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Perpetuating power: some reasons why reproductive health has stalled

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Abstract: *The 1994 International Conference on Population and Development represented a paradigm shift from vertical population control programmes to the broad-based promotion of sexual and reproductive health as human rights, through strengthening of health services and dealing with the underlying social determinants of health. In its Programme of Action, the global community set ambitious targets for reproductive health, based on strong political will among senior politicians and supported by many grassroots NGOs. Today, too little progress has been made, and the targets are not expected to be met. One of the reasons why may be that support for the reproductive health agenda has been de-politicised, with a focus on management and technical issues instead of unleashing the power necessary for change. Two other contributory trends, affecting more than reproductive health are discussed. Firstly, there has been a call for measurable goals and the use of indicators as a basis for planning, instead of valid and reliable measures for monitoring complex processes. This has led to a new form of vertical programme in reproductive health, in which the comprehensive nature of reproductive health has been left out, and a narrow definition of maternal health has been singled out for attention. Secondly, instead of nurturing the different roles of different actors in the struggle to achieve better reproductive health, the focus has been on coordination and harmonisation, which are not appropriate for dealing with controversial issues.* ©2011 Reproductive Health Matters. All rights reserved.

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AT the time of the International Conference on Population and Development (ICPD) in Cairo in 1994, the Programme of Action that was agreed was rightly seen as a paradigm shift.[1] The dominant population control paradigm was consigned to history and replaced with a new one that put reproductive and sexual health at the centre, framed in human rights with a strong focus on gender equality and empowerment of women. One year later, the Platform for Action of the 4th World Conference on Women in Beijing confirmed and reinforced many of the decisions from Cairo, in addition to its main focus on gender equality.

Top-heavy and broad-based political will combined, but little change

Both conferences involved UN member states in negotiating a document phrase by phrase, word by word. NGOs played an important role in lobbying and providing input to these negotiations. Some of the feminist NGOs were excellently organised and were very successful in building alliances with negotiators from like-minded governments, and they succeeded in influencing the outcomes substantially.[1] These conferences were broad-based, political processes, and also had substantial involvement of civil servants from member countries. While

there are shortcomings in the agreements from both conferences, they were rightly seen, at the time, as very progressive. A lot of optimism was created, as the strong political will demonstrated was expected to be transformed into changes on the ground.

This sense of imminent change was reinforced when the Millennium Development Goals (MDGs) were formulated at the turn of the century. Reproductive health was prominent, in that all three of the health goals were related to reproduction and sexuality. MDG4, reduction of child mortality, could only be achieved if neonatal mortality was substantially reduced, and that called for improved obstetric care. Reducing maternal mortality, MDG5, is at the heart of sexual and reproductive health. HIV, the sixth goal, is part of sexual health. The MDGs were adopted by a large number of heads of states and heads of governments at the Millennium Summit, held in September 2000. The process was by no means as inclusive as with the Cairo and Beijing conferences, but strong political commitment at the top levels in countries was certainly expressed from around the globe.

Why the changes have not happened: a hypothesis

It is now generally agreed that reproductive health has not fared as well as foreseen. While some improvements in the MDG reproductive health indicators have recently been reported,[2] the world is still off track for achieving the agreed targets. With demonstrated political will at the top and so much support from NGOs, why do we have this state of affairs?

Based on my participation in several of the global processes related to sexual and reproductive health, I would suggest that while much of the opposition to improvements in sexual and reproductive health has been highly politicised, the support for them has been de-politicised in a way that has hampered progress. While there has been a lot of emphasis on overarching goals, conflicts in interests may have been neglected at the levels where the important decisions are made. This implies that the power to change was not unleashed and, as a result, the political will has not been translated into the necessary changes. In what follows, I will discuss some possible reasons for this. My belief is that good intentions – as expressed in the decision to prioritise activities that would lead to quick results, combined with neglect of attention to the power games at the different levels where important decisions are made – may paradoxically have hampered progress.

Measurements and yardsticks gone astray?

Recent years have seen an increased focus on measurable goals and targets. In health care, evidence-based medicine came as a reaction to the use of interventions that were ineffective or even harmful.[3] In development assistance, there has been an increased call for interventions that can have an impact and are worth the investments. Many donors have introduced requirements for measurement, goals, targets and benchmarks to an extent not seen earlier as a part of efforts to increase aid effectiveness.[4]

But too much of a good thing can be harmful. In medicine, there is increasing awareness that the gold standard of double-blinding and case-controls are not applicable to all aspects of health research.[5] And in development assistance, not every change can be measured with simple yardsticks.[6] Complex situations call for decisions that are also based on experience and competence, and what has been called "informed creativity"[7] and not just simple interventions that can be subjected to mathematical calculations. There is a need for good indicators. But even more, there is a need for the understanding of proper use of such indicators, such as the indicators that were agreed in Cairo and with the Millennium Development Goals.

Reproductive health indicators agreed at global level

The ICPD set a lot of targets, based on an acknowledgement that improved reproductive health outcomes result from many processes. In the Programme of Action, there are ideals and goals for poverty eradication, ensuring environmental sustainability, education, gender relations, rights of persons with disabilities, indigenous groups and others. The quantified targets that are most specific for sexual and reproductive health are:

- reduction of the maternal mortality ratio (MMR)
- reduction of the infant mortality rate and under-five mortality
- provision of family planning services

- access to reproductive health for all individuals of appropriate ages, through the primary health care system.[8]

In addition, ICPD made general statements in relation to provision of health services to prevent and manage sexually transmitted infections, to combat female genital mutilation and HIV/AIDS, promote breastfeeding, and more.

The ICPD Programme of Action recognised that sexual and reproductive health was a package, requiring a cluster of inter-dependent activities. Bernstein and White call them "fundamentally interrelated, and unachievable without the others".[9] This comprehensive approach was a reaction to vertical family planning programmes, and to the neglect of sexuality and gender issues in family planning programmes. It was also a reaction to the knowledge that the mother-and-child health approach (MCH), which worked for improving child health, had been ineffective for women's health.[10] Paradoxically, the selection of the maternal mortality ratio, carried across as an indicator for MDG5, has led to a new type of verticality.

As mentioned above, all three health Millennium Development Goals are relevant to reproductive health. In addition, MDG3, promotion of gender equality and empowerment of women, is an underlying determinant of reproductive health, as are reduction of poverty and hunger, and improved education, which are other MDGs. Still, the MDG that most intimately represents reproductive health is MDG5, reduction of maternal mortality, which originally was the only target of that goal. In the spirit of ICPD, and if we accept that Bernstein and White's statement is true, maternal mortality reduction indicators can be seen as indicators of the functioning of all components of reproductive health care, combined with the underlying determinants and indicators for the functioning of health services. This was acknowledged at the ICPD+5 negotiations in 1999, where it was decided that "in health sector reform, the reduction of maternal mortality and morbidity should be prominent and used as an indicator for such reform" (para.62b).[11]

Maternal mortality ratio as an indicator for sexual and reproductive health

In recent years, there seems to have been a huge increase in the use of the term "indicator", which warrants discussion.

If we want to measure something that is complex and multifaceted, we have to find good yardsticks. This means something which is not only possible to count and acquire data on, but which is valid as well (telling something important about what we want to measure) and reliable (different persons will get comparable results). In addition, an indicator must be robust, which implies that it can act as a buffer against the bias which attention brings when an indicator has been selected. An example of such a bias, taken from health service provision, is when the coverage of immunisation is used as an indicator for health system performance more broadly, and levels of coverage are reported to the UN and other regional and global bodies. Once it becomes known that immunisation coverage is important enough to be used as an overall yardstick, it becomes the pride of national authorities and health professionals to achieve high coverage, and immunisation is given very high priority, which may potentially reduce the priority, attention and resources given to other equally important health issues. This bias decreases the validity of immunisation as a measure for the overall functioning of the health services.

Similarly, before maternal mortality reduction was selected as a Millennium Development Goal, it could be considered as a good indicator of all the elements of reproductive health. But in practice, it turned out not to be so. Why? Because it soon became apparent that there was a zooming in on maternal health care, often with the justification of ensuring that mothers should remain alive for their children. In turn, the linking of maternal health to child health was justified by the fact that newborn mortality had not been falling or falling too slowly compared to overall child mortality,[12] because newborn survival is strongly linked to maternal survival. For the survival of bigger children, the importance of a living mother has also been emphasised.[13] The term "maternal health" brings to mind mothers' health. But maternal health is in fact about pregnancy and the outcome of the pregnancy – be it the delivery of a living child, stillbirth, induced abortion, or miscarriage. These dimensions have been lost, not necessarily because of the indicator as such, but because of the way it has been interpreted and used.

Skilled attendance as a proxy indicator: further simplification

In addition to being valid, reliable and robust, an indicator should not require an abundance of resources for something to be measured. During the ICPD+5 negotiations, many felt a need for urgent change, as it had already become clear that maternal mortality reduction was lagging behind. Many also began to doubt the usefulness of the maternal mortality ratio for monitoring change from year to year and for small populations, because the number of deaths involved was small. This called for a process indicator. The importance of skilled attendance at birth for survival of women had been documented,[14] and this was seen as a parameter that was easy to measure. It was therefore agreed at ICPD+5 to adopt the proportion of deliveries attended by a skilled attendant as a benchmark indicator (para.64).[11] Again, it may not have been intended, but with hindsight, this seems to have contributed to the narrowing down of approaches to maternal health, specifically to the zooming in on delivery care by skilled attendants, even to the point of paying pregnant women to go to health institutions for delivery without improving the quality of delivery care they would receive,[15] and at the same time neglecting their other, often considerable, reproductive health needs.

Another decision made at ICPD+5, which had the potential to place maternal health more at the heart of health care and counteract verticality, was to use maternal mortality reduction as an indicator for the success of health sector reform (para.62b).[11] This reflected an awareness that in order to be successful, pregnancy-related care has to be fully integrated into health services, not delivered vertically. Yet compared to skilled attendance at birth, this indicator has gained very little recognition and is underutilised – precisely because the goal is a complex one to reach.

An attempt to return to comprehensive reproductive health services under MDG5

The UN General Assembly in 2005 adopted a resolution adding a new target to MDG5. That target (5b) states there should be universal access to reproductive health by 2015, similar to an ICPD target. This was adopted after a lot of groundwork in countries and after fierce discussions, bringing up the whole controversy around reproductive health.[1] The adding of target 5b could be seen as a return to the holistic view of reproductive health as a centrepiece of health care, one that underpinned the Cairo consensus. But it came late, and in many countries they had already zoomed in on delivery care. Moreover, there was a need for easily measurable indicators for the new target. Four were chosen: contraceptive prevalence rate, adolescent birth rate, antenatal care coverage and unmet need for family planning. These indicators are for highly laudable goals in themselves, but are hardly reachable without comprehensive, high quality reproductive health services. The question is whether these indicators can function as the necessary tools to motivate the change that is needed throughout health services.

The power to create change

The return of a power discourse?

In order to reach pre-set goals on which there is common agreement, a good management plan is needed. This is as true for the Millennium Development Goals as it is for the Cairo and Beijing action plans, which contain the elements for such a management plan. But in each case, these agreements were the result of a series of compromises, compromises that reflect inbuilt tensions that need to be resolved for the plans to be implemented. Why? Because the tensions arise from values-related issues that are essentially political and need to be resolved through the redistribution of power.

In the lead-up to the General Assembly 2005, the Millennium Project assigned a group of well-known technical experts in the field to map out what would be required to reach the Millennium Development Goals on women's and children's health. Their report, *Who's Got the Power? Transforming health systems for women and children*,[16] prescribes changes in priorities and reallocation of resources, in order for ordinary health services to be able to handle emergencies in relation to pregnancy, and for communities and health systems to provide children with necessary health care. It calls for targets that are equity-sensitive and states that the "trickle-down approach to addressing disparities will never work". In essence, the report calls for

political tools to solve the *political* problem of inequity in access to services. That means dealing with conflicting interests and making priorities in the context of the struggle over meagre resources. The report also calls for "tackling the social, economic, and political context in which people live and in which health institutions are embedded". But this is not the kind of perspective informing how "indicators" are increasingly being used. The report stresses the need to look beyond numbers reached to determine the longer-term health impact of the intervention and who has benefited from it.

Emphasis on management, neglect of power dimensions

Reproductive health does not exist in a vacuum; it is affected by more general views on how societies should be organised. According to Ewald,[17] there is a growing tendency globally to view all organisations with the same lens. In this way, he argues, it is taken for granted that public institutions should be run along the same principles as private companies. Businesses develop models and procedures that have later been recommended for and adopted by the public services. Thus, patients have become consumers of health care and clients of health services, while health professionals have become human resources. In line with this thinking, partnerships, coordination and harmony are proposed – not just for the production of consumables, but also to produce public goods. Downplaying the importance of conflicting interests, and the ways in which those differences can be handled, can be especially harmful in relation to controversial areas and areas where injustice and social inequality are prominent, which includes sexuality and reproduction.

An example: the Partnership for Maternal, Newborn and Child Health

While the ICPD process was essentially political, its Programme of Action is strangely silent about power. The handling of opposing forces and conflicting interests is described as something that calls for balance, compromise and harmony rather than struggle. In retrospect, there also appears to have been neglect of the role of power in the way in which implementation of ambitious plans has been attempted. An example of this is the creation of the Partnership for Maternal, Newborn and Child Health.

The Safe Motherhood Initiative was launched in 1987. It was created after it became known that the mother-and-child health approach had failed to improve women's health.[10] After the Millennium Development Goals had been adopted, and reduction of maternal mortality had become so prominent, an attempt was made to strengthen the Safe Motherhood Initiative. After a long and complicated process, the Partnership for Safe Motherhood and Newborn Health was formed, which in 2005 merged with the Child Survival Partnership to become the Partnership for Maternal, Newborn and Child Health (PMNCH).

The Partnership, as the Safe Motherhood Initiative did, sends a strong signal that what is required is coordination and harmony. Presently, the Partnership has about 260 members, including governments and governmental agencies, universities and other research institutions, NGOs and networks and umbrella NGOs, hospitals, UN agencies and the World Bank. Each of these organisations has their own decision-making bodies and constituencies, and they are fundamentally different in nature. Not surprisingly, the Partnership has taken a long time to find ways of working, so long that it is questionable whether it has been worth the cost in terms of the money and time it has consumed. Partnerships may be a rational way of organising production according to an agreed production plan, but the question remains whether such a set-up is at all appropriate for handling politically controversial issues such as reproductive health, of which maternal health is such an intrinsic part.

While it may be harsh to say it, at a certain point the Partnership's remit became almost a parody of what earlier had been a comprehensive approach to reproductive health, including family planning and care for women who get pregnant, and deliver or have abortions. On their website they had the following slogan: *No mother should die unnecessarily from their newborn*. One could tick a box to agree with the statement, and would then automatically get on a circulation list to receive information. Yet, around the world, states, institutions and individuals look to such global structures for guidance and for justification of their actions.

Not just for reproductive health: giant ideals and mega-plans vs. the messy reality of power

Global plans are mega-plans, and the decisions that are eventually needed for making a difference must be taken at many different levels. Researchers have examined what happens when lofty ideals meet the reality of everyday life. Catherine Weaver, for example, has analyzed the World Bank and found that there are huge discrepancies between what is said and what is done by the Bank, which she calls a hypocrisy trap.[18] She explains that the trap is so hard to escape because "hypocrisy" is the result of having to handle contradictory demands.

Danish researcher, Bent Flyvbjerg, in an analysis of mega-projects in construction and urban planning, also found an interesting mismatch between ideals and reality.[19] He uses planning in the Danish city of Aalborg as an example and a metaphor of the consequences when a huge plan, developed in accord with democratic processes and with the best of intentions, is implemented. The plan for Aalborg was to create buildings and outdoor spaces that were environmentally friendly, within agreed budgets and time periods, and accessible for all. They ended up exceeding budgets greatly, and with low quality construction, delays and poor access for people with disabilities. Based on this experience, Flyvbjerg talks about what happens when rationality (i.e. the plan) meets power (i.e. where all the decisions are taken). He argues that power defines and creates concrete physical, economic, ecological and social realities, and when rationality meets power, rationality loses and power prevails.

There are fundamental differences between the functioning of the World Bank, mega-plans for cities, and the ICPD Programme of Action and the MDGs. Still, there could be a lot to learn from studying an organisation (like the World Bank) or concrete structures (like a city) when analyzing abstractions such as the ICPD Programme of Action and MDG5. In order to make the Programme of Action a reality, a myriad of decisions are needed at various levels, both to rectify the conditions underlying reproductive ill-health and bring the necessary services into functioning. With decentralised health services, which are now the norm, the state's role is limited to stewardship.[20] Much of the prioritisation and decision-making processes that will eventually determine whether or not the necessary services will be put in place and sustained are taken at local levels, by decision-makers who are close to the problems and who experience, in very concrete ways, the shortages of financial resources and health service workers. In the power struggles that take place in these settings, ideals may easily lose out.

Confusion of roles

Alongside the undervaluing of political issues and an overly managerial approach to reducing maternal mortality, I would argue that there has been an increasing confusion of roles. In recent decades, many complicated charts have been produced, illustrating the different levels and multitude of actors needed to reduce maternal deaths. Such charts can be helpful in getting an overview of what is required, provide information and help actors select the most strategic approach. But they can also create a paralysing sense of having to deal with all possible aspects. Since we are dealing with technically difficult issues medically, socially and politically, the ability to interpet the myriad of data may be insufficient. The urge to do everything can lead to the failure to select a good strategy that fits the specific circumstances involved.

Since abortion is such a politically sensitive issue, it lends itself to good examples of the confusion of roles. The UN has to abide by what has been agreed by consensus among its Member States when it comes to norm setting. In terms of safe abortion services, this means that national legislation has to be referred to. The Cairo Programme of Action set the standard in para.8.25: *"In circumstances where abortion is not against the law, such abortion should be safe"*.[8] This is a normative statement. But the UN has many functions, one of which is to convey technically sound information, based in this instance on scientific evidence. The confusion of roles in a statement in a WHO document stands out in this respect:

"The vast majority of maternal deaths could be prevented if women had access to quality family planning services, skilled care during pregnancy, childbirth and the first month after delivery, or post-abortion care services and where permissible, safe abortion services."[13]

Here, it can be argued, WHO is mixing a technical, descriptive role with a normative role. The

evidence shows that safe abortion services reduce maternal mortality. But WHO is restricted by the political limitations on the UN, and can only say that safe abortion should be provided where it is not against the law, or, put in a more positive way, *"to the fullest extent allowed by law"*.[21] But the political restrictions do not change the fact that women die from complications of unsafe abortion, and that provision of safe abortion saves women's lives.

If WHO mixes up its roles, it is no wonder that individuals and organisations also do so. Even feminist NGOs at times add the phrase "where not against the law" every time abortion is mentioned, thereby unnecessarily censoring themselves and diminishing their potential influence.

The way forward

There is a lot of outright opposition to the provision of reproductive health services based on feminist values and human rights. This opposition has certainly been an important reason why progress in this area has been so slow. This analysis, however, has attempted to decipher some of the reasons why the promotion of the reproductive health agenda among its supporters has not been more effective, and why we have not been able to take more advantage of the strong political support expressed by global leaders and at the grassroots.

The suggestion here is that the reproductive health agenda has fallen victim to general tendencies that go far beyond reproductive health and even the health sector. The first is an overreliance on measurement that has led to a new type of verticality, where the comprehensiveness of reproductive health has been lost. This comprehensiveness is necessary also for successes in the areas that have been selected as targets, such as maternal health. Indicators have been used as simple planning tools, and not as valid indicators of complex, context-specific plans. While good selection of indicators is part of the answer, the inclusion of more strategic indicators could also make a difference. Composite indicators that take account of equity issues have a lot of potential for elucidating the social equity dimensions of maternal health, for example, and would help to focus efforts where they are needed. There are promising trends of increased focus on equity, related to the MDGs.[22]

Different levels of intervention also need different indicators. A reduction in the number of maternal deaths at a specific institution is not always a sign of improvement. I have observed health staff in developing countries who are eager to refer dying women in labour to another level, rather than trying to treat them or at least provide for a dignified death, because they are under pressure to improve their own statistics and do not want a death in their institution. Indicators should help health care managers and staff to improve their services, not the opposite.

Secondly, there is a tendency to an excessive belief in management and a corresponding disregard for the necessity of political processes that involve sensitive issues, such as reproductive health, in order to bring about the changes we seek to achieve. Coordination and harmony are not the best policy when there are differences in interests. The power issues should be acknowledged and dealt with explicitly as part of what is first and foremost a political process.

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Résumé

La Conférence internationale de 1994 sur la population et le développement a marqué le passage de programmes verticaux de contrôle de la population à une promotion à large assise de la santé génésique comme droit fondamental, par le renforcement des services de santé et le traitement des déterminants sociaux de la santé. Dans son Programme d'action, la communauté internationale a défini des objectifs ambitieux pour la santé génésique, basés sur une ferme volonté des dirigeants politiques et soutenus par beaucoup d'ONG locales. Aujourd'hui, trop peu de progrès ont été accomplis et les objectifs ne seront probablement pas atteints. L'une des raisons est peut-être que ce soutien au programme de santé génésique a été dépolitisé, la priorité

Resumen

La Conferencia Internacional sobre la Población y el Desarrollo, celebrada en 1994, representó un cambio de paradigma: de programas verticales de control de la población a la amplia promoción de la salud sexual y reproductiva como derechos humanos, mediante el fortalecimiento de los servicios de salud y el abordaje de los determinantes sociales subyacentes de la salud. En su Programa de Acción, la comunidad internacional estableció objetivos ambiciosos para la salud reproductiva, basados en una influyente voluntad política entre políticos de más alto rango y apoyados por muchas ONG de base. Hasta la fecha, se han logrado muy pocos avances y no se espera cumplir los objetivos. Una de las razones podría ser la despolitización del apoyo para la agenda

étant donnée aux questions techniques et à la gestion, au lieu de mobiliser la puissance requise pour le changement. Deux autres tendances ont contribué à ce phénomène et vont au-delà de la santé génésique. La première est l'exigence d'objectifs mesurables avec l'utilisation d'indicateurs comme base pour la planification, au lieu de mesures valables et dignes de foi pour surveiller des processus complexes. Il s'en est suivi une nouvelle forme de programme vertical de santé génésique, dans lequel la nature globale de la santé génésique a été négligée, et une définition étroite de la santé maternelle a été privilégiée. Deuxièmement, au lieu d'encourager les rôles différents des différents acteurs dans la lutte pour parvenir à une meilleure santé génésique, on a mis l'accent sur la coordination et l'harmonisation, qui ne sont pas adaptées pour traiter des questions controversées.

de salud reproductiva, con un enfoque en asuntos administrativos y técnicos en vez de desatar el poder necesario para realizar cambios. Dos otras tendencias que han contribuido y que afectan más que la salud reproductiva son el llamado a establecer objetivos mensurables y el uso de indicadores como base para la planificación, en lugar de medidas válidas y confiables para monitorear procesos complejos. Esto ha producido una nueva forma de programa vertical en salud reproductiva, en el cual se omite la naturaleza integral de la salud reproductiva y se enfoca la atención en una estrecha definición de la salud materna. Segundo, en vez de apoyar los diferentes roles de los diferentes actores en la lucha por lograr una mejor salud reproductiva, el enfoque se ha centrado en la coordinación y armonización, que no son adecuadas para tratar asuntos polémicos.

BELINDA STRONACH FOUNDATION

The G(irls)20 Summit (Paris, October 2011) is part of an international campaign called "3.3 Billion Ways", which is based on the premise that there are 3.3 billion girls and women in the world and therefore 3.3 billion ways to change the world.