creating (semi-)autonomous Hospital Boards was originally intended to improve hospital governance and quality of tertiary care – critical for reducing maternal mortality. Some countries additionally opened hospitals up to market competition. There is mixed evidence that this has improved access or quality of care, moreover autonomous and private hospitals can be difficult to regulate (Collins et al., 1999; Nakamba et al., 2002; Nandraj et al., 2001; PHR, undated). As hospitals have grown and come under pressure to be more cost-effective, mergers have taken place and market competition encouraged, although reservations have been expressed as to the effectiveness of market-forces for improving health services (Collins et al., 1994; Purohit, 2001; Nakamba et al., 2002). There is some evidence that hospital mergers involving Catholic facilities may often mean a loss of reproductive health services including tubal ligations, abortions and some fertility programmes (Bellandi, 1998).

1.1.3 Integration

Integration has been a key component of many SRH donor programmes in recent years, in a bid to streamline resources and increase efficiency. However, there is evidence that integration policies have not been accompanied by the necessary structural changes (e.g. integrating lines of management, logistic flows, and financing and reporting) (Lush et al., 1999; Mayhew et al., 2000). Again there is mixed evidence of the efficacy of integration; some SRH components are suitable such as HIV/AIDS and syphilis screening in ante-natal care or condom promotion within FP programmes. Others are not, for example, services for specific groups may require specialist services (commercial sex workers; adolescents who will not want to attend the same FP services as their mothers and aunts) and some clinical services such as emergency obstetric care and treatment for HIV that require vertical integration (Hill, 2002). Thus the 'integration' debate may require clear criteria by which to judge whether it will be effective or not.

1.1.4 Decentralisation

Decentralisation and a focus on the district health system is intended to[2] strengthen accountability and improve responsiveness of services. However, it may not be appropriate for the SRH components which require highly specialised tertiary care and vertical referral systems, for example specialist laboratory services for STI and HIV/AIDS or hospital theatres for emergency obstetric care.

If emergency obstetric care is to reduce maternal mortality, it requires a functioning referral system and quality tertiary care (UNICEF/WHO/UNFPA, 1997; Maine et al., 1997; Campbell et al., 1997; PPMN, 1997). This may require cooperation in service delivery and financing between decentralised districts, if some districts cannot offer all the required levels of care. Specific technical issues around provision of anti-retrovirals (ART) for pregnant women have large infrastructure implications (specialist administration, laboratory monitoring etc.) that can only be borne (if at all) at tertiary level (Austen, 2001).

Other SRH components may benefit from integrated and decentralised planning. For SRH components delivered at the primary health level (FP, ANC, PNC, STI screening), decentralisation may allow greater client-responsiveness and accountability. For example, a pilot study in Kenya showed that decentralisation to primary care level of syphilis screening facilities for pregnant women was logistically feasible and cost-effective (87.3% sero-active women treated on site and 50% partners returning to clinic for treatment), in the context of SRH programmes (Jenniskens et al., 1995).

Decentralisation of functions, requires clarity of organisational structures and responsibilities if the implementation of SRH programmes, particularly of newly integrated functions such as STI management, is to improve (Mayhew et al., 2000). Most organisations/agencies undergoing decentralisation retain some centralised functions. For example, in the Philippines most service delivery functions have been decentralised to provinces and municipalities, while the central office of the Department of Health continues to manage contraceptive procurement and distribution (Management Sciences for Health, The Manager ECR, 2001).

In some cases the decentralised structures were not adequately resourced and led to greater inequity of access and care. Early reform initiatives in Cambodia led to a two-tier implementation of the

[2] It should be recognised that "decentralisation" in many ways covers all programme components as well as many other elements of HSRs; in this paper we focus the discussion on its primary effect of devolving a range of decision-making powers and resources flows.

district health system based on a district referral hospital and a network of 10-20 health centres which were supposed to either attract people to the facilities or provide outreach to communities. However, the continuing insecurity in a number of districts and lack of funding for outreach has meant that people's access to public facilities was limited and they have been forced into the expanding but unregulated private sector (Hill, 2002; Huff-Rouselle and Pickering, 2001).

Key points

Restructuring of 'programmes' under reforms such as decentralisation and a shift to private sector provision, hold both benefits and problems for SRH.

Diversification of and competition among service providers may lead to better quality, more choice and more client-led responsiveness, but regulation of markets and private sector providers will be needed to help ensure quality and access

For SRH components requiring tertiary provision (EmoC, HIV treatment) structural changes involved with decentralisation and integration, in particular, may lead to a weakening of services.

1.2 Planning, priority-setting, management and accountability

1.2.1 Sector-Wide Approaches (SWAps)

SWAps are intended to improve the co-ordination of planning across the entire health sector, thus leading to more appropriate and accountable services. They require donors and other stakeholders like NGOs to give up part of their autonomy to work together with Government on nationally-agreed plans (Salm, 2000).

The main danger for sexual and reproductive health programmes is that they may not be a priority in a sector-wide integrated plan; therefore unless SRH advocates can lobby strongly for resources it may be that only the key SRH targets (e.g. contraceptive supplies, HIV prevention) receive attention or, worse, none at all (Elson and Evers, 1998; Standing, 1999; Krasovec and Shaw, 2000; Mayhew, 2002). Uganda provides an example of the latter, where weak leadership led to SRH resource-allocation being left out of initial SWAp planning (Krasovec and Shaw, 1999). Safe motherhood advocates see SWAps, with their goal of strengthening system wide planning and financing as of potentially great benefit to them (Goodburn and Campbell, 2001). They further suggest that safe motherhood could act as an indicator of the performance of sector-wide approaches.

1.2.2 Decentralisation

Lack of priority for SRH may be further impeded if SWAps are occurring alongside decentralisation. In this case, other ministries, typically Labour (where there is compulsory health insurance) and Local Government (where there is devolution) may be primary budget holders, and the MOH may no longer hold full control of all public sector health functions (Collins, 1994). This will be exacerbated where the Ministry of Health is weak or where other Ministries hold a negative perception of the Ministry of Health (Fielder, 1998; Bossert et al., 1998). Decentralisation may lead to the under-funding of SRH activities if they have to compete with other health and non-health priorities, and SRH advocates are weak (Elson and Evers, 1998; Krasovec and Shaw, 1999; Standing, 1999).

Decentralisation also appears to present challenges for accountable management and priority setting. A range of countries report difficulties when decentralisation occurred without the

necessary capacity to manage reproductive health services. Countries as diverse as Ghana, Kenya, Zambia, Bolivia and the Philippines, report a lack of experience and capacities at district level, resulting in management short-comings, confusion of responsibilities and deterioration of SRH services (CHANGE, 1998; Mayhew et al., 2000).

1.2.3 Priority setting tools

Prioritisation towards SRH is typically low-profile in reforming health systems. The development of formal mechanisms for these may help to secure the necessary benefits (Reichenbach, 2002; Mayhew, in press). Priority setting is influenced by political and organisational factors that are not considered by technical priority setting tools such as DALYs. They can potentially result in unforeseen social and equity implications. For example, promoting expensive tertiary screening for breast cancer over cheaper, primary screening for more prevalent cervical cancer, as was seen in Ghana (Reichenbach, 2002). Allotey and Reidpath (2002) also voice concern over the appropriateness of traditional 'evidence'-based tools with their economic focus, since SRH depends so much on social, cultural and political contexts as well as economic. They call for priority-setting to consider reproductive *health* rather than disease because many RH interventions do not fall within the disease-model on which the DALY tool was developed.

Key points

SWAps could benefit planning and management of SRH, particularly components dependent on well-functioning systems (e.g. EmOC), but only if SRH advocates are strong enough to negotiate adequate SRH targets for inclusion in the SWAp.

Strength of SRH advocates at district, as well as national, levels is critical to ensure SRH planning and management is sound at all levels.

Current priority-setting tools are not appropriate for SRH; national-level advocacy is needed to negotiate changes in these.

1.3 Financing

1.3.1 Cost-Recovery

The introduction of cost-recovery schemes has formed a large part of international aid policies requiring reform of public services. Two forms, user fees and health insurance are discussed.

Evidence for the efficacy in health of user fees is very mixed, with a number of countries reporting a decline in service use (Zambia, Nigeria, Honduras, China, Bangladesh), though others have reported little change (Godwin, 1991; Fielder and Suazo, 2002; Bogg et al., 2002; Kaufman and Jing, 2002; Schuler et al., 2002). In China, the introduction of fees-for-services in 1985 led to significant declines in utilisation of skilled attendance at delivery and hospital delivery; increased adverse pregnancy outcomes were also recorded in women paying out-of-pocket as opposed to those covered by insurance. (Bogg et al., 2002). The move to user fees in rural China led to a decline in preventive care (antenatal care, STI screening, health education about HIV preventive behaviours) relative to curative care, for which fees can be more easily collected (Kaufman, Zhang and Fang, 1997).

Generally, user fees in public services are agreed to have negative equity implications for the poor, even if private sector services in the same district provide quality and cost-efficient services (Creese and Kutzin, 1995; Sen and Koivusalo, 1998; McDonagh and Goodburn, 2001).

Another type of financing mechanism is that of community health insurance. It has become increasingly popular as a form of cost-recovery that offers some measure of protection for the poorest, and is being piloted in a broad range of countries including Uganda, Malawi, Bolivia and India (PHR Special Initiatives, undated; Ranson and John, 2001). To date the evidence on its efficacy is mixed, and points to the need for governments to be involved in regulating the efficiency, cost-effectiveness and access to these schemes. A study of hysterectomy care through a community health insurance scheme in Gujurat indicated a huge range of quality care from excellent to dangerous; the study suggested that community schemes should be helped to identify facilities providing the best care and contract directly with these (Ranson and John, 2001).

Disparate forms of financing for SRH services could mean that financial management becomes more fragmented, and more complex to plan, manage and monitor, requiring new skills and resources for managers and systems.

1.3.1 SWAps

SWAps are intended to ensure 'holistic' and co-ordinated funding for the health sector, but as the previous section discussed, SRH programmes may not be a priority within the SWAp although some individual components seen in most countries as priorities (reduction of maternal mortality and HIV) may benefit. For example, these services may be exempted from charging user fees.

Safe motherhood initiatives traditionally receive an insignificant amount of 'reproductive health' development assistance, since most funding goes to fertility control activities that have the backing of strong, vocal donors at national decision-making levels. Goodburn and Campbell (2001) suggest that getting safe motherhood programme advocates involved directly in SWAp initiatives may be a way forward: 'it makes better tactical sense for maternal health programmes to be linked with and tap into the greater funds available for health sector development, rather than to compete with a large, articulate constituency for family planning funds' (p. 119). This raises questions about separating SRH components into 'programmes' which would then have to compete against each other.

1.3.2 Decentralisation

Equity is a major concern in decentralisation of finances and there are reported inequities between rich and poor regions in countries where national allocation formulae did not take differential wealth-bases into account (Aitken, 1999). In Uganda conditional grants are issued to ring-fence essential health package and support costs because after decentralisation was first introduced there was massive decline in PHC spending, badly affecting SRH services (Krasovec and Shaw, 1999; Austen, 2001).

In one of very few detailed studies of resource allocation under decentralisation, Chitah and Bossert (2001) illustrate that local districts in Zambia were taking advantage of increased decision-making powers in their resource allocations and displayed a number of variations, with many districts choosing not to follow national expenditure guidelines. In general, there were significant declines in real per capita expenditure at district level (though these occurred in an overall climate of economic decline). Most districts showed an increase in spending on PHC over time, with richer regions consistently spending about 20% more than poorer ones. Neither decentralisation nor declining expenditures appeared to have any impact on service utilisation which remained constant over the decade of the study.

Key points

Cost-recovery schemes are mixed in efficacy.

Health insurance schemes need close regulation, especially to safeguard the poor.

SWAps are intended to allow the inclusion of a range of public and private sources in its planning and provide a holistic, sectoral approach; the main problem is that SRH, or many of its component parts, may not be considered a priority target.

Decentralisation may produce inequity in poorer districts/regions who may be unable to sustain SRH services without extra financial allocations.

1.4 Drug/resource logistics

1.4.1 SWAps

In many countries continuing availability of contraceptives and SRH drugs is secured through continued donor funding and procurement which are increasingly being streamlined (with varying success) with reforms such as the SWAp or decentralisation (Austin, 2001; Mayhew, 2002).

SWAps are aimed at strengthening indigenous health systems to take responsibility for decisions on local priority-setting and resource allocation. The holism of planning, however, is impeded when some donors remain outside the SWAp. This is particularly the case for contraceptive supplies which are in many countries heavily funded and procured by USAID and UNFPA. In Ghana this continuing dependence on donor supplies with their separate planning and budgeting procedures, meant that the initial SWAp plan did not include a budget line for condoms, a critical component of the national SRH programme (Mayhew, 2002).

A number of the major RH donors who remain outside SWAp initiatives have voiced concerns over the implications of reforms for contraceptive and drug logistics (Bates et al., 2000). A USAID funded study of contraceptive logistics in Ghana, Kenya, Zambia and Tanzania found that vertical contraceptive logistics are most effective for improving product availability and that health sector reforms could disrupt these specific logistic functions, especially through integration, decentralisation, cost-recovery and privatisation. The study concludes that while not all aspects of reforms have a negative impact, to ensure a good logistics performance, governments and donors must plan the details of the logistic system and implementation within reform contexts (Bates et al., 2000).

1.4.2 Decentralisation

Various parts of the logistics system are being decentralised including: distribution, storage, cost-recovery, monitoring and related decision making. This has often involved streamlining or 'integration' of disparate vertical programmes including SRH components. A number of countries (Bolivia, Philippines, Zambia, Uganda and others) report negative impacts on SRH of decentralised funding and decision making because poorer regions are unable to meet priority targets or reproductive health was not a priority, resulting in lack of drugs and equipment for SRH (Standing, 1997; Collins et al., 2000; Lubben et al., 2002; Jeppsson, 2001). Brazil has attempted to overcome this with a 'top-up' allowance for poorer regions where decentralised resources like user fees and local taxes are insufficient to allow constant SRH supplies (Collins et al., 2000). A number of countries (e.g. Philippines, Ghana) retain procurement of drugs/contraceptives at national level (Mayhew, in press; Management Sciences for Health, 2001).

1.4.3 Privatisation/contracting

Contraceptives and some drugs (notably for STI treatments) are increasingly procured or accessed through the private sector. In Ghana contraceptive social marketing accounts for 61% of the condom market with the Planned Parenthood Federation of Ghana (PPAG), accounting for a further 25% (i.e. only 14% is public sector). Similarly, STI treatment is seen mostly at private sector clinics and pharmacies (Mayhew et al., 2001; Austen, 2001; Wilkinson, 2001). Issues of drug/contraceptive quality control and regulation of the private sector are not generally addressed in health reforms; most countries have an essential drugs list, but government regulation of the private sector is notoriously difficult. In the public sector the introduction of user fees for cost recovery often was often applied to drugs and supplies. This was supposed to help secure flows and resources, but as discussed previously, it has had a mixed impact and often results in inequity of access for the poor.

Key points

SWAps may weaken security of contraceptive and drug flows for SRH programmes, unless current donor support (or equivalent) can be earmarked.

Privatisation and cost recovery for commodities may increase client choice and access (though there are equity implications for the poor), but regulation of quality is difficult.

Decentralisation may weaken drug/contraceptive security unless poorer districts receive extra financial help and/or SRH commodity procurement remains centralised and earmarked.

1.5 Human resource management

Management of change and the changing roles of human resources in management are given less priority in reform processes than other issues such as financing and accountability (Wang et al., 2002). HR management is a generic health sector problem, but since SRH staff make up a large proportion of staff at PHC level, it is of particular importance to SRH programmes undergoing change.

1.5.1 Decentralisation

Wang et al. (2002) found mixed evidence of the efficacy of deconcentrating or de-linking recruitment and payment of human resources, particularly where decentralised management is weak. Decentralisation of HR management creates great difficulties for SRH unless adequate capacities are in place before decentralisation. The extent of capacity-building needed for regional and district administrations to allow district/regional managers to carry out new responsibilities such as supervision, training and planning has been underestimated in many countries (Wang et al., 2002; Jeppsson and Okuonzi, 2000; Mayhew, in press). The loss of specialist technical expertise is a danger to quality of care, as was seen in Zambia TB control programmes (Bosman, 2002). Weil (2000) has called for systematic capacity development of polyvalent workers at sub-national level to take on their new functions.

In both the Philippines and Zambia, for example, transfer of funds from central to local governments was not accompanied by decentralisation of the technical support system and led to a loss of expertise and deterioration of quality of care. As well, changes in health workers' salaries and benefits resulted in lowered morale and performance (CHANGE, 1998).

A meeting of representatives from Haiti and 16 francophone African countries identified a number of pre-requisites for managers if decentralisation was going to be successful (Management Sciences for Health, The Manager ERC, 2001). These included: sufficient political will and resources at all levels; adequate management skills at all levels; clear implementation plans and legal administrative frameworks; interest, involvement and commitment of local leaders.

For decentralisation to work well, senior managers and policy makers must make decisions about the kinds of management and technical functions to transfer to lower levels and to whom those functions will be transferred. In Honduras ASHONPLAFA, the principal provider of FP services, analysed their process of decentralisation. They found that decentralisation of responsibility from central to regional management for activities such as income generation, marketing and IEC campaigns worked well and plans are underway to decentralise more responsibility including operational planning and evaluation. (Management Sciences for Health, The Manager ERC, 2001). Management styles and skills of regional managers at ASHONPLAFA were found to differ, with some still depending on the centre for direction; thus technical assistance and management training is being provided for regional managers as they take on new responsibilities. Socio-political and managerial contexts may influence the extent to which districts/managers take up their autonomy once it has been conferred on them (Atkinson 2000; Management Sciences for Health, The Manager ERC, 2001).

Devolution does have the (negative) potential to support local systems of political patronage and nepotism, with negative effects on the career development and motivation of personnel (Mayhew 1999 and in press). It may also be difficult to maintain adherence to national gender guidelines for human resource management, with effects on the quality of services. Gender-sensitive health care services are important in reproductive health, including the issue of provider-client relations and the sensitivity of providers, particularly to female clients. However, women are usually under-represented in decision-making positions in health, and gender expertise tends to be concentrated at national levels. How gender issues in human resources are affected by decentralisation and other aspects of HSD is not known (Standing, 2000).

To the extent that decentralisation involves an integration of programmes, there are major implications for human resources currently deployed in vertical programmes (FP, HIV/AIDS etc.) who currently benefit from privileged resources, cars, offices, training opportunities and so on. Integration means a loss of these things, risking the subsequent loss of power and staff motivation.

Key points

Management of human resources through changes in health systems (decentralisation and de-linkage (of HR management from the health sector)) has been neglected but will need serious attention if SRH staff are to be adequately managed and feel comfortable with any changes in pay, career-progression, working conditions, responsibilities etc.

Planning for the maintenance of technical expertise in decentralised SRH programmes, for training, technical supervision and monitoring of performance, is as critical as management expertise

Capacity development of personnel to allow them to take on new managerial and technical roles is needed before decentralisation proceeds

1.6 Monitoring/evaluation

There is very little literature on M/E. Most NGO and donor SRH monitoring tools are programme or outcome-based and even the most comprehensive do not usually take any account of health

systems issues (e.g. UNFPA RHI M/E guidelines, LSHTM 2002). The WHO's World Health Report 2000 sets out one way of evaluating health goals in a reform context, though its linking of goals with resources spent was controversial (Wibulpolpraserrt and Tangcharoensathien, 2001). Some writing has emerged on how to measure the 'fairness' and 'success' of reforms in general (Figueras et al., 1997; Daniels et al., 2000; Wibulpolpraserrt and Tangcharoensathien, 2001) but not in relation to SRH. One exception is an 'assessment and planning' manual produced by a South African NGO, The Women's Health Project (Tint et al., 1998). The manual covers detailed monitoring techniques for collecting information to inform health system development in relation to SRH. The methods, however, are more akin to research than routine monitoring.

It may be that for large and specific programmes of work, such as HIV/AIDS, separate project-based technical assistance and M/E remains the most effective and accountable way of maintaining quality of care and quality of information systems, particularly when issues like provision of ART through market mechanisms are beyond the regulatory capacities of most governments (Austen, 2001). However, under decentralisation, district management will have increased responsibilities for monitoring the whole range of SRH services. A number of guidelines for district managers have been developed recently which are tailored to helping district staff cope with increased management, supervisory and monitoring responsibilities in which district capacities are often weak (Green et al 2002; KIT 2003; Murray et al., 2001).

The increasing involvement of private sector and other stakeholders from non-health sectors adds urgency to questions of M/E of these providers in order to obtain complete information on service provision and enable accountability. There is a need to ensure good clinical protocols are established and monitored, but regulation is often difficult (Austin, 2001; Mayhew and Ambegaokar, 2002).

Key points

Tools for monitoring SRH (whether as part of a distinct project or not) within health systems need to be developed and should be based on indicators broader than financial/resource considerations.

Monitoring and evaluation of private sector SRH services needs to be developed.

1.7 Programme and policy guidelines

SWAps provide a strengthening of the policy framework, particularly where they include multi-actor partnerships and private sector linkage and therefore encompass, within a national framework, the components of SRH that are predominantly provided in the private sector (STI, ART, condoms).

Lush et al. (1999), Mayhew et al. (2000) and Mayhew (in press) show the importance of providing clear policies and programme guidelines for structural change otherwise confusion and weakness, particularly in decentralised and integrated structures, will predominate. They also show that programme structures and activities are often slow to come into line with national policies and structures.

Key points

Clarity of programme policies and guidelines (specifying changed functions, responsibilities etc.) is key to successful implementation of SRH programmes in reform contexts.

1.8 Programme integration

There is a considerable literature on integration of RH services, much suggesting that 'integration' is only appropriate for certain SRH components and in certain contexts (Lush et al., 1999; Snow and O'Reilly, 2000; Mayhew et al., 2000 and in press; Askew and Maggwa, 2002). It may be more appropriate to talk of integrating activities or components, rather than integrating programmes. Proponents of safe motherhood argue strongly that a vision of one large 'integrated' SRH programme may be untenable because of the different needs and foci of different component parts (Goodburn and Campbell, 2001). Many donors and agencies working in 'RH' began by funding family planning programmes and this focus tends to remain dominant, but the needs and strategies for the provision of FP (e.g. contraceptive social marketing) are very different from, for example, the needs of providers of emergency obstetric care (Goodburn and Campbell, 2001).

1.8.1 SWAps

Sector-wide approaches offer opportunities for sector-wide integration of planning, priority-setting, financing and management, as opposed to traditionally fragmented, donor-specific programmes. Some key SRH donors, however, remain outside SWAps in most countries (notably USAID, UNFPA, UNICEF) resulting in a continuation of non-integrated programme components (Mayhew, 2002).

1.8.2 Decentralisation

Decentralisation potentially offers the possibility for enhancing integrated service delivery at district level through decentralisation of resources to allow locally integrated management and greater responsiveness to local needs and priorities. In reality however, decision-making often remains centralised and district capacities are weak, resulting in poor service delivery and human resource management (Lush et al., 1999; Mayhew et al., 2000; Lubben et al., 2002). Similar experiences are reported in Bolivia and the Philippines which decentralised before sufficient capacity was in place at district levels, resulting in weakened service provision (CHANGE, 1998).

A study of the STD/AIDS control programme being implemented in a decentralised system in Tanzania indicated that programme integration could lead to cost-savings to the health system (a goal of HSRs), but might reduce resource allocation at decentralised level for SRH services (Hanson, 2000). Furthermore, the decentralised system was weak with poorly-functioning horizontal linkages and this led to reduced service outputs.

1.8.3 Private provision

Increasing private sector provision of SRH services, or contracting out of particular services may lead to greater fragmentation of delivery, contrary to integration goals (Lubben et al., 2002). Malawi indicates a potential solution in its contractual requirement of NGOs to provide integrated FP and RH services, through subsidising their facilities in return for compliance with government policies and protocols on integration (Krasovec and Shaw, 1999).

Key points

If SRH service integration is a goal, capacities at decentralised levels must be in place and arrangements with private facilities should be made to safeguard quality of SRH services.

It is important not to over-emphasise 'integration' of RH as it is not suitable for some SRH components, or if all components were integrated there may be a danger of creating another large vertical programme (of 'integrated RH').

Reform initiatives like SWAps may offer a more permanent and viable path for supporting SRH through the strengthening of the entire PHC system.

1.9 Community involvement

1.9.1 Decentralisation

Decentralisation is held up as one of the sectoral reforms that could go some way to enhancing community involvement in health care. Decentralising decision making on activities and resource planning offers an opportunity for community representatives to be involved in service-related planning and structure. In Mali, for example, facilities at sub-District level are run by community health boards that are responsible even for staff salaries. The extent to which decentralisation shifts responsibility and financing to communities may have severe equity implications for the poorest and most dis-empowered. It but may also improve the responsiveness of facilities to local health needs and priorities (although these may not include SRH). Depending on which groups (gender, social class, ethnicity and so on) in the community are represented on decision-making bodies, SRH programmes may address different priorities to those which governments considers important. For example, gender-based violence may be a national priority, but be ignored at a local level, due to lack of information, conservatism, lack of women's representation on councils, and other factors. Clear policy guidelines with mechanisms for accountability, and ways of addressing the tension between local and national priorities, are needed.

In Bangladesh decentralisation policies emphasised community involvement and community-managed family planning programmes were established in some 20% of the country. These have had a measurable impact on performance with contraceptive uptake in the community-managed programmes showing an average increase of 20% (Management Sciences for Health, The Manager, ERC 2001).

Key points

Increased involvement of communities in health service management under decentralisation may improve client-provider interaction and service quality, but may result in an inequitable shift of the cost-burden, as well as different priorities from those that government sets.

1.10 Multi-agency collaboration

Generally, commitment to inter-sectoral linkage in reforms has been weak with mixed evidence of collaboration between government structures, NGOs, community groups and other health-related agencies (Lubben et al., 2002; Jeppsson and Okuonzi, 2000; Jeppsson, 2002).

1.10.1 SWAps

An inherent problem with SWAps is that they concern only one sector and therefore predominantly one Ministry – Health. Thus multi-sectoral issues such as gender equity, sex education for adolescents, and indeed programmes such as HIV/AIDs and safe motherhood, may not be adequately addressed (Salm, 2000). Nevertheless, the SWAp may be able to deal with this problem if its planning process brings on board a range of international institutions (UNFPA, UNCEF etc.) and NGOs working on these issues, as well as other Ministries such as Education and Social Welfare (Salm, 2000). There is evidence that SWAps are increasingly paying strategic attention to co-ordinating multi-actor linkages e.g. in the second phases in Ghana and Bangladesh (Austen, 2001).

1.10.2 Decentralisation

Decentralisation may aid multi-agency collaboration by giving formal support to linkages that are already occurring between the district health personnel, NGOs/missions and private sector providers and community representatives, that may benefit reproductive health. Potentially beneficial initiatives for inter-Ministerial collaboration in Ghana for condom delivery broke down through lack of agreement on formal responsibility (Mayhew, 2000). The current strengthening of the district tier under Ghana's decentralisation policy serves to enhance existing informal links between missions, NGOs and the two ministries, which could strengthen future partnerships (Mayhew, in press). The challenge for reproductive health is to ensure that there are strong advocates who can build alliances with key individuals and groups to secure SRH priorities against other health and non-health issues.

NGOs have played a pioneering role in tackling HIV/AIDS in many countries (Austen, 2001). In Mali, decentralisation of the AIDS programme has enabled enhanced collaboration with NGOs at district level. Under the 'Un Cercle une ONG' initiative NGOs are contracted to adopt a district where they work with communities to develop AIDS prevention activities that are locally acceptable and appropriate (Mayhew, 2002). Although in an early stage, the initiative has been embraced enthusiastically by NGOs, district AIDS officers and community groups in the pilot districts and scale-up is underway.

Key points

SWAps may impede multisectoral links necessary for some SRH components unless they engage with a range of stakeholders at the planning stage.

Decentralisation may enhance multi-sectoral collaboration by offering the mechanisms for formal linkages.

1.11 Conclusions

What many of these studies to date indicate is that HSD does not determine any particular outcome in SRH programmes i.e. they are neither inherently beneficial nor detrimental. This means that there is the potential for SRH programmes to exploit reforms in order to positively benefit them, but the previous discussion also indicates that reforms represent many challenges for SRH programmes. (Lubben et al., 2002; Mayhew, 2002; Standing, 2002).

It may be more beneficial for SRH advocates not to negotiate for an 'SRH programme' within reforming systems, (since there could not feasibly be a single programme that covered maternal health, emergency obstetric care, family planning, STI management, abortion, screening of reproductive cancers and everything else) but to negotiate a range of SRH targets and indicators that are integral to systems planning and development. Whatever SHR advocates do, they cannot afford to ignore health sector reforms, since they are widespread and will stay on the policy agenda (Salm, 2000; Langer et al., 2000; Berer, 2002; Lubben et al., 2002; Mayhew, 2002).

2 Processes for dialogue

2.1 The need for dialogue

"The two policy areas of reproductive health and health sector change have developed separately over the last twenty years…. A critical feature in both these fields has been the lack of focus on policy dialogue…which results in fragmentary and incoherent policy making with reproductive health service programmes tending to develop without an understanding of the broader changes in the health sector or across the public sector as a whole."
(Lubben et al., 2002, p.1)

Health sector reforms are intended in many countries in order to address fundamental deficiencies in the health care system such as inefficiency, resource deficits, lack of accountability, and poor quality. These reforms involve radical changes in power at various political and bureaucratic levels, and have enormous implications for health policies, programmes and services (Population Council, 1998). Reproductive health and health sector reform share similar goals of equity and health status- but what, beyond such high-level goals, do SRH and HSD policy actors share? Why is there often such a gap between the two, and what is needed to bridge it?

Reforms are usually initiated by the most senior government managers inside and outside the health service, by politicians and donors. The pressing need to manage the multiple actors affected and the many tasks to be accomplished can result in technical programmes, such as SRH, being viewed as just one more issue amongst many to be dealt with. Even worse, technical programmes may be viewed as simply being at the receiving end of the system changes, with no input or influence possible or desirable. The technical programme managers are reduced to hapless lookers-on, without the knowledge and skills or power to engage in policy dialogue. Yet they have legitimate and specific programme needs and interests to negotiate with the system designers, in order to protect the ability of their programmes to provide accessible, equitable and gender-sensitive services.

The risks to technical programmes in reforming health systems are beginning to be better understood. Tuberculosis control programmes have seen evidence of negative effects on quality control, human resources, and logistics and drugs supply (Bosman, 2002; Collins, Green and Newell, 2002; Weil, 2000). Experience in Tanzania raises issues for STI/HIV control, which is at risk from integration into poorly functioning horizontal units and reductions in allocated resources (Hanson, 2000; Hill, 2002).

The previous sections of this paper have provided numerous examples of areas where SRH policy actors could examine their programmes, in order to attempt to reduce the potential negative effects, and obtain the benefits, of reform. They may also have to confront the existence of incompatible objectives. For example, SRH stakeholders may perceive that reforms do not take adequate account of gender issues and reproductive rights, such as the prevalence of gender-based violence, the needs for dignity and privacy of women and their preferences in the design of facilities, and the gender-biased attitudes of service providers (Population Council, 1998).

Evidence from a number of reform processes shows that the lack of dialogue and resultant lack of ownership between such groups can result in major difficulties. In Uganda, following decentralization and restructuring, the technical programmes at the center continued to work in the same manner as in the past, involving themselves in micro-management and in service delivery, resulting in conflicts with the developing local government system in the districts (Jeppsson 2002). In Bangladesh the main health sector strategy developed by international consultants and some seconded MOH planners, marginalized the technical programme managers, and was quickly put aside and superseded by other, more individualized plans of the technical programmes (Merkle, personal communication). Even if systemic changes are not rejected, they may be implemented less effectively and efficiently (Pillay, 2001).

To advance this dialogue, the SRH people will need to learn to talk the language of reformers and show how their programmes can also promote the reform objectives of efficiency, equity and quality. They need to take a proactive stance and explain their requirements on the basis of epidemiology and the standards and norms for programmes' effectiveness, so that the reformers can understand the potential effects of their organisational and system changes (Bosman, 2000; Collins, Green and Newell, 2002). Conversely, the HSD actors should realise that reaching their reform goals will depend on a clear understanding of the needs of technical programmes. The two sides are, in fact, co-dependent.

This dialogue may not be easy at first, especially if the SRH people are ill-informed or inexperienced in policy formulation, or the HSD people do not have a strong health background (Weil, 2000). Technical people will learn that policy decisions are made not solely on the basis of quantifiable evidence, but through a more complex interplay of written and verbal information, persuasion, bargaining, observation, experience, training and intuition (Hornby and Perera, 2002). The reformers, for their part, will have a focus on the details of complex organisational, financial and structural issues which may undermine their time and ability to understand the needs of technical programmes. An added complexity arises if technical programmes have different and even conflicting requirements from system reform (Lubben et al., 2002)

However, the issue is more complicated than simply the "reformers" and the "SRH people" within government. The public sector in many countries is dependent on other actors to reach its goals. Public management therefore requires the governance of complex networks of actors at national and sub-national levels of government, political and social groups, pressure and interest groups, social institutions, and private and business organisations. The multiplicity of actors, or stakeholders, in any policy issue means that central government cannot simply impose its will regarding a policy issue, because in a network a "single, central authority, a hierarchical ordering and a single organisational goal do not exist" (Kickert, Klijn and Koppenjan, 1997, p. 11). Instead its focus must be on "coordinating the strategies of actors with different goals and preferences with regard to a central problem or policy measure within an existing network of inter-organisational relations" (ibid. p. 10). By contrast, the "classical" management style is more suited to intra-organisational issues where government has a clear authority, and management is concerned with planning, organising and leading through a top-down structure.

It may be helpful at this point to introduce the concepts of policy communities and policy networks. Policy communities are a stable, tightly knit group of relationships, with dense interactions between actors and resource dependencies, restrictive membership and insulation from other institutions. The members share a view of the most urgent problems to be solved, and the main actions to be used in tackling the problems (Kickert, Klijn and Koppenjan, p. 27). The policy community focused on HSD issues will usually dominate the reform task force/transition team and its immediate advisory group; its membership will be very different from the policy communities focused on different technical programmes.

Policy networks are a broader system of relationships which are less stable and less restrictive, which can form ad hoc relationships around particular policy problems. It is in these networks that the HSD and the technical constituencies are more likely to overlap, thus, managing these networks to ensure dialogue between HSD and SRH actors is a key issue in reforms. It will also be important for SRH policy actors to meet with those other technical programmes, since all will face challenges from the reforms; consultation and alliances to learn from one another will help in their dialogues with HSD actors.

The table below shows the difference in management styles required for network organising compared to "classical" management styles.

Table 1: Classical and network management compared

Source: Kickert, Klijnand and Koppenjan, 1997, p. 12.

Perspectives:	**Classical perspective**	**Network perspective**
Dimensions:		
Organisational setting	Single authority structure	Divided authority structures
Goal structure	Activities are guided by clear goals and well defined problems	Various and changing definitions of problems and goals
Role of manager	System controller	Mediator, process manager, network builder
Management tasks	Planning and guiding organisational processes	Guiding interactions and providing opportunities
Management activities	Planning, designing, leading	Guiding interactions and providing opportunities

The advantage of different actors cooperating is that it may lead to mutually beneficially solutions which are greater than just a compromise between the various parties. When actors work together, modifying their perceptions of problems and interests, it is possible to find "new solutions which have a surplus value compared to solutions which actors pursue independently" (Kickert, Klijn and Koppenjan, 1997 p 40). The processes for managing networks to achieve the goals of reform are described in the following sections.

Key points

Technical programme managers are not part of systems policy decision-making and their programme needs are poorly understood by systems decision-makers.

HSD and SRH stakeholders are dependent on each other to reach their goals and objectives, but start from different vantage points and perspectives.

Lack of dialogue can result in ineffective implementation of both technical programmes and reforms.

The MOH must promote dialogue within its own organisation and engage with policy networks relevant to HSD and SRH to manage dialogue with them.

2.2 Starting the dialogue

Often the first step in reform is to create a task force, a transition team, which can focus on solving the defined problems and achieving the goals of the reform. Its aims are to:

- communicate ideas to stakeholders to improve their understanding of the process
- ensure that capacity exists for the tasks to be undertaken
- build ownership and commitment for changes
- create a minimum of consensus for collective decision-making and joint action, and
- improve the quality of the reforms by incorporating stakeholders' views and experiences

(Collins, Omar and Tarin, 2002; Kickert, Klijn and Koppenjan, 1997).

The transition team or task force can be mainly internal to MOH, or include other departments in government such as Finance, Local Government, the Civil Service Board, Social Welfare and others. The main advantages of an internal committee are that members have a deep knowledge and understanding of the issues, and can ensure an institutional memory. Political membership on this task force can underline the political importance of reform, and help to achieve it, but it is difficult to obtain frequent and ongoing political attention (Kalliecharan, 2003). However, internal members have a lack of time to focus on reform issues, if their other responsibilities are not removed, and, if internal transfers are frequent, institutional memory may suffer. The membership of the group may need to change occasionally, depending on the current issues being dealt with, but having a core group is important (Kalliecharan, 2003).

A team which is mainly external to government has the advantage of dedicated focus, but a problem with ownership and consistency. Reform can be a lengthy process, and it will be difficult and expensive to sustain full-time international inputs for a long period of time. Using external consultants may result in slower development of national capacity. If the external team is part of a national institution, such as an academic or research group, this will help with institutional memory and capacity to address new issues (Hornby and Perera, 2002; Kalliecharan, 2003).

This transition team will almost certainly be made up mainly of systems experts. In the MOH, many would have health technical qualifications and background, which enables them to share some of the technical actors' perspectives. However, their primary responsibility and interests would not be in technical programmes. Hence, the processes and skills needed to manage the various policy networks are critical, in order to develop partnerships for finding solutions. The first step is to identify what are the networks of significant actors, or stakeholders.

Key points

In order to promote dialogue amongst policy networks, managers must consider questions of how to initiate and sustain the process of dialogue, who will be members of a core group, at what point wider groups should be engaged, and what are the objectives of dialogue.

2.3 Identifying stakeholders

Techniques to identify individuals and groups who should be brought into the consultation process include *stakeholder identification* and *political mapping* (DFID, 1995; Varvasovsky and Brugha, 2000; Reich, 1995*)*.

Deciding which stakeholders are most appropriate to involve is done through the process of stakeholder analysis (DFID, 1995). This aims to:

- identify the characteristics of key stakeholders
- assess whether they would benefit from changes or have their interests threatened
- understand the relations between stakeholders (e.g. their legitimacy in the eyes of the others, potential conflicts of interest), and
- assess their capacity (staff time, expertise, funds) to participate
- assess the level of power/influence of each stakeholder.

"Secondary" stakeholders are usually those who would be most involved in the process of consultation: professional associations and unions, development agencies involved in health, training and research institutions, industry, NGOs and consumer groups, other sectors of government, representatives of sub-national levels of the MOH, and managers of technical programmes. "Primary" stakeholders, the people who will benefit from or be adversely affected by the health system, are often represented through some of the secondary groups, although they can also be consulted directly through various means such as public meetings, or consumer research.

Stakeholders will include groups both inside and outside government. The sub-national levels of government and non-governmental institutions should not be forgotten, as they understand and can explain the main issues in reform at their level. Other government departments, especially finance and civil service establishment, may be key to health reform, but may not place a high priority on changing their systems to help health reform.

Political mapping includes stakeholder analysis, but also analyses policy conditions and attempts to shape key political factors in favour of policy reform. Key factors

include the timing of reforms, that is, when policy change agents introduce their ideas into public debate, and managing interest groups to control the political effects of changing the distribution of benefits and power. Reich (1995) notes, for example, that physician associations must be taken into account, and strategies to co-opt, neutralise or mobilise this group are important.

There are costs to participation and dialogue. It slows down reform preparation and implementation because of the need to consult and negotiate, it takes up scarce administrative and advisory resources, slowing down disbursements. However, a World Bank study indicates that a participatory approach to project preparation correlated positively with rapid disbursement once the loan agreement was signed (DFID, 1995). Another effect may be that some reform objectives remain unimplemented, as in Ghana (Cassels and Janovsky, 1996). Small groups especially, may find the participatory process costly in terms of staff time and other costs, and may need assistance with at least their travel costs. The preponderance of some policy actors over others may skew objectives in reproductive health and reform, e.g. Goodburn and Campbell (2001) claim to be unable to find a donor-supported SWAP that emphasised safe motherhood as a goal.[3] Nevertheless, the view taken here is that the lack of participation and dialogue amongst the policy groups has more dire consequences than engagement and dialogue.

Key points

Stakeholder identification and political mapping can be used to systematically identify the most appropriate policy actors to engage in dialogue.

2.4 Means for pursuing and sustaining Dialogue

The overall aim is to find a way for HSD and SRH actors in separate policy communities to co-operate, without solutions being forcibly imposed, in other words, to act more like a network with similar interests, some overlapping goals, and possibilities for mutually beneficial joint action.

The processes can be summarised as:

- consultation (including pilot testing, evaluation and adjustment according to lessons learned)
- capacity-building
- conflict management and negotiation, and
- communication/advocacy.

2.4.1 Consultation

In order to understand one other, and develop a trusting working relationship, groups need to interact with one other. The point at which consultation occurs can be critical to obtaining both ownership and important inputs into the process. The later it occurs,

[3] The first phase of reforms in Bangladesh had safe motherhood as a major objective and indication of achievement (GOB 1998)

the more it risks being seen as tokenistic; the earlier it takes place, the more opportunity for influencing the outcome (Green, Collins et al., 2002).

The consultation process should start by agreeing on the mechanisms that will be used for consultation and collaboration, and having a clear understanding of the purpose for consultation, so that the expectations of the consultation process are realistic, and people's roles are understood (Collins, Green and Newell, 2002). The entry and exit rules on committees, time-schedules, contracts and informal agreements on arriving at decisions need to be clarified.

Once process issues are agreed, the group could start discussions to arrive at common understanding of the policy context (epidemiological, demographic, social, political, ideological, economic and international factors) they are working in. A minimum consensus on the policy problems to be dealt with and the values underlying the reforms will help to lead to an acceptance of the groups' interdependence and agreement on common means to achieve some key aims and objectives (Kickert, Klijn and Koppenjan, 1997). They will then be able to move on to determine the details of system design: strategies, resource allocation, monitoring and evaluation.

Strategies to manage actors' perceptions of problems and solutions include introducing new information about a problem, and engaging new actors in the policy process, such as an authoritative, neutral third party, to encourage further reflection. A technique to go beyond promoting reflection is known as "reframing", which changes perceptions, behaviour and relations, marking a paradigm shift in which parties can see a problem from the perspective of others. Striking or shocking events can service as a trigger for reframing e.g. confronting representatives of different coalitions, or conducting exercises in which policy actors argue for the opposite side's point of view. Reforms can also be reframed through presentation: as a way to deal with the problems in the central institutions of the health service, which have nothing to do with technical programmes, or as opportunities for technical programmes to solve long-standing systemic issues which constrain their effectiveness. The objective is to help policy actors redefine the problem situation and adjust mutual perceptions, so that all see the situation as an opportunity for improvement, and thus see the possibility of undertaking joint action (ibid, 1997).

The most influential methods for developing consensus involve bringing different groups together for face-to-face interaction, for example, inviting policy stakeholders to functions such as workshops and seminars that have a clear purpose and outcome. It may be most efficient for the reform task force to work with a small policy group to prepare position papers, and then consult with a wider policy network to review them. However, these consultations must be structured in order to generate genuine dialogue, where people trust that their views will be considered seriously. Consultation requires active listening. If the task force is open-minded and willing to adapt, it will encourage groups to share their ideas.

The danger of consultative meetings is that they are seen as empty exercises for public relations only, that the major decisions have already been taken by a small group. Feedback from these meetings, indicating the outcomes and the influence that the meetings had on the position papers can counteract this; otherwise, participation may

decline. In the Philippines, the task force carried out consultations with various sectors (academia, industry etc.) by preparing position papers with suggestions for discussion by the group. Revisions were then done to take into account the groups' views, followed by workshops and seminars with many groups at once (Reich 1995). This process helped to prevent the exclusion of new ideas, and created an institutionalised method for incorporating criticisms, whilst sustaining effective participation (Kickert, Klijn and Koppenjan, 1997).

2.4.2 Capacity development

An activity which can increase understanding and improve dialogue is *capacity development* e.g. in Bangladesh, many technical programme directors were taught to use logframes for planning, in Zambia SRH personnel were taught the new planning/budgeting process (Population Council, 1998). Capacity development also requires recognition of changing roles e.g. from programme management to technical leadership, and the need for new skills. Local levels of management need policy analysis capacity as well as technical and administrative capacity to deal with their new responsibilities and authority. Deployment of technical specialists from vertical programmes to integrated services at various levels must be carefully considered, in order to maintain the expertise needed by programmes to ensure quality. In Zambia, technical expertise from defunct vertical programmes was subsequently underused by the Central Board of Health, to the detriment of quality (Population Council, 1998).

HSD people will need to make the effort to become familiar with important technical issues, so that they understand clearly the implications of new systems for technical programmes. Furthering a common language takes time, and new ideas take time to be accepted. The task force's job is to create a climate in which doubt, inconsistency and time for reflection are seen as necessary, even valuable (Kickert, Klijn and Koppenjan, 1997).

Capacity development also requires phasing of reforms. It is important to move slowly and pragmatically, rather than on the basis of a strongly-held ideology (Collins, Green and Newell 2002). For example, involving the private sector in health is a currently favoured ideology, although it has dangers in terms of equity and control of quality of care, alongside potentials to improve access and coverage (Smith, Brugha and Zwi, undated). The value of research and of experience from pilot projects to inform the process of policy development and implementation is part of capacity-building; evidence from these must be communicated widely (Hornby and Perera, 2002). Ideally, major changes should be introduced gradually, on the basis of evidence, and co-ordinated with capacity building, so that staff at all levels can learn to make new decisions and exercise new skills, before new reforms are introduced widely (Russell, Bennett and Mills, 2002).

2.4.3 Managing conflict

A plan and skills for *managing conflict* are needed. Using stakeholder participation and political mapping techniques can help the task force to anticipate where they will encounter resistance to proposed changes. Compromise will inevitably be required between HSD and technical programmes, and between the different technical programmes. The reform task force should develop its strategies and skills for negotiation, compromise, advocacy and problem solving. Minor forms of conflict

require facilitation, whereas more serious conflict needs mediation and even arbitration (Kickert, Klijn and Koppenjan, 1997).; In the Philippines, the task force used strategies to contain the opposition, including building constituencies and alliances with pro-reform groups and the media, preparing extensive documentation to sue in court cases, allowing public demonstrations and protests by consumer groups against opposers, and "social marketing" of the reforms through the mass media to the public and health professionals. They also implemented policy in "relatively easy" areas first, in order to obtain co-operation from groups which were wavering (Reich, 1995). Tensions from disagreements can be reduced through having clear procedures for interaction – "the rules of the game" – along with a clear process and schedule for achieving change, central guidelines, and by having the means to monitor and communicate progress and achievements.

2.4.4 Communications

A *communication* strategy is important, to reach the public, political levels, other government departments, different interest groups and health providers in the public and private sector. It needs to communicate and advocate the aims and objectives of the reform, the main elements in the reform, the process to be followed, progress and achievements made, and issues to be resolved. The strategy should take account of the different groups to be reached, and recognise that different stakeholders may have different views about the different elements of the package. Cassels and Janovsky (1996) note that there is "an advantage in having a politically supported, publicly debated strategy to guide the process of reform. If overall intentions are widely accepted and understood, it becomes possible for ministries of health to work on several fronts simultaneously, and bold decisions can be taken…".

A clear "narrative" or "story" is helpful, which recognises that change is needed, and a new policy direction required. A simple but clear story needs to be set out, with an agenda for action, which gains the status almost of conventional wisdom, through repetition by many actors, the multiplicity of channels used, and communication from one group to another (Sutton ODI). A variety of channels, from mass public media, to in-house government newsletters, and meetings with staff and interest groups is best developed early on, in order to generate support and minimise opposition and resistance.

There may be an advantage in addressing the interests of internal government stakeholders separately from those of external, networked actors. Even where political will to reform is present, the capacity of government, the human resources and management and institutional systems, can combine to prevent implementation (Russell, Bennett, and Mills, 2002). Staff of MOH in Sri Lanka and India, through their unions and associations, opposed various reforms such as user fees, contracting out and hospital autonomy, for fear of loss of revenues and jobs (ibid). Lack of skills to take on new tasks also represented a block, as did organisational cultures of centralised decision-making which disempowered and demotivated staff. These internal issues may require separate strategies from those of network management.

During major institutional change processes, special efforts to maintain communication with staff, and improve participation and capacity are needed. Information vacuums are filled by rumours. Staff uncertainty over their job security

had deleterious effects on service provision in Bangladesh for over a year, which could have been alleviated by clearly communicating a decision which had in fact been taken, that no jobs would be cut (author's personal experience). A guide prepared by WHO (2001) on public service reform points out the need to consider questions of:

- mechanisms for effective communication and consultation,
- dissemination of information about reallocated powers and responsibilities,
- keeping staff aware of career development opportunities, and
- maintenance of trust between management and staff and between organised labour and management.

Managing change processes within institutions are essentially about dialogue and communication (Kotter and Schlesinger, 1979; Yoder and Scott, 1990). Management needs to communicate new policies and procedures as they affect employees and to have clear goals and plans for each unit. More broadly, employees need to be kept informed of the major policy changes and development in the ministry, and the reform timetable, aims and objectives, and achievements. Communication the vision of the reforms, so that employees can see their importance, celebrating achievements, and sustaining the momentum for change over years are all needed to ensure that changes are truly integrated within organisations. All of these ideas are basic to good management, but become even more important during institutional change processes.

Key points

Dialogue processes of consultation, capacity-building, conflict management and communication are useful for different policy actors at different points in the process of networking.

Consultation should start by agreeing the rule of the game, before discussing substantive issues in the reforms and the needs of technical programmes.

Developing capacities of various actors to use a common language and understand one another's' perspectives takes time, and an acceptance of some uncertainty and doubt; it also benefits from phasing of reforms, along with monitoring of impacts.

Managing organisational change and policy networks will encounter conflict, which can be constructive as well as negative, if skilfully handled through negotiation, compromise, advocacy and problem-solving.

A communication strategy for both intraorganisational and policy networks is critical for initiating and sustaining dialogue and change.

2.5 Conclusions

SRH policy actors must engage with HSD policy actors, whilst HSD actors need to clearly understand the functional requirements of SRH programmes in order to design the system to meet their requirements (Collins, Green and Newell, 2002).

HSD actors need to demonstrate the value they place on technical SRH expertise, by involving SRH programme managers and policy actors in the reform process. SRH policy actors, for their part, must learn the language of the reformers, and explain their requirements clearly and robustly.

In order to sustain participation of policy actors, the consultation initiator (in this case probably government) needs to recognise the need for dialogue, and have a clear, realistic purpose for it. The importance of developing and maintaining trust, commitment, and ownership of the outcome depends on clear and robust working arrangements amongst groups, backed up by ways to monitor progress and learn from the process (Hardy, Hudson and Waddington, 2000).

3 Policy issues for development partners including DFID

The preceding two sections have set out key issues concerning firstly the relationship between health systems development policies and SRH, and secondly dialogue between the key stakeholders in the process of policy development in pursuit of the MDGs.

This final section draws on these analyses and sets out a number of policy issues related to the above for consideration by development partners.

Development partners can bring three key aspects to this issue. Firstly they bring expertise, often based on experience in other countries; secondly they bring resources which may be targeted at the particular issue; and lastly, they bring, in part through the first two, policy leverage. This analysis contributes particularly to the first of these. As a preliminary it is important to issue a standard cautionary warning – that experiences from other countries have to be interpreted carefully, and with full recognition of the context within which they occur. It is also important to reiterate what is self-evident to many development practitioners, that new systems, service configurations and strategies take time to design (if done properly with full consultation) and yet the project cycle timetables and bureaucratic incentives may run counter to this.

3.1 Support to the development of policies

3.1.1 Health system development policies

A number of development partners have a particular interest in the reconfiguration of health systems. The preceding analysis suggests that more attention needs to be given to ensuring that the development of such policies is founded on the needs of those health services that the system is expected to support. There are, as has been outlined, a number of critical areas in the development of health systems where damage can be inflicted on SRH services. Health system 'designers' need to develop mechanisms for ensuring that there is dialogue with programmes, and that their needs are met. The relationship has been likened to that between an architect (the health system designer) and the client (the programmes) for whom the former is designing the structures within which the programmes will operate. Development partners need to ensure that their involvement in such initiatives (either as key stakeholders at the policy table, or as providers of technical support to the process) supports this approach.

It is also important to recognise that effective SRH programmes require appropriate numbers of qualified and motivated staff. HSR programmes have tended to ignore this, at the expense of organisational and system issues. Furthermore in a number of instances, specific HSR elements have had negative effects on human resources. It is suggested that development partners need to place greater emphasis on this area of HSR and system development.

3.1.2 Health programme[5] policies including SRH

Conversely to the above, programme policy makers need to develop the ability to analyse the system needs of their programmes and express these clearly to system designers. Each different programme, including SRH, needs to recognise the key preconditions for the effective attainment of their programme objectives, and present this to the system designers. Greater dialogue between the different health programmes (such as SRH, TB, malaria etc) may lead to a recognition that they face similar system design needs, and help them, as a group to express these effectively to health system developers. Health programmes however also have to recognise that there may be conflict between the requirements of 'their' programme and those of other programmes and that mediation and compromise is likely to be inevitable. Again development partners supporting such programmes need to encourage and provide support to this process.

3.1.3 Priority setting

One clear concern arising from certain aspects of reforms concerns the way in which priorities are set and the tools deployed to do this. We would not suggest that development partners should interfere with local determination of priorities. However there are two areas in which development partners can support an appropriate process. Firstly, it is important to support, as part of any system changes, the development of appropriate priority setting processes. These include ensuring that all key stakeholders, including those representing SRH interests, are genuinely and appropriately consulted, and that any priority-setting tools do not unfairly disadvantage SRH. Secondly, in health systems which are developing SWAps, development partners need to ensure that the strategic planning processes similarly do not disadvantage SRH.

3.1.4 Support to the planning and policy formation processes

Closely related to the above, is a recognition that planning and policy processes (both generic and programmatic) need to be strengthened with additional technical resources to ensure that these processes are appropriately conducted. One potential casualty of the dominance in many countries of externally supported projects has been the disempowerment of national planning processes and this needs to be reversed.

Within these processes particular attention needs to be given to stakeholder analysis, priority setting through consultative processes, communication strategies and programme development. Development partners can play an important role as catalysts in encouraging policy networks as described earlier.

[5] The term 'programme' here should not be taken to imply 'vertical' programmes, but the provision of a collection of services related to specific programme objectives.

3.1.5 Gender policies and reproductive rights

Gender policies need to be developed and mainstreamed into both programmes and health system development policies. Whilst SRH is most obviously associated with gender issues, there are important and often overlooked issues related to health system development e.g. the differential impact of user fees, the effects on gender issues in human resources (Standing 1997; Standing 2000). Much more needs to be known about the implications for gender and reproductive rights of systems changes such as decentralisation, privatisation and integration. Enhanced dialogue between policy-makers in these two areas may enhance recognition of the wider gender and rights implications of health system development. For development partners with a genuine concern for such issues, this area provides both challenges and opportunities to further the gender and reproductive rights agendas.

3.2 Capacity development

Closely related to the above is the more general need for support to capacity development. This should be interpreted in a very broad way to include not only human resource development, but support to systems development. The previous section has set out the need for planning and policy processes to be improved and strengthened. Alongside the system development side is the need for wider human resource development in areas to include the following:

- Priority setting
- Advocacy
- Consultation processes and networking
- Negotiation and conflict management skills
- Programme issues.

Such capacity development should not be restricted to the public sector but should include key stakeholders including private institutions and NGOs (such as service delivery, professional groups and advocacy organisations).

3.3 Relationships with INGOs and NGOs

Development partners channel significant funds through both INGOs and increasingly through national NGOs. Such support may be less specified than traditional government to government projects, allowing greater freedom to NGOs to set their own priorities and programmes. It is important, given the above, however that development partners provide appropriate support to such NGOs both in terms of general capacity development as set out above, to ensure that they recognise the critical issues outlined earlier in the paper, and that a clear message regarding the importance of SRH is sent to such organisations.

3.4 Inter-sectoralism and a broad view of health

Partner agency relationships have tended to mirror technical/sectoral boundaries; health support working with health ministries, education with education ministries, and so forth. Whilst this is entirely natural, it is important, particularly within the two areas of health system development and SRH that wider contact is made and maintained with other key ministries including finance, local government, and central

offices (such as president or cabinet office). In such ministries the requirements of SRH may not be well understood and it is important that development partners recognise this.

3.5 Partner policies

3.5.1 Internal linkages

The lack of dialogue and failure to recognise the mutual inter-linkages between health system development and SRD which have been described above in the context of national developing country health systems, may be mirrored in the development agencies themselves. Within such organisations, there may be a similar need to take explicit steps to ensure the same linkages between technical areas. This may be at a number of levels including:

- Technical departments or interest groups within a particular development agency (e.g. DFID)
- Between different government departments within the same government (e.g. between DFID, DTI, DOH) all with potential involvement in development
- Between research or consultancy programmes of activity funded by such agencies.

3.5.2 SWAps

A number of development partners such as DFID are actively supporting the development of SWAps. This raises two issues for such agencies in the context of this paper. Firstly, given that a number of other development agencies are reluctant to join such SWAp processes, there is potential for continued distortion of health programme priorities and activities. As part of the strategic planning process, SWAp partners need to explicitly recognise the dangers of this and devise ways to counteract it. Secondly, given the potential concerns raised earlier about the submerging of SRH within SWAp processes, such partners need to ensure that policy discussions continue to keep SRH, and in particular those aspects such as sexual and reproductive rights which may be marginalised unless they have vertical funding support, on the agenda.

3.6 International forums and regional initiatives

ICPD had a major impact on SRD policies internationally and contributed to the setting of MDGs. It had been widely expected that there would be a follow up conference to the ICPD in 2004. This however is not happening. It is important therefore that development partners look for international forums at which the issues raised in this paper are highlighted and taken forward.

Development partnership relationships tend to work on a North-South basis. It is increasingly recognised that there is considerable potential for intra-regional learning on approaches to SRH and HSD. Development partners can support this in various ways – through providing resources for meetings, tours etc, but also through facilitating contacts.

Global programmes and partnerships, such as UNAIDS and public-private partnerships focused on specific diseases can act like strongly vertical programmes, with distorting effects on national plans and priorities. However, many features of HIV/AIDS programmes, for example, are such that multi-function health services are better placed than specialised ones to implement most aspects of the programme. Development partners involved with HSD are well placed to advocate for global programmes to allow flexibility, encouraging them to expand the opportunities for national inputs to decision-making on objectives and strategies. They are also able to monitor the goals and impacts, transparency and accountability of such programmes, which can inform national governments' plans and strategies.

3.7 Research and development and dissemination of lessons learnt

The preceding has drawn attention to a number of areas in which there is little firm evidence of the relationship between HSR and SRD. Whilst we are aware of ongoing research both in DFID Knowledge programmes and more widely, there are still significant gaps in our understanding of the interplay between these two areas, for which support is required.

In addition development activity is needed to develop practical tools for the policy planning and implementation processes. These include tools for priority setting, monitoring and regulatory tools.

4 Summary & Conclusions

This paper has provided background to the key issues identified in available published and 'grey' literature. It is clear that there is no single – and certainly no easy – answer to the question of whether health systems reforms and restructuring have a beneficial or a detrimental effect on sexual and reproductive health and services.

The key points from the preceding sections are summarised below according to 1) the programmatic implications of HSD policies for SRH stakeholders (considered under 10 programmatic components); 2) processes for dialogue; 3) policy issues for development partners.

4.1 Programmatic Implications

4.1.1 Sexual-Reproductive Health Programme Organisation and Structure

- Restructuring of 'programmes' under reforms such as decentralisation and a shift to private sector provision, hold both benefits and problems for SRH

- Diversification of and competition among service providers may lead to better quality, more choice and more client-led responsiveness, but regulation of markets and private sector providers will be needed to help ensure quality and access
- For SRH components requiring tertiary provision (emergency obstetric care, HIV treatment), structural changes involved with decentralisation and integration, in particular, may lead to a weakening of services.

4.1.2 Planning, priority-setting, management and accountability

- SWAps could benefit planning and management of SRH, particularly components dependents on well-functioning systems (e.g. emergency obstetric care) but only if SRH advocates are strong enough to negotiate adequate SRH targets for inclusion in the SWAp
- Strength of SRH advocates at district as well as national levels is critical to ensure SRH planning and management is sound at all levels
- Current priority-setting tools are not appropriate for SRH; national-level advocacy is needed to negotiate changes in these

4.1.3 Financing

- Cost-recovery schemes are mixed in efficacy
- Health insurance schemes need close regulation, especially to safeguard the poor
- SWAps are intended to allow the inclusion of a range of public and private sources in its planning and provide a holistic, sectoral approach; the main problem is that SRH or many of its component parts, may not be considered a priority target
- Decentralisation may produce inequity in poorer districts/regions who may be unable to sustain SRH services without extra financial allocations

4.1.4 Drugs and resource logistics

- SWAps may weaken security of contraceptive and drug flows for SRH programmes, unless current donor support (or equivalent) can be earmarked
- Privatisation and cost-recovery for commodities may increase client choice and access (though there are equity implications for the poor), but regulation of quality is difficult
- Decentralisation may weaken drug/contraceptive security unless poorer districts receive extra financial help and/or SRH commodity procurement remains centralised and earmarked.

4.1.5 Human Resource Management

- Management of human resources through changes in health systems (decentralisation and de-linkage of HR management from the health sector) has been neglected but will need serious attention if SRH staff are to be adequately managed and feel comfortable with any changes in pay, career-progression, working conditions, responsibilities etc.
- Planning for the maintenance of technical expertise in decentralised SRH programmes, for training, technical supervision and monitoring of performance, is as critical as management expertise
- Capacity development of personnel to allow them to take on new managerial and technical roles is needed before decentralisation proceeds.

4.1.6 Monitoring & Evaluation

- Tools for monitoring SRH (whether as part of a distinct project or not) within health systems need to be developed and should be based on indicators broader than financial/resource considerations.
- Monitoring and evaluation of private sector SRH services needs to be developed

4.1.7 Programme and Policy Guidelines

- Clarity of programme policies and guidelines (specifying changed functions, responsibilities etc.) is key to successful implementation of SRH programmes in reform contexts

4.1.8 Programme Integration

- If SRH service integration is a goal, capacities at decentralised levels must be in place and arrangements with private facilities should be made to safeguard quality of SRH services
- It is important not to over-emphasise 'integration' of SRH as it is not suitable for some SRH components, or if all components were integrated there may be a danger of creating another large vertical programme (of 'integrated' SRH)
- Reform initiatives like SWAps may offer a more permanent and viable path for supporting SRH through the strengthening of the entire PHC system.

4.1.9 Community Involvement

- Increased involvement of communities in health service management under decentralisation may improve client-provider interaction and service quality, but may result in an inequitable shift of the cost-burden, as well as different priorities from those that government sets.

4.1.10 Multi-Agency Collaboration

- SWAps may impede multi-sectoral links necessary for some SRH components unless they engage with a range of stakeholders at the planning stage
- Decentralisation may enhance multi-sectoral collaboration by offering the mechanisms for formal linkages.

4.2 Processes for dialogue

4.2.1 The need for dialogue

- Technical programme managers are not part of systems policy decision-making and their programme needs are poorly understood by systems decision-makers
- HSD and SRH stakeholders are dependent on each other to reach their goals and objectives, but start from different vantage points and perspectives.
- Lack of dialogue can result in ineffective implementation of both technical programmes and reforms
- The MOH must promote dialogue within its won organisation and engage with policy networks relevant to HSD and SRH to manage dialogue with them

4.2.2 Starting the Dialogue

- In order to promote dialogue amongst policy networks, managers must consider questions of how to initiative and sustain the process of dialogue, who will be members of a core group, at what point wider groups should be engaged, and what are the objectives of dialogue.

4.2.3 Identifying Stakeholders

- Stakeholder identification and political mapping can be used to systematically identify the most appropriate policy actors to engage in dialogue.

4.2.4 Pursuing and Sustaining Dialogue

- Dialogue processes of consultation, capacity-building, conflict management and communication are useful for different policy actors at different points in the process of networking
- Consultation should start by agreeing the rule of the game., before discussing substantive issues in the reforms and the needs of technical programmes
- Developing capacities of various actors to use a common language and understand one another's' perspectives takes time, and an acceptance of some uncertainty and doubt; it also benefits from phasing of reforms, along with monitoring of impacts
- Managing organisational change and policy networks will encounter conflict, which can be constructive a well as negative, if skilfully handled through negotiation, compromise, advocacy and problem solving
- A communication strategy for both intra-organisational and policy networks is critical for initiating and sustaining dialogue and change.

4.3 Policy Issues for Development Partners

4.3.1 Support to the development of policies

- Development partners need to ensure that their support for development of health systems policies supports an approach based on the need of health *services* through consultation with programme managers in the design of structures within which programmes need to operate & support to programme managers to analyse and express their systems needs.
- Human resource issues (appropriate numbers of qualified, motivated staff) in policy development need greater emphasis.
- Development partners should ensure that appropriate priority-setting & strategic-planning mechanisms are developed in reform processes, including genuine and appropriate consultation with all key stakeholders
- Development partners have an important role in strengthening, and encouraging appropriate conduct of, planning and policy formation processes (including stakeholder analysis, consultative priority-setting, communication strategies and programme development).
- Gender and reproductive rights policies need to be mainstreamed into both programmes and health system development policies.

4.3.2. Capacity Development

- Development partners need to support capacity development in public, NGO and private sectors, of both systems development and human resource

development including priority-setting, advocacy, consultation, negotiation and conflict-management skills.

4.3.3 Relationships with INGOs and NGOs

- Development partners should provide appropriate support to NGOs for capacity building, awareness-raising of key SRH issues and the importance of dialogue/engagement with systems development processes.

4.3.4 Inter-sector links and broad view of health

- The importance of linkage with other sectors such as Finance, Local Government and central offices (e.g. President's office) should be recognised in the promotion of wide-ranging health goals.

4.3.5 Partner policies

- Internal linkages: development partners need to make explicit efforts to link their technical & programme areas
- Development partners involved in the development of SWAps need to avoid the polarisation of other non-SWAp partners within health programme priorities & activities; they should also ensure that SRH, particularly the components that are prone to marginalisation (such as reproductive rights) are kept on the agenda.

4.3.6 International forums and regional initiatives

- Development partners can support South-South learning through provision of resources for study tours, meetings etc. and facilitating contacts
- Development partners involved in HSD are in a good position to advocate for global programmes to allow flexibility, expand opportunities for national inputs & monitor goals, impacts, transparency and accountability.
- It is important that development partners look for international forums and opportunities to raise the issues identified in this paper.

4.3.7 Research and development & dissemination of lessons learnt

- Development partners should support the development of research to fill some of the still significant gaps in knowledge about the interplay between SRH and HSD

- The development of practical tools for policy planning and implementation processes, including priority-setting, monitoring and regulatory tools, needs to be supported.
- Dissemination of lessons learnt is an important way of learning and experience-sharing and needs substantial support.

4.4 Conclusions

The development of health systems and global aid and development structures is an ongoing and irreversible process. The ambiguity in the effect of reforms on sexual & reproductive health means that it is important for SRH advocates and programme managers to engage with the reforms in order to positively benefit from them and to minimise their potentially detrimental effects.

Health systems development decision makers and 'architects' have to balance the requirements of a range of programmes. If they are to take the requirements of SRH programmes seriously, they need to understand the functional requirements of SRH programmes in order to design a responsive system. For this to occur, SRH advocates must be clear both about what they consider to be the key sexual and reproductive goals that must be addressed through re-structured health systems, and what their requirements of the system are to fulfil these. For their part, HSD actors should also demonstrate the value they place on SRH expertise by involving SRH programme managers and policy actors in the reform processes.

Some lessons can be learned from past experience, and cautions may be sounded. How much heed we take of these, and how reforms can proceed in a way that constructively promotes sexual and reproductive health & rights will in large part depend on the willingness of both 'camps' to engage with each other in dialogue and strategic action. The international conference for which this paper provides the background, is a first concerted step in this direction.

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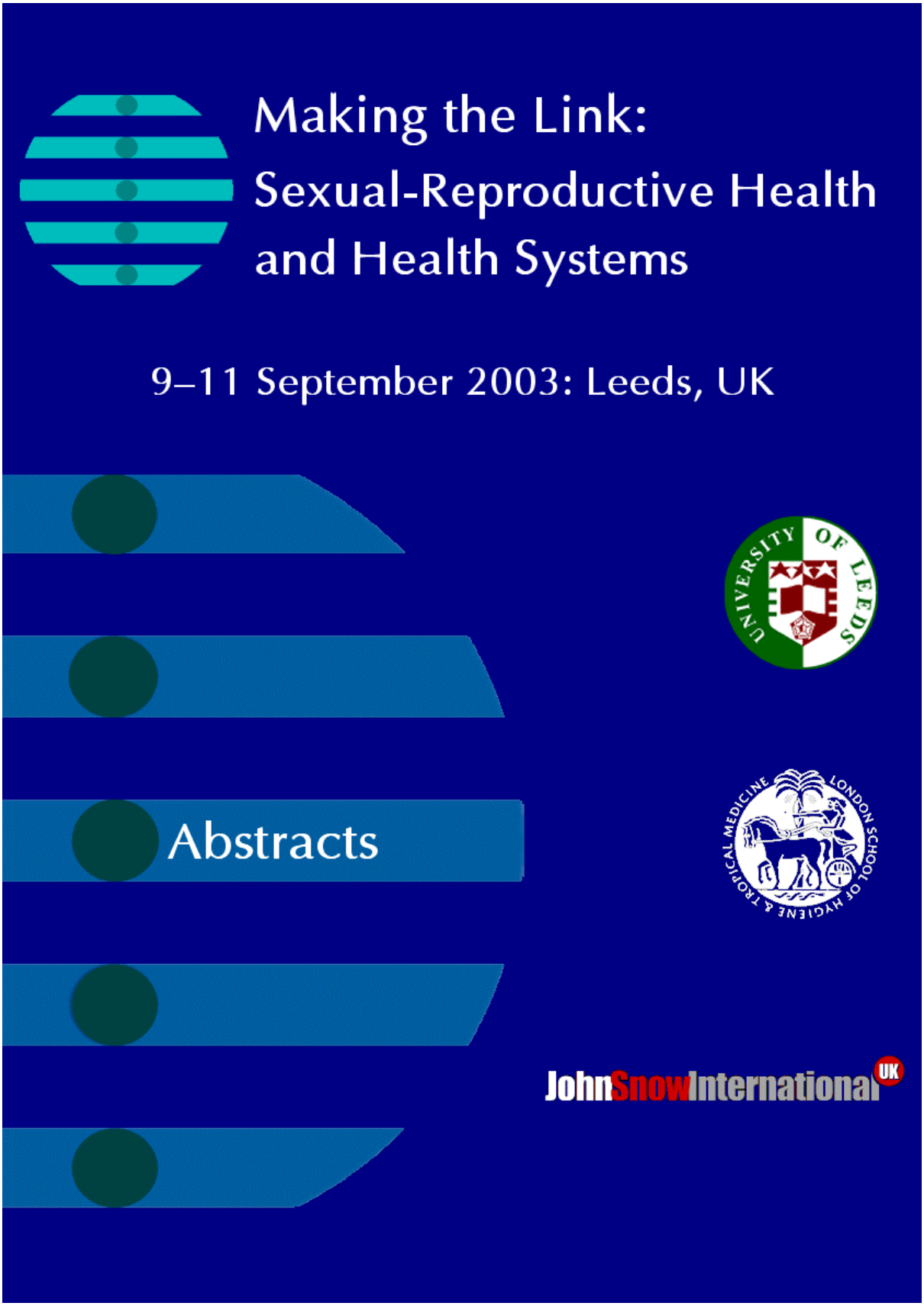
Making the Link:
Sexual-Reproductive Health
and Health Systems
9–11 September 2003: Leeds, UK
Abstracts
UNIVERSITY OF LEEDS
LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE
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Panel Speakers

Panel 1, Theme 1: Implications of systems design issues for SRH		
Duane Blaauw	University of Witwatersrand, South Africa	Intergovernmental coordination and the delivery of HIV services
Sundari Ravindran	Independent consultant, India	Health Sector Reform and public-private partnerships for reproductive health in Asia.
Hilary Standing	Institute of Development Studies, UK	The systems challenges of improving maternal health.
Marge Berer	Editor, Reproductive Health Matters	Integrating HIV/AIDS and sexual & reproductive health policies and programmes
Panel 2, Theme 2 (i): Implications of resource and financing reforms for SRH: Africa		
Loveday Penn-Kekana	University of Witwatersrand, South Africa	Impact of financial accountability reforms on midwives in 2 district hospitals in South Africa.
Frank Mugisha	FRONTIERS, Makerere University, Uganda	Do health sector reforms increase the vulnerability of reproductive health NGOs in Uganda?
Daniel Arhinful	Ngouchi Memorial Institute for Medical Research, Ghana	Do community health insurance schemes provide effective financial access for maternal health care? A Ghanaian case study
Trish Arau and Jane Namasasu	Ministry of Health and Population, Malawi	Sexual and reproductive health and the development of SWAps in Malawi
Panel 3: Theme 2 (ii): Implications of resource and financing reforms for SRH		
Fang Jing	Kunming Medical College, China	Health sector reform and its implication for RH service provision and utilisation in poor rural China.
Daniel Maceira	Center for Study of State & Society (CEDES), Argentina	Sexual & reproductive health, financial reforms and decentralisation in Latin America and the Caribbean
Tania Dmytraczenko	Partners for Health Reform, Abt Associates	Is insurance a viable strategy? Experiences from Rwanda, Egypt and Bolivia
Yot Teerawattananon	IHPP, Ministry of Public Health, Thailand	Determination of reproductive health services in the universal health insurance scheme in Thailand: match & mismatch of

		need, demand & supply
Panel 4: Theme 3 Priority setting, advocacy and accountability for SRH in reform contexts		
Susannah Mayhew	LSHTM with Ghana Health Service	Priority setting in Ghana's health reforms: where is sexual & reproductive health?
Ranjani Krishnamurthy	Independent consultant, India	Service accountability and community participation in the context of health sector reforms in Asia.
Rounaq Jahan	Southern Asian Institute, Columbia University, USA	Sustaining Advocacy for ICPD Agenda in health Reforms under Regime Change: lessons from Bangladesh

Poster participants

Theme 1: Implications of systems design issues for SRH		
Tim Ensor, Sandra MacDonagh and Susan Murray	Options, London, UK	Examining the role of the private sector in maternal and newborn health in India, Nepal & Tanzania.
Maia Ambegaokar and Louisiana Lush	London School of Hygiene and Tropical Medicine, UK	Family planning and sexual health organisations: pioneers of health system reform?
David Peters, Mirchandani G.G. and Hansen P.M.	Johns Hopkins School of Public Health, USA	Strategies for engaging the private sector in sexual and reproductive health: How effective are they?
Dileep Mavlankar, KV Ramani and Jane Shaw	Indian Institute of Management, Ahmedabad, India	Management of RH services in India and the need for health system reform
Sophie Arborio	Nuffield Institute for Health, University of Leeds, UK	Management of uncertainty and trust between stakeholders in safe motherhood initiatives.
Theme 2: Implications of resource and financing reforms for SRH		
Sarah Ssali	Women and Gender Studies Department, Makerere University, Uganda.	Negotiating sexual and reproductive health services and resources within the household.
Freddie Ssengooba, Christine Kirunga & Sam Okuonzi	Makerere University, Ministry of Health & National Council for Children, Uganda.	Public financing of private-not-for-profit health provision in Uganda: how is equity balanced?

Chin-Shyan Chen & Tsai-Ching Liu	Department of Economics, Taipei University, Taiwan	National Health Insurance and ante-natal care use: a case in Taiwan.
Gustavo Nigenda	Funsalud, Mexico	Tbc (presentation on Mexico)
Representatives of NPFPC	National Population & Family Planning Council, China	Tbc (presentation on China)
Theme 3: Advocacy, priority setting and accountability for SRH in reform contexts		
Guindo G., Dubourg D. and De Brouwere V.	Institute of Tropical Medicine, Antwerp	Measuring unmet obstetric need at district level: a tool for improving communication between district officers and population.
Asha George	Indian Institute of Management, Bangalore	Demanding health reforms and accountability in Karnatarka.
Rina Sen Gupta & Shireen Huq	Naripokkho (NGO), Bangladesh	Decentralisation and accountability of health services for women: lessons from Bangladesh.
Elsa Gomez	Pan-American Health Organisation (PAHO)	Mainstreaming gender equity in health sector reform: The Chilean case.
Laura Reichenbach	Harvard Centre for Population and Development Studies	Priority setting methodologies for reproductive health: a case study of breast and cervical cancer in Ghana.
Lynn Freedman	Mailman School of Public Health, Columbia University	Using the UN Process Indicators on Emergency Obstetric Care to assess and monitor health system development

THEME 1
IMPLICATIONS OF SYSTEMS DESIGN ISSUES FOR SRH

PAPER

Title: Intergovernmental coordination and the delivery of HIV services

Authors:
Duane Blaauw, Lucy Gilson, Precious Modiba, Gugulethu Khumalo, Ermin Erasmus, Helen Schneider
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Abstract:
Decentralisation has become a key component of health sector reform across a wide range of countries. Decentralisation is supposed to improve the flexibility, efficiency and responsiveness of health services but may have negative consequences for health system performance by exacerbating and increasing coordination costs. Beyond identifying integration as a problem, the health system literature has paid little attention to how intergovernmental relations should be structured or strengthened within decentralising systems. The objective of this study is to explore issues relating to intergovernmental coordination within the South African health system using HIV services as a health system probe or tracer. The study involved document analysis and key informant interviews and included a national overview as well as detailed case studies in three sites. The research highlights the multiplicity of actors and structures involved in health service delivery and the significant complexity of public sector management. The current allocation of roles and responsibilities within HIV services and existing mechanisms for intergovernmental coordination are described and evaluated. Some key themes emerging from the analysis include weaknesses in intradepartmental coordination, poor linkages with local government, the reliance on political and executive coordination mechanisms, tensions between national integration and local accountability, and neglect of the developmental and support role within cooperative governance. The implications for HIV service delivery and health system performance are discussed.

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THEME 1
IMPLICATIONS OF SYSTEMS DESIGN ISSUES FOR SRH

PAPER

Title: Health sector reform and public-private partnerships for health in Asia: Implications
for sexual and reproductive health services

Author: Sundari Ravindran, WHO-Gender and Women's Health in Travindrum, India

Abstract:
Public and private sectors working complementarily or collaboratively in the health sector is not a new phenomenon. However, the term 'public-private partnership' is new, a phenomenon of the 1990s. So also is the growth of ideological and policy support for the idea that public and private sector should work together. 'Public-private partnership' and increasing the role of private sector in health are themes, which currently occupy a central position in health sector reform agendas throughout the world.
This review paper examines public-private partnerships in health in select countries of Asia, especially those related to sexual and reproductive health services. The paper is based on information collated from published papers and articles as well as unpublished reports and project documents. It attempts to understand the potential implications of public-private partnerships in the provision of sexual and reproductive health services for equity in the availability, accessibility, affordability and quality of services.
The first section of the paper looks at the nature of public-private partnerships and the global and country levels, and the factors that underlie their emergence. Section two starts with looking at diverse public-private partnerships in sexual and reproductive health services that have existed in developing countries over the past several decades. It then presents case examples from Asia of specific types of partnerships. Section three draws on the general literature on public private partnerships to interrogate the implications for sexual and reproductive health services.

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THEME 1
IMPLICATIONS OF SYSTEMS DESIGN ISSUES FOR SRH

PAPER

Title: The challenges of improving maternal health

Author: Hilary Standing, Institute of Development Studies and DFID Health Systems Resource Centre

Abstract:
We now know a great deal about the causes of high maternal mortality and morbidity in poor populations and the kinds of interventions that can prevent or reduce them. But progress has been terribly slow. Programmes to improve maternal health are often either small or modest-scale successes which are not easy to scale up, or are constrained by systems level failure and lack of commitment at critical levels.

This paper reports on work-in-progress being conducted for the DFID Health Systems Resource Centre. The aim is to develop the evidence base on effective ways of addressing systems failures in different socio-economic and political contexts. The methodology is desk based, reviewing "grey" literature from a range of both successful and unsuccessful initiatives, and conducting interviews with key stakeholders involved in the financing, design or implementation of programmes.

The paper will examine the main systems related challenges to scaling up good practice. It will also consider the challenges posed by current and proposed aid instruments such as SWAps, budget support and demand side financing

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IMPLICATIONS OF SYSTEMS DESIGN ISSUES FOR SRH

PAPER

Title: Integrating HIV-AIDS and sexual and reproductive health policies and programmes

Author: Marge Berer Editor, Reproductive Health Matters

Abstract:
HIV and AIDS have a myriad of effects on sexual and reproductive health, and sexual and reproductive health services are important for those affected by HIV and AIDS. Yet until recently, HIV/AIDS programmes and sexual and reproductive health programmes have taken far less account of the intersection of these prevention and treatment needs than could be expected for a number of reasons:

- few leaders in both fields have come together in a concerted way to discuss, design and implement joint policies and programmes;
- responsibility for programmes in national health systems and funding for these, both in from national budgets and donors, are kept separate, and vertical programme structures have been initiated or maintained;
- policies have often not been followed up with effective planning and budgeting or the dedication of resources and personpower;
- work within and between international agencies such as the World Health Organization and UNAIDS to address these interlinkages has been limited;
- bilateral and multilateral donors have separate departments for HIV/AIDS and for sexual and reproductive health, and have been funding programmes, projects and services in these fields separately for the most part.
- the separation of funding has been greatly exacerbated by the remit of the Global Fund to Fights AIDS, Malaria and TB.

Today, given this history, it is widely considered an unassailable fact that sexual and reproductive health is in competition with AIDS for money and resources, at least at international level, a far from equal "battle" given current international priority setting and power brokering and political trends in the health field.

Nonetheless, a number of serious attempts have been made at service delivery level to bring the two sets of issues together since the early 1990s; successes and limitations of these efforts will be discussed. I will argue that it is to the detriment of both sexual and reproductive health needs and STI/HIV/AIDS control if each continues to be treated as a separate, vertical programme. Greater awareness is needed of the intersection of prevention and treatment issues in these two fields of health care and in national policies and programmes. The example of STI prevention and treatment is used to argue that jointly planned, multi-faceted interventions across both programmes are called for.

The presentation concludes that the emphasis on vertical programmes should be reversed, and a range of integrated approaches to sexual health care, reproductive health care and STI/HIV/AIDS prevention and treatment and care should be developed, in the clinic and the community, designed to target those who need different services. This will involve integrating some services, adding and strengthening others, expanding outreach to new population groups and creating well-functioning referral links to optimise outreach and impact. Countries with a generalised HIV and STI epidemic need different plans from those with a low or high prevalence of STIs and a low prevalence of HIV, and those with large sex industries or high rates of injection drug use need to factor these in as well. But all countries need sexual health services and reproductive health services, which are not the same thing, and how these all intersect requires national planning and priority setting within the health sector, and with the involvement of education and finance sectors.

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THEME 1
IMPLICATIONS OF SYSTEMS DESIGN ISSUES FOR SRH

POSTER

Title: Examining the role of the private sector in maternal and newborn health in India, Nepal & Tanzania

Authors: Tim Ensor, Sandra E. MacDonagh and Susan F Murray

Abstract:

Background and Purpose

Women's lifetime risk of dying from a pregnancy related cause shows the greatest disparity between developed and developing countries. Over half a million women die annually and 99% of these are from poor countries. Many more suffer severe complications as a consequence of pregnancy, childbirth and unsafe abortion. Intrinsically linked to maternal health status and care, neonatal death accounts for approximately 2/3 of all infant deaths and 40% of deaths in childhood globally.

The Millennium Development Goals call for substantial reductions in both maternal and child deaths. There is a recognised need to improve access to, and quality of, maternity services including ensuring skilled attendance at delivery and referral in the event of an obstetric or newborn emergency. To date, Safe Motherhood initiatives have primarily focused on improving skills, resources, and referral systems within the public sector services. The private maternity care sector has received little attention. In many developing countries, however, there is reportedly a growth in the non-government provision of maternity and obstetric care, and health sector reform strategies are promoting private and public sector "mixes". If the ambitious targets set for reduction in maternal and child health are to be reached, the role played by different elements within the private sector, their limitations and their capacity, and their interface with government services in key areas such as obstetric emergency, all need to be far better understood. This paper reports key findings from an international literature review and a three-country exploratory study of private sector provision of maternity care.

Data and Methods

To improve understanding of the role of the private sector the following tasks were undertaken by an interdisciplinary team of researchers:

- A review of published and unpublished international literature
- Development of a set of questionnaires to collect data on private sector provision of maternity care from a range of respondents including policy makers, managers of private sector institutions, practitioners and users.
- Case studies of private sector provision of maternity care using these tools in three settings: Andhra Pradesh, India, Nepal and Tanzania.

Findings, lessons and conclusions

Analysis is ongoing. The paper will present:

- A synopsis of the current state of knowledge and key knowledge gaps
- synthesis of insights from the three-country studies
- future programme, policy and research priorities

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THEME 1
IMPLICATIONS OF SYSTEMS DESIGN ISSUES FOR SRH

POSTER

Title: Family Planning & Sexual Health Organisations: Pioneers of Health System Reform?

Authors: Maia Ambegaokar & Louisiana Lush Health Policy Unit, Dept. of Public Health & Policy, LSHTM

Abstract:
In many developing countries, the nature of the relationship between government Ministries of Health and independent, not-for-profit family planning and sexual health NGOs was a precursor to the recent "New Public Management" approaches being implemented as part of health sector reform efforts. Even when working closely with government to achieve agreed public health goals, these NGOs had autonomous management and financial control. Other countries, whose strategy for family planning involved vertical government programmes rather than independent NGOs, also experimented with innovative approaches to service provision, such as worker incentive payments (although these were not necessarily approaches that promoted decentralisation or managerial autonomy). In addition, many countries implemented contraceptive social marketing programmes which, with their explicitly market-oriented approach, are certainly precursors to the increased market-orientation promoted by new public management advocates. Using examples drawn from the family planning programme literature, we show that a range of so-called new approaches (such as user fees, worker incentive payments, and contracts from the public sector) were being used in the family planning and sexual health sector in many countries long before the advent of the recent health sector reform movement.
However, the health sector reform and SRH networks have different objectives and values which lead to communication barriers. Furthermore, in developing countries, international funding sources for the two have differed. For example, SRH is rarely prioritised under SWAPs or included in related baskets of funds. These differences mean that the health sector reform network continues to be unaware of the quasi-private market experience of SRH. While there are some countries that are notable exceptions, broadly speaking the family planning & sexual

health sector, far from being a stodgy, late arrival to health systems reform, was an early pioneer. Indeed, as we demonstrate in this paper, lessons from the experience of the family planning and sexual health sector may be of use to those countries now implementing health sector reform.

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THEME 1
IMPLICATIONS OF SYSTEMS DESIGN ISSUES FOR SRH

POSTER

Title: Strategies for Engaging the Private Sector in Sexual and Reproductive Health: How Effective Are They?

Authors: Peters DH, Mirchandani GG, Hansen PM., Johns Hopkins Bloomberg

Background & Purpose:
The private sector—including for-profit, non-profit, formal, informal and traditional providers—supplies a large part of the sexual and reproductive health (SRH) services used in developing countries. Governments have recently begun to look for ways to better engage the private sector to solve problems in coverage and service quality. The types of strategies proposed include regulating, contracting, financing, franchising and social marketing, training, and collaborating. However, little is known about how well these strategies work.

Methods:
We conducted a systematic review of the literature in PUBMED from 1980 to the end of April, 2003, to examine the effectiveness of different strategies for engaging the private sector in selected SRH services in developing countries. These services include: maternity care (antenatal, delivery and post-natal services), abortions, treatment of sexually transmitted diseases (STDs), and family planning. Studies were included if they employed a strategy to involve the private sector, and measured an SRH outcome. They were analyzed according to the strength of evidence based on their study design, and the outcomes achieved.

Key Findings:
We reviewed over 700 published reports on private sector interventions in SRH in developing countries, from which we identified only 73 studies that met our inclusion criteria. Over half of the private sector studies (41 studies) addressed maternity services, while another third (23 studies) involved STD prevention and treatment, including condom distribution. Eight studies examined family planning, and only one study involved abortion services.

Few of the studies have robust designs: only 5 were randomized controlled trials (RCTs), considered the strongest research design; 18 were non-randomized controlled studies; 28 used before-after comparisons but no controls; and 20 were cross-sectional assessments. None of the RCTs examined a change in the health status of beneficiaries, though one led to changes in knowledge and use of contraceptives. Most studies examined short-term effects among the providers. Four of the RCT studies involved training private practitioners – one led to an increase in contraceptive use in the intervention area, two showed substantial improvements in knowledge and practices of health providers, and in another found little effect. The one regulatory intervention was conducted as an RCT in Vietnam, and demonstrated increased compliance with syndromic treatment guidelines for STDs among private pharmacists.

Training private providers was the most common strategy (70% of the studies), with the majority targeting TBAs for maternity services. More successful training interventions were often combined with other interventions. For example, equipping TBAs with safe birthing kits produced better results than training alone. The second most common strategy was social marketing (15%), usually for condoms or contraception. Although considerable data on sales volume and revenue can be found in social marketing programs, the few studies that used control sites showed mixed results. There were only 1 to 3 eligible studies for each of the other types of private sector strategies examined.

Lessons & Conclusions:
The evidence about the effectiveness of strategies to influence the private sector in SRH services in developing countries is weak. In particular, evidence about how these strategies affect reproductive health outcomes is lacking. Most of the existing literature is descriptive rather than evaluative, with many studies poorly designed.

Interventions in developing countries involving major SRH service providers other than TBAs—such as pharmacy vendors, village doctors and private physicians—should be tested. In addition to training service providers, other strategies should be assessed rigorously, such as franchising, contracting, financing, regulating, and collaborating.

Future interventions need to pay more attention to experimental design if they are to answer important questions about which type of strategies work best in different contexts. Although tools to work with the private sector offer considerable promise, key questions regarding their feasibility and impact remain unanswered.

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THEME 1
IMPLICATIONS OF SYSTEMS DESIGN ISSUES FOR SRH

POSTER

Title: Management of RH services in India and the need for Health System Reform

Author: Dileep Mavlankar, KV Ramani, Jane Shaw

Abstract:
For the last ten to fifteen years, a comprehensive agenda of health sector reforms and health systems development has engulfed the health system in many countries in structural and organizational changes. Experience with varying degrees and types of reforms have now been reported from many countries. In our paper, we describe some important issues facing the management of RH programmes in India and argue that certain improvements in the management and delivery of RH services can only be realistically achieved with reforms of the health system. We support our arguments for health system reforms by drawing on experience elsewhere which may be relevant to the Indian context.

Research done in a few states in India over the last three years have given us a clear understanding of the various issues facing the management of RH services in India. Effective and efficient delivery of RH services is hampered by several policy and management constraints. Of particular concern are the no availability of staff, weak referral system, recurrent funding shortfalls, and lack of accountability for quality care. Poor Human Resource management practices lead to many of the problems in the District Health System (DHS) which consists of Primary Healthcare centres (PHCs), Community Healthcare Centres (CHCs) and the District Hospital. For example, limited clinical and managerial positions, sanctioned posts lying vacant for a long period of time in rural areas, difficulties for temporary appointments fill leave vacancies, preoccupation with sterilization camps, polio eradication and other special campaigns are some of the factors contributing to the non-availability of doctors in the DHS. Non-availability of doctors and non-empowerment of nurses to examine and/or prescribe medications when doctors are absent make the services ineffective and undependable. The

referral system in the health card structure in ad-hoc, un-systematic and technology-poor and therefore RH services, which require referrals to the district hospital for surgical procedures, management of infertility etc do not get the attention they deserve. Poor financial systems and outdated financial procedures leading to recurrent funding shortfall, and delay in release of funds adversely affect the quality of patient care due to non-availability of essential drugs, poor maintenance and long downtime of equipment and instruments. Systems of accountability for the quality of clinical care are almost non-existent in the DHS.

It is obvious that the failures in the management of RH services are complex and multi-factorial, and cannot all be addressed through health system reform. For example, if sanctioned posts are lying vacant because qualified staff do not want to work in rural areas, the solution may lie more with the incentives and rewards than in any health system reform. Similarly, if the referral system is weak because transport to the district hospital from some PHCs and CHCs is not available, no health system reform can be of any help.

However, concerns such as staff absenteeism, systemic inefficiency in filling sanctioned posts lying vacant, lack of coordination between the PHCs, CHCs, and the district hospital in the chain of the referral system, poor quality of care due to recurrent funding shortfalls, and so on, can be best addressed through health system reform. It is therefore necessary to identify which failures in service are attributable to causes which could be removed or changed by reform in the health system. In our paper, we identify those failures and causes which could be corrected through health system reforms and propose certain reform initiatives in the health system to enable the improvement of RH services in India.

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THEME 1
IMPLICATIONS OF SYSTEMS DESIGN ISSUES FOR SRH

POSTER

Title: Management of Uncertainty and Trust Between Stakeholders in Safe Motherhood Initiatives

Author: Dr. Sophie Arborio Nuffield Institute for Health, International Development, Sexual and Reproductive Health Programme

Abstract:
From a health management viewpoint, HSD implies a changing environment in the way that health systems are funded and structured. From an anthropological viewpoint, this changing environment stresses social shifting with regard to health issues. Thus, the major parameters determining HSD acquire an additional significance from anthropology, pointing out local context characteristics and social relationships as well. The whole system of health includes different actors who manage health with their own perceptions, their own priorities, their own languages and their own practices. Thus, implementation of health reforms address the discrepancies between decision makers and local managers at a political level, medical staff at a professional level and population at a daily level.

In a specific are of SRH , the **"Safe Motherhood Initiative" (SMI-1987)** represents a plurality of concepts and practices embedded in the diverse approaches characterizing these mail levels of health management. The SM concept incorporates the general idea of risk, which is a shared concern between the political, managerial, professional and consumer levels in a changing environment. Ideally, all of them tend to a "zero risk" target through the "safe motherhood" concept. However, while the medical risks seem well known in SM, it appears that the practical outcomes in health are far from reaching this ideal target. In fact, "safe motherhood" is not only a medical or a quantifiable concept of health but also, represents a wide network of ideological, political, organizational and socio-cultrural components that interact through health system reform.

As a result, in order to implement effective programmes of SRH, communication and cooperation between the diverse levels of health systems might need to be improved.
The understanding of the "Safe motherhood" concepts is used as a "tracer", enabling us to explore the linkages between Health Sector Reform and Sexual and Reproductive Health through the main levels of decision and action.

Two countries will serve as a base of a case-study comparison between Anglophone and Francophone health reforms: Uganda and Mali. In each country, one aspect of the most prominent health reform will be investigated through risk analysis. In Mali, the creation and the development of community health centres (CSCOM) calls into question the management of human resources through the changing roles and responsibilities of health actors at the different levels of reform. Uganda health reform has been characterised by the creation of health sub-districts. This decentralisation process incorporates the transfer of skilled health workers from central hospitals to health sub-district levels. Uncertainties over professional futures as well as fear of changes implies by the transfer of human resources make the reform a time of high anxiety for health workers.

General Objective: The general objective is to provide an understanding of relationships, organisational linkages and communication processes between actors involved in safe motherhood initiatives in reform contexts in order to promote effective dialogue and inform future strategic and policy directions beneficial for reproductive health.
The general objective underlines two main aspects, one concerning the communication between the different levels of health system, closely associated to the second aspect, the linkage between HSD and SRH. What is general in terms of health system reform and communication, and what is specific about SRH and communication, are questions that highlight the considered linkages and determine the overall orientation of the anthropological research. The later focuses on socio-cultural, contextual and existential aspects of the linkage and therefore, stresses the social relationships between the diverse actors as a major determinant of human resources management within health reforms.

Specific Scientific Objectives:

- To conduct a comparative analysis of human resources issues for safe motherhood in
  Francophone (Mali) and Anglophone (Uganda) health reform contexts.
- To use a risk analysis approach to investigate the different perceptions of changes, risks and uncertainties implied by health reforms for health personnel and beneficiaries of "Safe Motherhood Initiatives".
- To map the linkage between selected aspects of decentralisation and safe motherhood
  initiatives, from an anthropological viewpoint, highlight local context characteristics
  (historical, political, economical) and social relationships at different levels.
- To identify and explain the tensions and synergies (communication, organisation, social functioning) between political and organizational levels and individual and social functioning in the specific linkages between HSD and SRH
- To develop recommendations about improving relationships and communication

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THEME 2 (i)
IMPLICATIONS OF RESOURCE AND FINANING REFORMS FOR SRH: AFRICA

PAPER

Title: Impact of Financial Accountability Reforms on Midwives Working In Two District Hospitals in South Africa.

Authors: Loveday Penn-Kekana, Duane Blaauw, Helen Schneider. Centre for Health Policy.
School of Public Health. University of the Witwatersrand. Health System's Development Project. Funded by DFID.

Abstract

Introduction: Since 1994 the South African Department of Health at a national and provincial level has been faced with both implementing major health sector reforms, primarily around the decentralizing of services and the promotion of PHC, alongside participating in major new public management reforms being carried out through out the whole civil service. At a district and hospital management level managers have had to deal with severe fiscal constraints, as attempts were made to redistribute resources to primary health care, but also with instituting tough new financial management systems to ensure financial accountability. This paper will discuss how the implementation of the Public Finance Management Act, in the context of fiscal constraints, has affected the level below hospital management, and will look at the impact on the everyday practice of midwives in two district hospitals.

Methodology: An ethnography of two maternity wards in two district hospitals in South Africa. One urban and one rural. Fieldwork was carried out by a medical anthropologist who spend time in both labour wards observing practice, talking to staff, attending workshops, attending staff and management meetings and monitoring communication between the staff working in the labour ward and the rest of the health system.

Discussion: In this paper the authors will recount a number of incidents that they observed in the labour wards in which they were working, to illustrate how staff were introduced to financial accountability reforms,

how staff view these reforms and how it affected their everyday practice. These incidents will show how staff perceive the reforms to have negatively affected the quality of their working environment and the quality of care they give to patients in very concrete ways. For example the story will be recounted of a pair of lost episiotomy scissors and the extremely time consuming and labour intensive process that had to be gone through to replace them, taking nurses away from their patients. This and other incidents will be used to illustrate how implementing these reforms has lead to tensions between staff and management; made staff feel that filling in forms and being financial accountable is more important than how they care for patients, and made them consider leaving the health department. All of these being far from what was intended by those who developed and are attempting to implement the reforms.

Conclusion: Health sector reforms have unintended consequences. When implementing and assessing the impact of any element of health sector reform it should be recognized that these reforms are implemented and interpreted in the social context of the hospital, the labour ward and the lives of those working in the wards where the reforms are being implemented. Meaning and intentions are created around a reform that are often not the same as, and sometimes directly contradictory to those of the policy makers.

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THEME 2 (i)
IMPLICATIONS OF RESOURCE AND FINANING REFORMS FOR SRH: AFRICA

PAPER

Title: Do Health Reforms increase the vulnerability of Reproductive Health NGO's in Uganda?

Author: Frank Mugisha, Harriet Birungi and Ian Askew

Abstract:
The paper identifies and discusses sustainability issues that are confronting reproductive health non-governmental organizations (RH NGO's) in Uganda within the context of the current Health Sector Reforms (HSR) process. In particular, it examines how the HSR process, and specifically the use of a Sector Wide Approach (SWAp) to financing reproductive health services, facilitates or constrains the financial sustainability of RH NGOs. Data for the study are drawn from an assessment of 15 RH NGOs carried out in April 2002; the data were gathered through 36 semi-structured individual interviews with staff from the NGO's as well as from their funding agencies and from the Uganda Ministry of Health (MOH).

Findings from the study show that RH NGO's in Uganda are expected to be part of the HSR process. They have been affected by the dynamics of that process since they are 80-100 percent dependent on external support, they have limited investment capacities to generate income, and they all lack an "exit strategy" for when external support ends.

The assessment highlighted the fact that the HSR process has promoted policies that are intended to be supportive of improving the financial sustainability of RH NGOs. Through broadening the range of health financing options available to them, introduction managed competition among them, and encouraging public-private sector partnerships. The intention of these reforms is to increase the "intimacy" of the relationship between government, NGO's, private sector, communities and donors. NGO's are expected to actively participate in the development of a long-term strategic vision for their sector.

They can be contracted the MOH and local governments to render reproductive health services. The possibilities for NGO's to deliver

equitable health for the less privileged are also expected to be greatly enhanced. One drawback with the process however, is the shift in funding mechanisms from direct project support by donors to individual NGO's to budget support for activities through the MOH. This change requires both donors and NGO's to find different ways to interacting and to be successful depends heavily on their ability to work through the MOH.

There are several limitations however to NGO's being able to fulfil these expectations. Neither the government nor the donor community has engaged the NGO's directly in the HSR process. There has been no effort to educate them about the implications of the SWAp or to build their capacity to work within this framework. Virtually none of the RH NGO's in Uganda are able to position themselves as entrepreneurs to market their vision and services to local government, donors, the private sector or even the households they serve. Consequently, the vast majority remain isolated from the reform process and lack linkages with governmental systems (and the finances that exist within these systems) at any level. As a consequence, they are unable to take advantage of the new policy and financing arena.

The study concludes that however individual countries pursue HSR. RH NGO's must strive to ensure that they adapt to the new situation immediately and seek to exploit it to enhance their financial and programmatic sustainability. Rather than shy away from engaging in the HSR process. NGO's should embrace and effectively implement the major "pillars" of sustainability inherent in HSR, namely develop the capacity to undertake strategic planning, financial management, costing of services, marketing and human resource management. Those implementing the HSR process, it could be argued, have an obligation to build the capacity of NGO's to be self-propelling through enabling them to lobby for inclusion in the SWAp, to develop a financially sustainable strategic plan, and to market their services so as to access resources.

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THEME 2 (i)
IMPLICATIONS OF RESOURCE AND FINANING REFORMS FOR SRH: AFRICA

PAPER

Title: Do community health insurance schemes provide effective financial access for maternal health care? A Ghanaian case study

Author: Daniel Arhinful

Abstract:

Background: Health insurance has become prominent on the national agenda in Ghana as one health care financing scheme for improving access to health care particularly for the poor and vulnerable including pregnant women. It is envisaged that if adequately designed, social and community health insurance schemes can lead to an improvement in the mobilization of resources without the problem of fees that the poor and vulnerable in particular face at the point of service. The Ministry of Health in Ghana is therefore developing appropriate policy and regulatory frameworks for the establishment and running of health insurance schemes in the country to guide interested groups and institutions.

This paper presents data from one rural district in Ghana to show that community health insurance schemes have potential as a cost effective mechanism for increasing the financial access of pregnant women with obstetric complications for care where other strategies such as exemption mechanisms have failed in the past.

Data and methods: The data was obtained from primary research carried out in Nkoranza district which operates Ghana's pioneer private not for profit community health insurance scheme for hospital admissions. The material is part of a bigger study carried out in three districts that investigated the social and cultural feasibility of rural health insurance in Ghana. A combination of in-depth qualitative and quantitative data collection techniques were used to explore how people for whom insurance is planned perceive it and how they do or are likely to participate in it.

Key findings: Among the key findings that have implications for maternal health is that, community health insurance schemes could provide timely access to women's health needs arising from complications of pregnancy

and childbirth. However, one issue that is a source of controversy is that benefit of the scheme in the case study does not cover normal deliveries and complications related to self-induced abortions. The community conceptualise health insurance in terms of the tangible direct benefits (for themselves or their immediate relatives) they obtain from being members or subscribers. The situation influences heavily on people's desire to subscribe to the scheme.

Lessons and conclusions: The analysis concludes that community health insurance schemes have the potential to compliment exemption policies that only provide primary care provisions for pregnant women. Thus, if implemented effectively, they constitute timely and cost effective options for addressing the problem of financial access for women with obstetric complications. However, the challenge in providing any such access lies more in the preparedness of people to accept the need and embrace the concept of risk sharing in solidarity with others in spite of their self-interest. The findings of the study present some important evaluation questions for IMMPACT, a new maternal health research initiative that has recently commenced in Ghana. Further information on IMMPACT is available at http://www.abdn.ac.uk/immpact.

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THEME 2 (i)
IMPLICATIONS OF RESOURCE AND FINANING REFORMS FOR SRH: AFRICA

PAPER

Title: SRH and the Development of SWAps in Malawi

Authors: Trish Araru and Jane Namasasu

Abstract:
Background and purpose: To discuss how the entry point through SRH can contribute towards the Development of SWAps and future strengthening of systems essential for the delivery of SRH services.
Lessons and conclusions: The lessons learnt so far is that it is possible to move into wider sector ways of working from a sub programme approach whilst at the same time influencing the elements of the system necessary for the delivery of Sexual Reproductive Health services. The challenge now is how do we ensure that the poor have improved access to quality reproductive health services while reforms are made to management systems and ways of working at the higher levels during the process of implementing a Sector Wide Approach.

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THEME 2 (ii)
IMPLICATIONS OF RESOURCE AND FINANCING REFORMS FOR SRH

PAPER

Title: Health Sector Reform and its Implication on Reproductive Health Service Provision and Utilization in Poor Rural China

Author: Fang Jing, **Institute for Health Sciences, Kunming Medical College, Yunnan Province, P. R. China**

Abstract:
Background: The 1994 International Conference on Population and Development (ICPD) formally set up reproductive health into international agenda, a number of reproductive health service objectives have been formulated in the form Program of Action in order to improve and achieve the ideal reproductive health status of global population. However, the concept of reproductive health has been put forward in the era of health sector reform. Both developed and developing countries are being in the process of reforming their health service system, which will unavoidable produce implications, positively or negatively, on reproductive health service. Without a carefully examination and analysis on those implications, it will be hard for any practical and feasible action to be taken by any country to fulfil the ICPD goal.

Affected by the enormous socioeconomic reforms commenced in the end of 1970s, China has experienced health sector reform since the early of 1980s. Major changes have occurred in the finance, management, structure and service delivery of both the urban and rural health systems. In rural China, the collapse of collective medicine scheme (CMS) which covered the basic medical fee of most rural population in the past pluses the introduction of fee for service mechanism pose the question of accessibility of health care by poor people. A few empirical studies reveal the extremely low utilization of basic reproductive health services such as prenatal care and safe delivery by poor women in poor areas (Fang, et al, 1997; He, et al, 2000; Yan et al, 2000; Ma et al, 2000). Also enormous evidences show much higher maternal mortality rates (MMR) and infant mortality rates (IMR) in poor rural areas than in non-poor rural region (Hou, et al, 1994; Gu, et al, 1994.) Thus, a critical review of the relationship between health sector reform and its effects on

reproductive health service provision and utilization in poor areas is crucial in order to approach Reproductive health goal. Because a large part of china is poor or underdeveloped rural areas and still 34,000 thousands poorest people whose basic life needs such as eating and clothing haven't been guaranteed according to the national statistics left behind in the country by the beginning of new millennium although continually anti-poverty efforts. Unless enough attention and concrete efforts is paid to those marginalized areas and people, the fulfilling of ICPD goal will be an impossible task.

This paper first gives a brief review of the major rural health sector reforms and features, then present some findings uncover by empirical studies on reproductive health service provision and utilization, and then analyze the implication resulting from the rural health reforms. Finally some reformations are proposed.

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THEME 2 (ii)
IMPLICATIONS OF RESOURCE AND FINANING REFORMS FOR SRH

PAPER

Title: Sexual and Reproductive Health, Financial Reforms and Decentralization in Latin America and the Caribbean

Author: Daniel Maceira, Ph.D, Center for the Study of State and Society (CEDES) Buenos Aires – Argentina

Abstract:
During the last fifteen years, Latin American and Caribbean nations have been exposed to a series of reforms in the provision and financing of their health care systems, with the aid and tutelage of international credit agencies and donors. Their global goals were to expand coverage and to increase equity; to provide fiscal and financial viability to health systems, and to improve quality of care and users' satisfaction. Five main instruments were used: (1) Reorganization of services, including alternative models of medical care and hospital self-management, (2) Implementation of basic packages of services in the context of redefined social security institutions, (3) Utilization of alternative provider payment mechanisms, (4) Changes in modes of financing, including participation of the private sector, mechanisms of cost recovery, and subcontracting, and (5) Decentralization and stimulation of social participation. In some nations the decentralization process became a tool to redistribute political power from the national level to the provincial, state or municipal governments, while in others they were oriented towards higher efficiency in the allocation of resources. In addition, decentralization is considered as an alternative way for local/municipal development through local capacity building and the empowerment of specific minorities (racial, linguistic, etc.). In all cases, health systems reforms had as a secondary goal the search for more precise mechanisms to monitor and evaluate performance, increasing the control and accountability of the resource allocation process.

The paper analyzes the academic production regarding the effects of reforms on sexual and reproductive health, as an attempt to identify existing gaps, and proposing issues for a common research agenda. It present a brief summary of the financial reforms applied to Latin

American health care systems, characterized by highly segmented and fragmentary structures, discussing the potential impacts and incentives generated by financial reforms on the provision of SRH services. In addition, the document presents a conceptual framework relating the traditional objectives of a decentralization process within the Latin American context.

Despite the importance of the relationship between financial reforms and decentralization in health care and their impact on sexual and reproductive health indicators, the evidence provided by the literature regarding this connection is scarce. Also, given the dissimilar characteristics of the financial reforms implemented in the region, the results documented are highly contrasting. In general, financial reforms have been successful when priorities were clearly defined and well connected to the population's priority needs. Basic packages of services as a way of organizing the financial structure of social security institutions or the provision of subsidies for vulnerable groups have proven to be a useful tool for the implementation of specific health interventions on SRH. On the contrary, little information has been found regarding successful experiences in self-managed hospitals and the incorporation of alternative payment methods to the health care sector. However, the intersection between these reform mechanisms and SRH has been limited, and results are associated with experiences which are difficult to generalize without a common methodological framework.

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THEME 2 (ii)
IMPLICATIONS OF RESOURCE AND FINANING REFORMS FOR SRH

PAPER

Title: Is insurance a viable strategy

Author: Tania Dmytraczenko

Abstract:
Many developing countries are restructuring their health systems in an effort to achieve public health goals more affordably and effectively. Many are also attempting to expand and improve reproductive health services, which include family planning, measures to ensure safe pregnancy and childbearing, preventing and spread of HIV and other sexually transmitted infections, and other measures to improve women's health. The need to pursue reproductive health objectives while implementing strategies to strength health systems poses a major challenge for health managers.

In most developing countries, household expenditures account for a large share of total spending on health. These funds are spent mostly as out-of-pocket payments on a fee for service basis, leaving households vulnerable to the potentially devastating effects of unforeseen, large expenditures on necessary medical care. There are also inequities associated with this financing structure, as wealthy households are better able to pay for services out of pocket. Risk-sharing arrangements, or insurance schemes-managed by either the government or for-profit or nonprofits private entities-lower individual liability by spreading risk across a group of members and, hence, can help prevent vulnerable populations from incurring major health expenses due to serious illness or injury.

This research reviews the experience of three countries that have implemented distinct risk sharing arrangements to assess the impact of the schemes on utilization of family planning and reproductive health services. Service utilization is tracked from a variety of sources including patient encounter and household survey data. Utilization

patterns are assessed over time or between member and non-member groups.

In Rwanda, community-based insurance schemes are owned, managed, and financed by their members. Members who pay an annual premium receive a basic health care—including preventive and curative care, family planning and reproductive health services, maternity care, and drugs-fee of charge in health centres and district hospitals(for Caesarean sections).

In three governorates in Egypt, individuals and employers contributions and government revenues are combined into a social health insurance fund that grants enrolees an essential package of health services. The package includes child immunizations, reproductive health services, and prevention and treatment of communicable diseases.

In Bolivia, municipal governments must use at least 6 percent of the central government funds they receive to support an insurance fund that guarantees some reproductive health and child health services and other care free of charge to all clients. There is evidence that these schemes have contributed to increased use of family planning and reproductive health services. However, inclusion of family planning and reproductive health in the package of services covered by insurance is not a given. Reproductive health managers and advocates need to become familiar with system strengthening principles and strategies and involved in the decision-making process in order to effectively promote family planning and reproductive health.

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THEME 2 (i)
IMPLICATIONS OF RESOURCE AND FINANING REFORMS FOR SRH: AFRICA

PAPER

Title: Determination of Reproductive Health Services Package in the Universal Health Insurance Scheme in Thailand: Match and Mismatch of Need, Demand and Supply

Authors: Yot Teerawattananon, Viroj Tangcharoensathien
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Abstract:
Health expenditure in Thailand has significantly increased since 1980 from 3.82% of GDP to 6.21% in 1998. However, in 2000, there were about 20 million or 30% of the total 60 million Thai population remain uninsured. In October 2001 Thailand has introduced universal health care coverage (UC) financed by general tax revenue. A capitation contract model was adopted to purchase ambulatory and hospital care, and preventive care and promotion, including sexual and reproductive health (SRH) services, from public and private service providers.

Though the design of universal coverage fully supports delivery of a comprehensive range of preventive, promotive and primary care service package, including SRH services. This paper aims to assess the design and content of health benefit package of the universal health insurance scheme (UC) focusing on the reproductive health service. We apply economic concept of need, demand and supply in the process of developing reproductive health services packages.

The analysis indicated that sexual reproductive health services contribute a major part of the packages including control of communicable and non-communicable diseases, promotion and maintenance of reproductive health, and early detection and management of reproductive health problems. Also, the authors determined seven areas of three overlapping spheres: need, demand, and supply when burden of disease study on reproductive was used as a proxy of need, the finding from a study of private practice in public hospitals as a proxy of patient's

demands, and designing and content of the UC package as a supply of health care.

The author recommended Healthcare planners consider the interventions in which demand meets needs of the consumers but not included in the health service package to be included in the packages when they want to put additional resources into the programme and expand the package. Prioritisation of the interventions using burden of disease and economic appraisal of alternative cost effective interventions are recommended.

The healthcare managers have to stimulate consumption of the services that need matches supply, but not demanded by the patients by providing information and education along with using financial incentives to healthcare providers to stimulate service provision.

The interventions in which only need occurs but not for demand and supply the healthcare managers should encourage consumer awareness and include these interventions into the package when resources are available.

Healthcare managers or researchers must play an important role to identify the services in which supply matches demand but not necessary the health need of the population or the services that only demand or supply occurs and then exclude from the benefit package. The government should left the private sector to provision of the service and government play a role in regulating price and quality of care.

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THEME 2
IMPLICATIONS OF RESOURCE AND FINANING REFORMS FOR SRH

POSTER

Title: Negotiating Sexual and Reproductive Health Services within the Household

Author: Dr. Sarah Nabwire Ssali, Lecturer, Women and Gender Studies Department, Makerere University,

Abstract:

This research considers the impact of user fees upon the way women make household health care decisions, especially sexual and reproductive health care services. The research arena was Mukono district in Uganda, selected because of the early introduction in Uganda of user fees in 1992 and the representative nature of the district. From the outset, the introduction of user fees by the World Bank was conceived within a neo-liberal framework, where they were supposed to stimulate market allocation of health care, to resolve the crisis in health care provision characterised by inadequate expenditure on cost-effective health programmes; internal inefficiency; and inequitable distribution. The principle behind these resolutions was one of allocative efficiency. The World Bank had argued for some time that less developed nations had inefficiently distributed scarce health resources through state mechanisms. The World Bank urged that developing nations prioritise the allocation of scarce resources through consumers, who would rationally maximise their utility if provided with price signals through user fees. Consequently, for the consumers, market allocation of health care was supposed to enhance their individual choice of health care.

This paper argues that the economic principle of allocative efficiency employs a generalised and simplistic perception of gender. To research this from a gender perspective, the research employed a qualitative methodology within grounded theory. The findings established that in Mukono households, paying for health care, especially antenatal and obstetric care was the responsibility of the man, the cultural owner of the pregnancy and the child therefrom. User fees did not have a significant impact on the way women in Mukono households made antenatal and child delivery decisions. Whereas allocative efficiency through user fees may have enhanced women's freedom to choose, their

choices were restricted by a variety of social and economic limitations, determined by culture and household gender division of labour. Such constraints devalued allocative efficiency as an effective rationing mechanism for health care. This thesis concludes that for women to maximise their utilisation of sexual and reproductive health services, women should be empowered with income, while those too poor to pay should be provided with free reproductive health services.

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THEME 2
IMPLICATIONS OF RESOURCE AND FINANING REFORMS FOR SRH

POSTER

Title: Public Financing of PNFP health provision in Uganda: How is equity balanced?

Authors: Freddie Ssengooba; Makerere University, Institute of Public Health
Christine Kirunga; Ministry of Health
Sam Okuonzi; National Council for Children

Abstract:

There has been a remarkable increase in health financing in Uganda despite its overall insufficiency relative to regional and international experience. Debt relief from HIPC initiative and general economic recovery trends of the last decade have enabled financing for health sector to increase by over 30 percent over the last 5 years.
In advent of the public-private partnership in health, Private-not-for-profit (PNFP) health providers have received an increasing share of the government health budget with the objective of increasing access to the minimum health care package. Over the last four years, the public subsidy to PNFP has increased to about one third of their operational costs and about 20 percent of the overall non-salary health sector budget. Two parallel allocation formulae are being used to allocate the public health budget, one for the public and another for PNFP provision. The allocation for public provision follows formulae that have population and needs-based weighting, while the PNFP allocation is based on the number of health facilities and their service profile in a district. Districts that have a higher index of PNFP health facilities/service profile have the potential of attracting more additional funds than those with less. On the other hand, PNFP health facilities are more likely to have been established in underserved districts following the religious mission of serving the poor. In this paper we will analyse the public budget allocation to both PNFP and Public facilities with a view to understand the equity implications of the two allocation mechanisms (public and PNFP) on the health sector budgets available to districts ranked by levels of need and by district population.

The paper will attempt to illustrate the challenge of taking on board new initiatives such as Public-Private Partnerships as wells as ensuring equitable health development through budget management. The analysis will also inform the debate on ongoing fiscal decentralization and resource allocation decisions aimed at balancing both equity and partnership objectives in the Ugandan health care system.

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THEME 2
IMPLICATIONS OF RESOURCE AND FINANING REFORMS FOR SRH

POSTER

Title: National Health Insurance and the Antenatal Care Use: A Case in Taiwan

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Tsai-Ching Liu; [b] Department of Public Finance, National Taipei University, Taipei, Taiwan
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Abstract

Many studies have found evidence for the importance of antenatal care on pregnancy outcomes. This paper focuses on determinants of antenatal care use in Taiwan and provides a comparison of access to care before and after National Health Insurance (NHI) was implemented in 1995. A negative binomial model is applied to data from the 1989 and 1996 Taiwan Maternal and Infant Health Surveys to analyze antenatal care use. The results show that women in some situations had more antenatal care visits than average regardless of NHI implementation. These situations include: having a highly-educated husband; gaining more weight than average during pregnancy; experiencing a first pregnancy; carrying twins or triplets; having care provided by a doctor rather than other caregivers; and switching to another health care facility during pregnancy. Regarding societal change, the trend toward delaying pregnancy is causing a change in care use. Additionally, three changes in care patterns after NHI are noteworthy. First, antenatal care visits at maternity clinics increased more than visits at hospitals. Second, before NHI's implementation, women who did blue collar work or farm work sought care more frequently than housewives, but after NHI began government employees and businesswomen sought care more frequently. Third, antenatal care visits of mothers living in Taiwan's central area increased more than visits of those in the northern area. The expansion of medical care in aboriginal areas and outlying islands may prove to be one of NHI's best achievements.

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THEME 3
PRIORITY SETTING, ADVOCACY AND ACCOUNTABLILITY FOR SRH IN REFORM CONTEXT

PAPER

Title: Priority Setting in Ghana's Health Sector Reforms: Where is Sexual and Reproductive Health?

Author: Susannah Mayhew, London School of Hygiene and Tropical Medicine, Sam Adjei, Deputy Director, Ghana Health Service & Henrietta Odoi-Agyarko, Director Reproductive and Child Health Unit, Ghana Ministry of Health.

Abstract

There is mounting concern that reform components such as the development of sector-wide approaches and the implementation of decentralisation, employ priority-setting mechanisms that are not suited to recognising or taking account of the needs and priorities of sexual and reproductive health services.

Priority setting is influenced by political and organisational factors that are not considered by current priority setting tools such as DALYs , potentially resulting in unforeseen social and equity implications. There is also concern over the appropriateness of traditional 'evidence'-based tools with their economic focus, since RH depends so much on social, cultural and political contexts as well as economic. There is a call for priority-setting to consider reproductive *health* rather than disease because many RH interventions do not fall within the disease-model on which the DALY tool was developed.

The main aim of this research was to assess the sensitivity of the priority setting tools and mechanisms that were used in the development of the health sector reforms in Ghana, to the needs and priorities of sexual and reproductive health services. SRH needs and priorities were defined as those outlined in the package agreed at the 1994 Cairo International Conference on Population and Development (ICPD). We used in-depth key-informant interviews and document analysis, to answer a series of research questions:

1) **What priority setting tools and mechanisms were used at different levels of the MoH during the reform process, and who were the key actors involved?**

   We documented the priority setting mechanisms and tools used in Ghana at national level in the development of SWAp, decentralisation and essential package policies and those used currently at decentralised (district) levels. We documented who had been/is involved in the development of priorities at these levels (i.e. key stakeholders).

2) **How far are SRH priorities reflected in the reform indicators?** We identified the SRH priorities/indicators expressed in the reforms and compared these with the Cairo package.

3) **Whose priorities are reflected in the reforms?** We identified SRH priorities held by a range of stakeholders at different levels and mapped these against the Cairo- identified priorities and against the actual priority indicators current in the SWAp, essential package and decentralisation strategies.

4) **Can priority setting mechanisms and tools be developed that are sensitive to the needs and priorities of SRH services?** We assess the potentials and challenges for developing such tools by application of a three pronged analysis framework developed by Reichenbach (2002):

   a. Direct attention measures (epidemiological and financial data available)
   b. Process attention measures (presence of budget, guidelines, training)
   c. Political attention measures (cultural, political and legal factors)

We conclude that priority setting tools in Ghana's reform process were rudimentary and opportunistic; many Cairo priorities are not reflected in the reform indicators partly because SRH donors and advocates were little involved in the reform process. We suggest that there is an opportunity to develop pro-SRH priority setting tools providing that a number of issues are addressed. These include: generation of data on, and political commitment to, the full complement of SRH components and their associated costs; ensuring that the SRH programme in Ghana does not become polarised outside the health system SWAp by virtue of its particular donors not being involved in the system-reform processes.

Finally, we conclude that it is critical for reform processes to include key SRH and other programme stakeholders in their priority setting and consultation phases; SRH stakeholders need to be proactive to engage with the reform debates in order to advocate for their priorities. The Ghana reforms have profound implications for the future delivery of reproductive health services and their momentum will not be reversed; SRH advocates cannot afford to be isolated or left behind.

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THEME 3
PRIORITY SETTING, ADVOCACY AND ACCOUNTABLILITY FOR SRH IN REFORM CONTEXT

PAPER

Title: Service accountability and community participation in the context of Health Sector Reforms in Asia: Implications for sexual and reproductive rights and health.

Author: Ranjani.K.Murthy and Barbara Klugman, 2003

Abstract:
This paper reviews existing strategies for community participation (CP) and accountability to community (AC) within and outside the context of health sector reforms (HSRs) in Asia, and examines the nature of CP and CA promoted and how far they have strengthened sexual and reproductive health services and rights. It observes that CP and AC strategies within HSR projects chiefly comprise of decentralization, community financing, establishing of community health structures, and recently, regulation (client, government, and occasionally self-regulation) of health sector. CP in HSR projects has been by and large limited to the level of "consultation". Such participation has strengthened at best accountability with regard to health delivery but rarely accountability with respect to the nature of policies that get made. Available evidence does not support the assumption of the World Bank that community financing strengthens participation of, and accountability to, marginalized people. Neither does it support the view that all models of decentralization promotes community accountability. It is only the devolution model of accountability that offers scope for strengthening community accountability, and that too when powers and resources are devolved and quotas are put in place for marginalized groups. The available evidence suggests that only 33% of HSR projects in Asia include HSR services. Even in these case services are mainly in the area of strengthening FP and MCH services for women in reproductive age, and at times RTI/STD/HIV/AIDS. Rarely have interventions in area of violence against women, or services in the area of abortion, infertility treatment, reproductive cancers, or contraception for adolescents been prioritized.

Community participation and accountability outside the context of HSRs has taken place both in spaces created by the government, as well as demanded by communities and civil society organizations that represent their interests. The shortcomings of community participation and accountability in reform processes/projects well apply to participation in invited spaces outside. On the other hand, community participation and accountability strategies in demanded spaces has been more diverse and innovative, raised controversial health and SRH issues, promoted not just managerial accountability (of health workers, providers and managers) but also political accountability (of health policy makers) and, entailed a higher level of participation by community and civil society organisations. Yet issues of representation of marginalized people, resolving power and conflicts, and strengthening institutionalization, up-scaling and legitimacy remain. Strong tradition of democracy and space for dissent seems a pre-requisite for such demanded participation, but are not always present. Demanded participation and accountability strategies have more successfully prevented violations of women's reproductive rights by the state, markets and civil society, than promoting SRH services in the areas of abortion, (arresting) domestic violence, adolescent RH services or reproductive tract cancers

Some of the constraints to SRH service impact of community participation and accountability within and outside HSRs include the extent of democracy, the broader cultural mileu, and funds available with government, legal and policy environment (including other elements of HSRs like financing).

Key recommendations include i) widening of CP and AC strategies currently promoted within HSR projects especially in health/SRRH policy (learning lessons from non HSR initiatives), ii) promoting such strategies with respect to design and monitoring of HSR projects as well, iii) emphasizing devolution but not community financing as a strategy for accountability and participation, iv) institutionalizing, legitimizing and up-scaling successful strategies v) raising additional government resources for facilitating and building capacity of stakeholders for CP and AC, and on SRRH, vi) political and legal reform for allowing demanded participation and CSOs to flourish, vii) mobilization and building capacities of marginalized groups for demanding accountability, viii) research into non participatory strategies for strengthening accountability to communities.

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THEME 3
PRIORITY SETTING, ADVOCACY AND ACCOUNTABLILITY FOR SRH IN REFORM CONTEXT

PAPER

Title: Sustaining Advocacy for ICPD Agenda in Health Reforms under Regime Change: Lessons from Bangladesh

Author: Rounaq Jahan

Abstract:
This paper analyzes how the ICPD agenda was adopted by the Government of Bangladesh (GoB) during the design of the health sector reforms in the mid-1990s and how a part of the agenda was undermined after a regime change in 2001. The paper identifies the strategies used by ICPD advocates during the design of the reforms and the gains made and challenges faced during their implementation. It draws lessons from the Bangladesh experience on the importance of autonomous civil society advocacy for the ICPD agenda and suggests strategies and actions that can be taken by civil society to sustain advocacy amidst regime changes and shifting political commitments for ICPD.

The findings presented in this paper are based on the author's research carried out over the last eighteen months. Data sources include review of published and unpublished agency documents, interviews with key informants and the author's own personal notes and observations as a member of the World Bank-led team negotiating the reforms with GoB, during 1996-98. Moreover, the author has maintained contact with key actors implementing the reforms and has organized multi-stakeholder civil society dialogues to discuss and debate the links between ICPD goals and health sector reforms.

In 1997, Bangladesh adopted a Health and Population Sector Strategy (HPSS) and in 1998 a five year Health and Population Sector Programme (HPSP). This initiated major policy and organizational changes such as a shift from vertical to integrated SRH delivery through unification of health and family planning services and a client-centred provisioning of an Essential Services Package (ESP) in the public sector that covered comprehensive SRH. A key finding of this research is that such a shift in

policy and programming was made possible by a sustained community and stakeholder consultation over a period of 24 months, which helped build consensus around the ICPD agenda. In addition, advocates were directly involved in the technical work of designing the various elements of reforms. Opposition from a section of GoB officials against unification of the bi-furcated wings of health and family planning was overcome when support from top political leadership was secured after a new government came into power in 1996.

However, translating policy commitments into practical strategies and actions and demonstrating positive results from reforms needed time and sustained public advocacy. Another key finding is that information about the gains and the challenges of reforms was not placed in the public domain to create better understanding about the complexities of the tasks and build a wider constituency for ICPD. As a result, after a change of regime in 2001, opponents of reforms started highlighting the shortfalls of HPSP without noting its achievements and succeeded in changing policy commitment to unification of health and family services.

Several conclusions and lessons emerge from this research. First, during implementation, the reformers prioritized only one of the means (unification of health and family planning services) of achieving the goal of providing client-centred comprehensive SRH neglecting even more important interventions such as training and internal and external accountability mechanisms. Second, a shift from the previous family planning bias to a comprehensive SRH needed elaboration of strategies and commitment of resources to address other dimension of SRH. This should have also included a long-term vision going beyond the five year HPSP as well as a public advocacy campaign that could have oriented various stakeholders about the long-term nature of the project. Third, because civil society engagement and independent assessments of HPSP were neglected, the project was a non-transparent GoB-donor driven enterprise.

One major lesson that can be drawn is that sustained advocacy by civil society is needed to keep the ICPD agenda alive particularly if the agenda is to survive regime changes.

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THEME 3
PRIORITY SETTING, ADVOCACY AND ACCOUNTABLILITY FOR SRH IN REFORM CONTEXT

POSTER

Title: Measuring the Unmet Obstetric Need at district level: from improving communication between health providers, health managers and population to restoring confidence in health services?

Authors: Guindo G. (MOH, Mali) Dubourg D. and De Brouwere V. (ITM, UON Network)
Department of Public Health, Prince Leopold Institute of Tropical Medicine, Antwerp

Abstract

Background: Health system reform of Mali started beginning of 1990s with an original change strategy. This strategy relied on the development of community health centres providing a minimum package of care and essential drugs, the involvement of the community in the process (not to say the total ownership) and on a structural shift from an administrative structure to a two tier operational structure. Early in the process, maternal health process indicators were chosen to monitor progress.
In 1999-2000, a national survey of the unmet obstetric need (UON) for major obstetrical interventions (MOI) was carried out by the MOH on 1998 figures. District medical officers were involved in the collection and the analysis of the retrospective data.

Methods: In Koutiala, a 400,000-inhabitant district, the district medical team (DMT) decided in 1999 to prospectively collect data in order to monitor the progress in the coverage of major obstetrical interventions for absolute maternal indications. To get accurate data, the DMT had to improve the hospital records. This turned out to be a complex exercise requiring the justification of diagnosis (evidence), the follow-up of care (what patients received, when, why?) and also the notification of the origin of the women. Efforts to improve the reliability of the women's addresses led to a dialogue with the families that went beyond the simple collection of data, and led to a new relationship between providers and

families.

Key findings: After a first year of data collection, the UON analysis showed considerable deficits contrarily to what the DMT thought: about half of women in need of a MOI did not get it. These results were presented and discussed with the community representatives, the administrative authority, the health centres staff and the local donor (Dutch co-operation agency). All stakeholders were shocked by the magnitude of the deficit (more than 100 women with a life-threatening condition did not access the hospital). This suddenly emerging awareness of the maternal mortality had several consequences. First, the population discovered that health personnel was concerned by the fate of mothers. Because the number of cases requiring a referral is relatively low in each village, the community decided to assist any woman in need emergency care. Second, local politicians engaged in buying an ambulance. Third, the Dutch agency changed its policy and accepted to finance the upgrading of the operation theatre. Fourth, the Regional Directorate of Health, after years of refusal, allowed district hospital's to carry out blood transfusions. Fifth, health personnel realized how important having a relationship with the families is to restore their confidence in the health services. Finally, the DMT learned to play a new role as an intermediate level between health centres and district hospital.

Lessons & conclusions: Deficits began to decrease before the implementation of visible interventions such as the blood transfusion, the purchase of the ambulance, the training of health centre auxiliary midwives and the opening of new community health centres. This suggests that the necessity to dialogue with the families in order to get required data led to the establishment of a relationship between health personnel and the population. This attitude started a positive circle: the confidence of the population increased the sense of responsibility of the health personnel, which in turn reinforced the confidence of the population and decreased the barrier to access to emergency obstetric care.

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THEME 3
PRIORITY SETTING, ADVOCACY AND ACCOUNTABLILITY FOR SRH IN REFORM CONTEXT

POSTER

Title: Demanding Health Reforms and Accountability in Karnataka

Author: Asha George, Indian Institute of Management Bangalore

Abstract:
Karnataka, a southern state in India, has recently experienced two important indigenous reform efforts demanded and supported by its public health community. The Karnataka Task Force on Health and Family Welfare, a body led by civil society members and constituted by the state government, and the Karnataka Lokayukta, a judicial body that aims to improve the standards of public administration, have envisioned and are enforcing a more accountable health system for Karnataka. The poster will discuss these two reform efforts and their impact on health system functioning and reproductive health concerns. Analysis will be based on the review of policy documents, as well as qualitative interviews carried out at the state level.

The Task Force was initiated in December 1999 in order to suggest public health improvements, submit proposals for population stabilization, recommend improvements for the management and administration of the Health Department, recommend changes for the clinical and public health education system, and monitor the impact of its recommendations. During 14 months of intensive and participatory work it commissioned 9 research studies, sat 59 times and undertook visits to all districts. In April 2001 it submitted a final report entitled, "Towards Equity, Quality and Integrity in Health". The key areas of concern highlighted were: corruption, neglect of public health, distortions in primary health care, lack of focus on equity, implementation gap, ethical imperative, neglect of human resource development, cultural gaps and medical pluralism, from exclusivism to partnerships, ignoring the political economy of health and research.

The sections of the Task Force report dedicated to 'Women and Child' and 'Population Stabilization' are permeated with a gender and equity analysis and concern about the quality, access and accountability of

government services. Recommendations focus on tackling gender inequality and addressing violence against women, as well as detailing specifics for improving the quality and staffing of government health services.

Significant changes have been made. With respect to reproductive health the following are most relevant. Vacancies of doctors and lab technicians in rural areas began to be filled through contracting, with efforts to post more Lady Medical Officers to primary health centres. Auxiliary Nurse Midwife (ANM) training was reinitiated after a delay of 3 years. Equipment and essential drugs were purchased. Efforts were made to ensure at least one blood bank in each district existed. Actions were taken to provide 24 hour delivery services at First Referral Units.

The work of the Task Force is laudable for its comprehensive and participatory approach in articulating urgent health needs for Karnataka and a public commitment to address them. Despite important progress, not all its recommendations have been met. More time will be needed due to the scale of reforms recommended. More strategically critical aspects of its functioning need to be examined. For example, does it have an independent monitoring capacity, especially in a state noted for severe regional disparities and what is its recourse to enforcement when compliance is not forthcoming?

Interestingly, the work of the Task Force coincided with various reforms and a new leadership in the Karnataka Lokayukta. As the Task Force highlighted corruption as the single most critical obstacle to effective and equitable health services, the Chairman of the Task Force was invited to join the Karnataka Lokayukta to target corruption and other acts of mal administration by public servants, including those serving in government health care services.

Working in a challenging environment, the Karnataka Lokayukta has proven to be more effective than its counterparts in other states. It's success is due to a highly committed leadership working in a visible and proactive manner with impeccable credentials, outreach efforts to all 27 districts, immediate rectification through public hearings, engendering of attitudinal changes and high levels of public exposure through the media. It's work in health has focussed on addressing corruption, as well as monitoring services for basic standards: that health workers stay in their

posts, cleanliness of health institutions, availability of drugs for the poor, etc.

Although reproductive health concerns were articulated in the Task Force's work, improvements in this area have largely been indirect. Efforts have primarily focussed on improving the availability, quality and integrity of government services, without which more direct efforts to address reproductive health within the health sector would flounder.

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THEME 3
PRIORITY SETTING, ADVOCACY AND ACCOUNTABLILITY FOR SRH IN REFORM CONTEXT

POSTER

Title: Decentralisation and Accountability on Health Services for Women: Lessons from Bangladesh

Authors: Rina Sen Gupta and Shireen Huq

Abstract:

Background: The research was part of a multi-country study on Gender, Citizenship and Governance undertaken by The Royal Tropical Institute in Amsterdam, Holland. The Research built on Naripokkho's prior work on Women's Reproductive Health and Rights and its advocacy work with the Government of Bangladesh in connection with ICPD and its follow up.

Research objectives: The research addressed the issue of developing effective state accountability as a critical aspect of the assertion of citizenship rights. The research did so by (a) examining the delivery of health services at an Upazila Health Complex focusing in particular in its treatment of women, and (b) initiating citizen actions and reactivating established accountability mechanisms. In doing so it explored the role that external catalysts can play in activating government accountability mechanisms and in making health services gender sensitive.

Methodology: A primary survey was done using a structured questionnaire to assess women's health needs and the quality of services provided to women and to identify the critical factors that inhibit accountability.

Regular monitoring of the Upazila health facility was carried out through regular outdoor and indoor visits and observations recorded.

To achieve this the project worked with the health service providers of the Pathorghata Municipality, as well as women's groups and patients in the area.

The findings of the survey and the regular monitoring were then presented in different dialogue sessions with the local health authorities,

local Member of Parliament, journalists, members of the municipal council as well as local administration.

The principle strategy that Naripokkho followed was to activate the Upazila Health Advisory Committee, which is a formally constituted body of the government, and make it play a regulatory role ensuring accountability of the government health services at the local level. In order to this, Naripokkho carried out the following activities:
Raising awareness about the health problems of women and the problems with the delivery of health services.

1. Technical support to members of the UHAC, local leaders, government health service managers and providers to review the reality of the health services and develop actions for improvement.
2. Facilitate the monitoring and collection of information by a local NGO partner and compilation, analysis of data and preparation of reports.
3. Building capacity of local women's groups and women patients to hold the health services accountable.

Findings: The research showed that the first step towards setting up a system of accountability of governance institutions is to create *a culture and demand* for accountability. Results indicate that the UHAC, which has a multi-stakeholder representation, proved to be effective in ensuring accountability of the local health service.
The action research project has created awareness about women's health and rights among women in the locality, and has encouraged women to assert their rights as citizens by making demands on the government health services and protest any wrong doings. The community as a whole has gained from this and not only women.

Conclusion: Merely building formal supervisory structures cannot ensure accountability of governance institutions. What is required is creating a culture of demand for accountable services and an active partnership of state and civil society stakeholders in making institutions accountable to the public they are supposed to serve.

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THEME 3
PRIORITY SETTING, ADVOCACY AND ACCOUNTABLILITY FOR SRH IN REFORM CONTEXT

POSTER

Title: Mainstreaming gender equity in health sector reform: The Chilean case

Author: Elsa Gómez

Abstract:

Introduction: The advocacy processes reported here are part of the "*Mainstreaming Gender Equity in Health Sector Reform*" initiative coordinated by the *Gender and Health Unit* of the Pan American Health Organization (PAHO) with the support of the Ford and Rockefeller Foundations. This initiative is currently developed at the Regional (Pan American) level and in two Latin American countries, Chile (since 2001) and Peru (since 2002). It will be extended in 2004 to Nicaragua, Guatemala, El Salvador and Honduras, with support from the Governments of Sweden and Norway.

Objectives: The "*Mainstreaming Gender Equity in Health Sector Reform*" initiative constitutes an attempt to bring together stakeholders from government, civil society and academia for the following three main objectives:

a) Generate policy oriented information and knowledge about gender inequities in health and sexual and reproductive health (SRH) within the context of health sector development (HSD).
b) Use this knowledge to advocate the incorporation of a gender equity perspective into HSD policies.
c) Create mechanisms to institutionalize both, a gender equity approach in key HSD government agencies, and the participation of civil society in policy formulation and monitoring processes

Characteristics of the Chilean context:

a) A 20-year history of health sector reform that retains a strong public sector with a steadily increasing encroachment by the private sector.
b) A heated debate between government, associations of health professionals, and the private sector regarding HSD legislation.

c) High rotation of key political actors: three Health Ministries and two Women's Ministries in two years
d) An active women's health movement, however more interested in specific gender issues (abortion, emergency contraception, gender violence) than in the development of public policy at the macro level.

Project's main results:

a) In the area of the *generation of knowledge,* a partnership between academia and the women's health movement produced analytical tools, and policy oriented information and proposals that served as basis for dialogue between government and civil society.
b) *In the advocacy arena,* the technical team, in consultation with a Political Advisory Committee, supported:
   - The MOH production and dissemination of a gender policy document in HSD.
   - The creation of an information network with some 150 organizations and individuals.
   - A continuous dialogue between women's groups and the executive and legislative branches of government.
   - A series of intersectoral seminars and workshops and a research project on the subject of women's economic contribution as informal unpaid caregivers which raised awareness among government officials about the need to introduce a gender approach to the National Health Accounts.
   - Several subnational, national, and international for a to discuss SRH issues and other gender equity challenges related to HSD.
   - The mobilization of women's groups into an assembly named the *Women's Parliament for Health Reform,* which presented demands to the Health Ministry.
   - A communicational campaign that secured press coverage of the events held by the project; dissemination of publications to the media; steady production of journalistic items and columns; press conferences; and delivery of situation reports to inform women's groups.
c.) In the area of institutionalization
   - A formal agreement was signed between PAHO and the Ministry of Women to collaborate in mainstreaming gender in health sector policy.

- The project's technical team is also furthering with UN agencies the interest of government officials to mainstream gender in National accounts.
- Negotiations are underway to constitute an Observatory of Gender Equity in Health policy based in the University of Chile which would coordinate similar efforts at the Regional level.

Some lessons learned

a) Continuity and maturation of the project's fledgling achievements at the government level were curtailed by continuous changes in Ministerial authorities which demonstrated the need to reinforce actions directed to the more stable sector of policy making, i.e., civil society.
b) Severe obstacles have yet to be overcome regarding a less than enthusiastic attitude towards citizen participation in policy making (encountered, albeit for different reasons, not only within government but also among women's organizations)
c) A partnership between academia and the women's health movement proved to provide a solid foundation for working at more influential levels in terms of policy and social control.
d) The production of information and knowledge on gender, SRH and HSD contributed to a discussion on gender issues that involved social sectors beyond those strictly concerned with health and women's affairs.
e) A communication strategy is crucial to rally women's groups around public policy issues and heighten the impact of advocacy on the decision-making levels.

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THEME 3
PRIORITY SETTING, ADVOCACY AND ACCOUNTABLILITY FOR SRH IN REFORM CONTEXT

POSTER

Title: Priority Setting Methodologies for Reproductive Health: A Case Study of Breast and
Cervical Cancer in Ghana

Author: Laura Reichenbach, Research Scientist, Harvard Center for Population and Development Studies

Background and purpose of research: This poster presents a priority setting methodology that incorporates measures for the impact of organizational and political factors on priority setting processes for reproductive health issues. The priority setting methodology is illustrated through the case study of priority setting for breast and cervical cancer in Ghana during the period 1990-1997. This methodology suggests that frequently employed priority setting tools such as cost-effectiveness analysis and disability-adjusted life years (DALYs) do not consider organizational and political influences on the priority setting process and therefore cannot fully explain or predict which health issues are successfully prioritized. This is especially important when these priority setting tools are applied to SRH issues which often become politicized.

Data and methods: The research develops and applies a new empirical measure of priority setting – policy priority – which incorporates empirical measures of political and organizational attention to an issue. The research was conducted in Ghana in 1996 and 1997. Data collected includes: 115 key informant interviews with senior policymakers, field personnel working on reproductive health, and program managers in Ghana and senior policy makers and program managers in the international women's health community working on reproductive health. International and national policy documents related to reproductive health and reproductive cancers were reviewed as well as Parliamentary proceedings. The international and local medical and scientific literature was reviewed and media attention to breast and cervical cancer in Ghana during the period of 1990-1997 was also examined. Research methods included: content analysis of interviews and documents, secondary analysis of

epidemiological and economic data related to breast and cervical cancer for the years 1990–1997, media analysis, and an in-depth comparative case study of breast and cervical cancer.

Key findings: The case study of breast and cervical cancer in Ghana during the period 1990-1997 illustrates how traditional priority setting methods such as CEA and DALYs do not explain the priority given to breast cancer in Ghana during the period studied. It also demonstrates how the priority setting process can have unexpected and unforeseen equity and social implications. Despite attempts by international technical agencies that address SRH issues and the support of the MOH in Ghana to address cervical cancer, national women's groups outside the health sector in Ghana successfully prioritized breast cancer over cervical cancer. They did this without using or referring to traditional priority setting tools such as CEA and DALYS. They also achieved this without dialogue with HSD or SRH actors.

Lessons and conclusions: Traditional priority setting methods do not explain the higher priority for breast cancer over cervical cancer in Ghana. This is because these methods do not take into account the social and political context of priority setting. Without considering these aspects a complete picture of national health priorities is not possible. This poster presents an argument for the inclusion of both normative and empirical indicators in determining priorities but does not call for the rejection of normative measures or "evidence" which are important as they provide a common metric for discussion and comparison. This poster also suggests the importance of expanding beyond the SRH community of actors to include other groups in the priority setting process for reproductive health.

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THEME 3
PRIORITY SETTING, ADVOCACY AND ACCOUNTABLILITY FOR SRH IN REFORM CONTEXT

POSTER

Title: Using the United Nations Process Indicators on Emergency Obstetric Care to assess and monitor health system development

Authors: Lynn Freedman, Associate Professor of Clinical Population & Family Health
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Abstract:
To prevent maternal deaths, women with life-threatening obstetric complications need access to good-quality emergency obstetric care (EmOC). In 1997, UNICEF, WHO and UNFPA issued the 'UN Process Indicators' to assess and monitor the availability, utilization and quality of these EmOC services. Based on a specific package of medical services that must be available at health facilities to save women with direct obstetric complications, the UN Process Indicators have proven to be a practical tool linking the progress toward reduction of maternal mortality with the development of the health system. UN Process Indicator data from several Averting Maternal Death and Disability Program (AMDD) projects will be used to demonstrate the utility of this tool.

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SUMMARIES FROM WORKING GROUP DISCUSSIONS

Accountability

Priorities to be addressed

- Accountability is a process, not a goal in itself
- Accountability is about consultation, but also enforcement, punishment and monitoring
- Accountability is a series of relationships among different groups – context specific
- Accountability to SRH is challenging because conservative groups may not agree on gender, sexuality and abortion.
- Devolution (not necessarily other forms of decentralisation) does improve accountability
- Little consultation/participation in policy implementation
- Need to hold accountable both those with and without power
- Democratic values and contexts are important; in war/conflict contexts accountability is critical, especially of donors

Strategies

- Develop mechanisms of consultation/participation in policy implementation
- Enhance representation of civil society – e.g. women's NGOs, but check how representative they are
- Develop accountability contracts – needs transparency, consultation and capacity
- Need to document different models of accountability and enforcement experiences
- Use/undertake legislative measures to open spaces and improve accountability e.g. anti-corruption act, right to information act.
- Use media, opposition groups, social movements etc. to promote accountability

Promotion of dialogue

- Health systems and ministerial personnel should promote inclusive consultation for development of accountability mechanisms
- SRH advocates should network with legal groups, women's groups/civil society organisations, media etc. to promote accountability in government, especially for SRH

Advocacy

Priorities to be addressed

- Different countries may have/need different priorities for advocacy
- Advocacy priorities may be influenced by donor agendas
- Advocacy priorities may be developed individually or as consensus by many groups

Strategies

- Develop evidence base for informed advocacy
- Use Millennium Development Goals (MDGs) – lobby and participate at national level to promote SRH
- Link HIV/AIDS and SRH (use HIV agenda and funding as a way in)
- Set financial allocation targets and lobby to meet these – e.g. 8-10% aid to SRH
- Access Global Fund via own countries to promote SRH
- Develop and use evidence to educate, advertise and inform
- Use variety of methods for advocacy – media, traditional communication methods etc. being sensitive to national contexts
- Train and use network of journalists
- Form alliances for advocacy: in HSD + with weak health sector stakeholders (midwives, nurses), outside health sector (consumer organisations, trade unions, judiciary), & with political leaders/parliamentarians. May need to identify/establish an organisation to lead the alliance
- Liaise with business leaders/organisations, popular figureheads etc. to find champions

Promoting dialogue

- Don't insult each other
- Try to speak same language
- Participate in development and use of priority-setting tools
- Explore ways to use existing groups and meetings
- Demand that SRH people are invited to/involved in HSD meetings and processes

Priority Setting

Priorities to be addressed

- Official & theoretical processes rely on biomedical/individual opinions (including donor priorities) – Global Burden of Disease & DALYs don't adequately reflect SRH
- Lack of data to use for SRH priority setting
- Real-world priority setting reflects budget constraints, poor management information systems etc.
- Need to make and be aware of the distinctions between need (epidemiological information), demand (defined by public) and supply (defined by health services providers)
- Should services be provided to maximise outputs with cost-effectiveness as main consideration **or** should services emphasise rights of the poor and marginalised? Can they do both?

Strategies for action

- Develop a wider, holistic understanding of SRH issues
- Develop clear tools for priority setting
- Evidence base needed for SRH and poverty impact, including tools to collect data on broader SRH issues (e.g. on gender-based violence)
- Need to revise/ develop new tools to replace DALYs and cost-effectiveness Burden of Disease analysis (e.g. include views of sick people in hospitals; community ranking of health priorities)
- Develop methods on how to promote a truly participatory approach to priority setting - involving communities in decision-making, especially at national level, as well as SRH advocates, NGOs etc.
- Inclusion of wide network of stakeholders in SRH priority setting and give them visibility through institutional mechanisms, e.g. legal framework
- Ensure SRH inputs into priority setting e.g. getting SRH components into essential and insurance packages
- Strengthen expenditure tracking and capacity to make better use of available information
- Training at service delivery level in priority setting

Promoting dialogue

- Understand common objectives: scope for collaboration between human rights and epidemiology specialists
- Develop a common language – joint development of 'needs-ranking' methodology
- SRH specialists should identify specific areas for special monitoring at then local level (e.g. quality of care, funding, staff movement, equity, access)
- Lobbying (with the common language) (for involvement, change etc.)
- Continue the dialogue

Decentralisation

Priorities

- Clear roles/responsibilities, especially if there is a move to integration of services
- Clear priority setting mechanisms with stakeholder representation (SRH, local as well as national, poor); including indicators incorporating national standards and local targets
- Issues of capacity to manage decentralisation + logistic, training, financing implications & how these affect sexual and reproductive health and service delivery
- Equity: need clear documentation of benefits
- Need political commitment for SRH in MDGs, PRSPs & any health sector development plans

Strategies for Action

- Harmonise service delivery
- Develop inclusive negotiation mechanisms (national and local)
- Develop evidence base through research & documentation of effects of decentralisation & what factors/conditions influence these
- Develop consensus at local & national levels and on thematic issues
- Strengthen health systems to deliver services at local level
- Promote awareness of importance of SRH by showing its linkage with poverty reduction

Promotion of Dialogue/collaboration

- Promote South - South as well as South - North interactions and partnerships to share experiences & identify points of common ground
- Organise groups for local voices
- Dissemination of research results
- Develop legal framework for dialogue among stakeholders
- Ensure Chairs/organisers of policy meetings are informed of importance of SRH representation

Human Resources

Priorities to be addressed

- Need to recognise the impact, often adverse and difficult, on health workers
- Evidence base for effect of reforms on human resources
- Reorientation of HR to patients and accountability
- Development of local process and autonomy are critical
- Issues of brain drain especially from poor/rural areas
- Job/skills identification
- Investment in training, releasing capacity, empowerment and monitoring

Strategies for action

- Involve professional bodies in HR policy development
- HR training should go beyond technical skills and include rights, gender, sexuality, power relations, norms
- Develop evidence base to inform management, planning and advocacy
- Develop appropriate incentives for health staff to reduce brain-drain

Promoting dialogue

- Involve professional bodies in HR policy development
- Consultations with health providers on policy changes and issues of incentives

Multi-sector links

Priorities

- Recognition of need for systems design to incorporate intersectoral coordination mechanisms with equally important areas such as education and transport
- Need greater recognition of links between household, sector and government policy levels
- Other sectors involved in SRH: Education, Infrastructure/Transport, Labour
- Different sectors impact at different levels – e.g. household (gender, legal framework), health/other sectors (education, infrastructure, health services), policy, legal issues

Strategies

- Link champions in civil society across sectors and levels
- Get cross-cutting issues (gender, HIV) into PRSPs, HIPC etc.
- Work with female jurors on legal framework
- Establish cross-sectoral working groups
- Learn from other sector good practice
- Sectoral ministries to have incentives to work with poverty linked health outcomes
- Audit mechanisms and identify focal points for cross-sector collaboration e.g. MoH = SRH-HSD link + links with other sectors; Other Ministries to look at health and gender links; donor to support these interlinks.

Promotion of Dialogue

- Mediated language: teach SRH advocates the language of reformers (e.g. WBI Course)

Programme Integration

Priorities to address

- No single model for integration – context specific
- Need clearer understanding of integration and co-ordination, especially as between different sets of interests. Where do they mean the same and different things? Are they compatible views?
- Need comparison of models: cost-effectiveness, benefits, competence etc.
- Client needs/preferences paramount, but provider satisfaction also important
- Budgets – vertical funding but promote integration
- How far does SRH continue to require ringfencing of finances and structures to maintain its priority? What is the trade off between this and the advantages of integration?
- Clear policies, tools and guidelines needed
- System-wide improvements are essential for SRH

Strategies for Action

- National level develop clear policies, tools & guidelines on integration through negotiation and co-ordination - involve SRH, HSD and financial stakeholders
- Adapt budget allocations to better promote the chosen form of integrated service delivery
- Develop evidence base and disseminate findings/lessons through publication & dialogue

Promoting dialogue

- Design coordinating structure – e.g. committees to oversee development of integration policies/guidelines
- Involve SRH, HSD and financial stakeholders when designing logistic and financial mechanisms for integration

Insurance Schemes

Priorities to be addressed

- Need to build capacity to enhance engagement
- Articulate rationale for importance of SRH
- Need equity built into a social scheme
- Benefits depend on context
- Issues of acceptability, accessibility, affordability & availability
- Risk-sharing principle needs to be understood
- Requires political commitment

Strategies for action

- Proactive inclusion of SRH services in insurance packages including maternal care
- Stimulate demand for preventive services
- Further research to clarify what insurance 'can' and 'can't' do
- Educate adults to accept risk-sharing
- Use right set of incentives (who defines these?)
- Develop mechanisms for including views of community (including marginalised groups)
- Advocacy for policy makers

Promoting dialogue

- Involve range of stakeholders, including community & SRH advocates, in development & monitoring of insurance schemes
- Advocacy for and with policy makers, community & other health partners – foster cooperation through meetings/ information sharing etc.

PRSPs/HIPC/Macro-financial initiatives

Priorities to address

- Consensus needed on strategies
- Risks associated with raising profile of 'sensitive' issues (abortion, sexuality etc.)
- Weak budget management and monitoring – in medium term, social sectors may lose out
- Increase advocacy capacity (of SRH advocates) & expand partnerships (national, international SRH-HSD etc.)
- Target gender inequality

Strategies for action

- Develop range of specific SRH indicators
- Cost/analyse the poverty impact of SRH/quality of life/ill health linked to RTIs, violence, lost productivity etc.
- Use the evidence we do have – DHS data, World Bank equity data etc. – SRH indicators come out consistently the most unequal (between rich and poor).
- Develop and support mechanisms for consultation + capacity for advocacy: inclusive, transparent, continual
- Promote South-South leaning and knowledge sharing

Promoting Dialogue

- Establish networks for information sharing

Public-private mix

Priorities to be addressed

- Lack of knowledge about what works
- Need public subsidies that benefit the poor
- Strategies must be context specific – national governments should drive the design
- Need to speak the same language and foster mutual respect
- Clarify terminology – public-private
- Capacities/attitudes of both public and private sectors are major challenge – need regulatory functions
- Need to define criteria of 'success'

Strategies for action

- Look at what private sector offers SRH – may be necessity in some settings
- Strengthen capacity and quality with protocols, recognition and allowing contribution of private sector
- Research urgently needed to identify and learn from PPPs on appropriateness to SRH including equity & accountability issues – through dialogue/exchange of ideas
- Develop mechanisms to make HSD and SRH stakeholders accountable to each other
- Recognise and use the profit motive
- Promote strategic/tactical use of subsidies
- Develop criteria for 'success': could include health outcomes (equity, access), sustainability, household budgets, long-term public sector implications.

Promoting dialogue

- Analyse and build on existing structures to learn lessons
- Consultation with new stakeholders
- Sharing of experiences through workshops, conferences & documentation of best practice
- Consultation to broader range of stakeholders including NGOs and other SRH partners
- Documentation of SRH experiences in HSD language early in development of strategies

Sector-Wide Approaches/Donor aid co-ordination

Priorities to address

- All levels of government & donors need to understand SWAp
- Building government capacity takes time – governments must know their priorities
- SRH critical for poverty and development goals
- SRH actors need to be involved in the SWAp process
- Is HIV in or out of the SWAp – what effect on SRH?
- Coordination of human resources (in SWAp/non-SWAp) critical
- Issue of earmarked funds in the SWAP

Strategies for action

- Connect PRSPs to SRH since SWAps are often linked to these
- Generate evidence on whether SWAps, direct budget support or other donor coordination mechanisms have reduced SRH programmes or not – the role, opportunities and threats
- Document lessons from key mechanisms and experiences
- Ensure women's groups and NGOs are included as stakeholders in PRSP and SWAp development process
- SRH specialists need to understand the new processes in order to participate and advocate well
- Ministries of Health need capacity building and awareness raising re: importance of inclusive consultation and importance of SRH for poverty goals
- Donors can still earmark SWAp funding for SRH
- Need to develop monitoring, evaluation & accountability procedures
- New name for 'donor coordination' = 'Development Partnership'

Promoting Dialogue

- Dialogue between communities
- Reformers and technical people must learn each other's language

User Fees

Priorities to address

- What are the fees for?
- Is there any leverage for quality? – only if there is real choice
- General evidence of negative effects of user fees: expensive to collect, don't work, discriminate because poor and women have less access to funds

Strategies for Action

- Develop a calculation of maternal morbidity in DALYs
- Generate cost-effectiveness data
- Involve stakeholders in plans
- Lobby and advocate for an alternative to user fees & end those that exist

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INTERNATIONAL CONFERENCE on LINKAGES

between Sexual-Reproductive Health (SRH), & Health Systems Development (HSD).

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Websites and further dissemination

Full presentations and working group discussion notes can be found on the following websites:

www.lshtm.ac.uk/cps/events/link/

www.nuffield.leeds.ac.uk/content/research/international_development/conf03.asp

A discussion board is being hosted, accessible from either website, we encourage participants and all interested parties to contribute comments, share examples and further debate.

Selected papers will be published in a special edition of the international journal Health Policy and Planning scheduled for September 2004.

An Action-Point document arising from the conference is being prepared and will be launched in 2004 as part of global ICPD+10 activities.