Priority Setting of Sexual and Reproductive Health in Africa in the Context of Health Sector Reform: An Overview

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Introduction

Priority setting has to do with decisions about how to allocate limited resources (Reichenbach 2001: 1.)

Reichenbach offers a beguilingly simple definition of the process of priority setting. However, this chapter is interested in the many dimensions which inform, and sometimes impede, the process of appropriate priority setting in respect of sexual and reproductive health and rights (SRHR) in Africa. Central to this discussion about priority setting is a concern with the gender agenda in the context of health sector reform (HSR).

Priority setting is only one aspect of HSR. Ravindran (2001: 17) explains that, since the nineties, HSR falls into one of four categories or a combination of these aspects.

- Changes in mechanisms of finance, shifting the balance between those who contribute to the health budget, including private insurance, user fees and donor aids;
- Changes in the mechanisms used, resulting in provision of different services shifting between the public and private sectors;
- Changes in the role of the state. These shifts usually involve the state’s having less responsibility for direct health provision and more responsibility for regulation; and
- Accompanying changes in the organisational structures include decentralisation, integration of services, sector-wide approaches and reforms in logistics and supply systems (Ravindran 2001: 17).

Priority setting can play a role in each of these four categories and can determine the direction of change within each. This is so because the decision to engage in reform often reflects a desire to re-examine priorities and a perception that existing services are not addressing the needs of the users. Priority setting thus becomes the underlying mechanism which informs other aspects of HSR.

This chapter is concerned with the values that inform priority setting. More specifically, it considers how these values might be affected by the African context, by the nature of patriarchy, and by the fact that much of the budget in most countries comes from external sources in the form of donor aid.

AbouZahr (1999) explains that, in defining priorities around health reform in general and reproductive health in particular, there is a contestation among differing values. On the one hand, cost-centred efficiency and management driven systems can inform the development of priorities. However, if the driving value is equitable health for all, then perhaps another set of priorities would be established. In addition, there are also sometimes differences of opinion around priority setting between global and national policy makers. These differences
cannot easily be resolved. One factor which impedes resolution is that the mechanisms for priority setting are hampered by weak institutional frameworks that do not facilitate dialogue.

This chapter argues that in spite of recent attempts (a) to widen the scope of reproductive health from a narrow focus on fertility to a wider concern with women's health, and (b) to turn this more broadly defined area into a priority, HSR in Africa is driven by cost-focused efficiency which translates into a health system based on free markets, user fees and decentralisation. In addition, a vision of health which is based on a burden of disease (BOD) model has often excluded public health interventions which would bring gender into the equation of reproductive health.

The next section of the paper provides a brief historical overview of the development of the current approaches to SRHR, and discusses the extent to which commonly used technical tools used in priority-setting can reflect a progressive approach to SRHR. The following section provides a brief history of HSR in Africa, as well as a description of the key players in the current processes. These sections provide the background for three country case studies of Ghana, Uganda and Kenya as well as a short discussion of the lessons. On the basis of the previous sections, the final section provides a brief gendered critique of priority setting.

**Historical overview**

AbouZahr (1999) suggests that reproductive health policy has been informed, and to a large extent determined, by an approach dating from the sixties. The United Nations Population Fund (UNFPA) was formed in the 1960s with the specific mandate of raising awareness about the population problem. The paradigm set forth by UNFPA aimed to raise awareness and develop interventions in the developing world about what they referred to as "standing room only", "population bombs", "demographic entrapment" and the resultant scarcity of food, water, and other resources. This concern with population growth in the developing world resulted in a proliferation in the availability of drugs to reduce fertility.

The need to expand the definition of reproductive health emerged clearly as an issue at the level of international policy formulation in 1994 at the International Conference for Population Development (ICPD) in Cairo. Three factors influenced this shift. The first was the growing strength of the women's movement and its critique of the emphasis of the existing approach to reproductive health on control of female fertility, while excluding women's other needs. Secondly HIV/AIDS emerged as a serious concern. It thus became imperative to respond to consequences of sexual activity other than that of pregnancy. As a result, it became possible and even essential, to talk about sex both within and outside of marriage. Thirdly, the concept of reproductive rights was articulated.

The shift in mindset culminated in the articulation of three essential rights which were proclaimed at the ICPD:

- The right of couples and individuals to decide freely and responsibly the number and spacing of children and to have the means and information to do so;
- The right to attain the highest standard of sexual and reproductive health; and
- The right to make decisions free of discrimination, coercion or violence.
These rights, and in particular the paradigmatic shift in respect of women’s reproductive health, will be used as a primary evaluative measure when this chapter considers the ways in which governments in Africa set priorities around SRHR.

**Technical tools for determining priorities**

Priority setting is essentially a political process. However, it often draws or claims to draw on seemingly objective and technical methods.

In an unpublished paper, Olowu (2003) lists the following as possible technical methods of determining priorities: demographic and epidemiological indices, analysis of resources (including cost analysis and resource flow analysis), evidence-based economic methods such as cost-effectiveness and cost-benefit analysis, and evidence-based epidemiological methods such as the BOD method.

A full elucidation of these approaches is beyond the scope of this chapter. In summary:

- **Demographic and epidemiological indices** includes measures such as quantitative evaluations of populations. They are generally available in most countries in Africa and are often used by Ministries of Health and Population Councils. While this tool illustrates the problems and points quite clearly to the priorities that need to be addressed, it often fails to consider the cost or feasibility of the suggested interventions (Olowu, 2003, 8).

- **Analysis of resources** involves the estimation of costs of reproductive health services. Olowu (2003) argues that use of the approach in sub-Saharan Africa is often hampered by the paucity of health economists as well as the poor quality of available data. As a result, internationally estimated cost data are used although they are not necessarily appropriate.

- **Cost-effectiveness analysis (CEA)** and cost-benefit analysis and epidemiological methods are explored in detail in the chapter as they have been used fairly extensively throughout the African continent.

CEA, BOD and related approaches include a range of methodologies. However, they all involve the application of relevant data (epidemiological or economic) to a decision-making process. Stated crudely, epidemiological evidence informs the allocation of resources to address the biggest health problems, while economic evidence informs the selection of a programme or intervention that is the best buy.

Reichenbach (2001) provides a critique of two of the methods, namely cost-effectiveness analysis and BOD. She explains that CEA ranks priorities in the health sector using a ratio where the difference in outcome (of two different approaches) is divided by the difference in costs. She claims that CEA is not adequately standardised, leading to inaccurate outcomes. In addition, CEA is not successful in improving the efficiency of resource allocation.

In respect of BOD or epidemiological measures, Reichenbach quotes Prost and Jancloes to the effect that these cannot be the ultimate rationale for decision-making in health (in Reichenbach, 1993: 3). Using epidemiological measures as the sole factor is especially problematic in developing countries where often it is difficult to obtain good epidemiological data. Moreover, she suggests that epidemiological measures do not take social, ethical or
political concerns into consideration. These are factors that are integral to health policy making when using a gender perspective.

More broadly, Reichenbach (2001) critiques the widespread usage of disability-adjusted life years (DALYs), CEA and morbidity data as normative measures to decide on health priorities. The assumption behind normative measures is that the data presented is objective and can therefore be used to determine priorities which are unbiased by particular agendas. Reichenbach claims that the commonly-used normative measures can result in the misallocation of resources, and that this is of particular concern in Africa where resources are especially limited. She claims that the seemingly objective measures of DALYs and CEA fail to account for the social and political influences on priority setting. The emphasis on DALYs, CEA and BOD analysis comes about because of what Reichenbach describes as the dominance of an evidence-based approach to priority setting. However, evidence is neither neutral nor objective – it must always be interpreted. Reichenbach claims that the somewhat reductive models of CEA and BOD may be objective on some level, but their interpretation is not. To address the shortcomings, Reichenbach develops the idea of empirical (as opposed to normative) factors, such as political and organisational components, and argues that these also need to be included in the process of priority setting.

AbouZahr (1999) and Olowu (2003) discuss different ways in which ideological, political and economic factors influence policy. For example, Olowu refers to debates around adolescent reproductive health, the abolition of female genital mutilation (FGM) and gender violence in sub-Saharan Africa (Olowu 2003: 10) and the debate in Kenya regarding illegal abortions. AbouZahr discusses how population policies were developed out of concerns about growing populations in the so-called developing world (AbouZahr 1999: 767) and among the poor. Yet Olowu notes that political influences have often been more implicit than explicit on the African continent, and that explicit political analysis tools have not been widely used.

The technical tools and sexual and reproductive health and rights

The shift in mindset at the heart of ICPD essentially involved a change in the definition of SRHR. However, this change in definition was not necessarily reflected in the tools used in priority setting and other processes.

In an article exploring the challenges of defining reproductive health, Sadana (2002), like AbouZahr, points to what has been excluded through a historically quantitative definition (in terms of morbidity, mortality, fertility) when measuring reproductive health. She argues that a major shift occurred when the ICPD developed a general definition of reproductive health, which included aspects of physical, mental, and social well-being (Sadana 2002: 407). This new definition allowed for family planning to be seen as only one component of reproductive health services. It also raised the importance of regarding reproductive health through the lens of an entire life-cycle. The new definition makes room for complex links between direct and indirect determinants of health, and between the individual and her (or his) environment. This approach also reveals a shift in the conception of gender, seeing woman not only as mother, but also as human being with physical needs and challenges which shift throughout her life.
Sadana argues that the new definition of reproductive health requires qualitative measures in addition to quantitative measures. She also advocates for the use of quantitative indicators of reproductive health or well-being (i.e. a positive measure) rather than using only the absence of disease (a negative measure) as an indicator. Unfortunately, thus far the priority setting process in Africa has not given much weight to qualitative indicators. It has also not paid sufficient attention to the development of indicators of well-being to complement the current indicators reflecting absence of disease.

**Health sector reform in Africa**

**A brief history**

Prior to the current wave of HSR, between 1972 and 1984 post-colonial Africa’s health policies were heavily influenced by the revolution (Olowu 2003: 2) of primary health care (PHC). Today PHC is often perceived as being externally imposed and donor-led. However, Olowu suggests that PHC developed from the actual lived experiences of people in developing countries, particularly in sub-Saharan Africa. At the time of PHC’s apotheosis (1972-1984), sub-Saharan Africa had excellent national research institutions and academics who led the debate around PHC from within Africa. Yet by the 1990s, due to the effects of poverty, brain drain and budgets cuts, many of these intellectual centres moved overseas. Multilateral institutions and foreign journals then became the leaders in the PHC debates and academics from sub-Saharan Africa struggled to have their voices heard.

Implementation of PHC was hampered by limited funds. Already by the end of the seventies, the economies of most countries in sub-Saharan Africa were in trouble. With the rise of international interest rates in the eighties as well as debt burden and droughts, countries resorted to sporadic adjustment efforts (Olowu 2003: 1). Despite these efforts, the economic crises deepened. Between 1986 and 1992, thirty countries in sub-Saharan Africa therefore adopted programmes under the International Monetary Fund’s structural adjustment facility and its successor, the enhanced structural adjustment facility. These facilities were offered as a way of stabilising the economies of the countries. However, they invariably resulted in cuts in public spending in the health sector as well as on other social services (Olowu 2003: 1).

These challenges were among the motivations for the introduction of the Bamako Initiative in 1993. The Bamako Initiative, described in the World Development Report of 1993 (World Bank 1993), included an attempt to develop a minimum services package. This was intended to ensure that people had access to the basics. The Initiative can be seen as an early attempt to set priorities in the face of limited resources. However, because of a simultaneous focus on privatisation and efficiency in government expenditure, the Initiative did not have much effect.

The current round of HSR can also be seen as a response to the perceived inadequacy of a PHC approach. AbouZahr (1999) claims that, unlike PHC, the current HSR is externally imposed and donor-driven. In attempting to shift global priorities around health, the current HSR has influenced the ways in which reproductive health is defined and addressed. HSR has been driven by the World Bank as well as a number of other interest groups including multilateral agencies, bilateral donors, consultancy firms, and academic and related research.
institutions. As discussed above, the two prominent forms of analysis which have been used in the process of HR – BOD and CEA – are based on narrow economic or epidemiological arguments.

AbouZahr observes that international donors generally operate on the basis of narrow concerns around accountability and efficiency. Their concern with accountability does not involve accountability to citizens, but rather accountability to the holders of the purse-strings. This external supervision often impedes attempts to move towards a more progressive reproductive health approach. At the same time, the lack of concern about gender equity and reproductive health cannot be blamed only on the external donors. A culture that is embedded in patriarchy, and which values families and female subservience, must impact on the ways in which government sets priorities. This can happen, in particular, at the local level where HSR includes a decentralisation strategy. Unfortunately, such cultures are widely prevalent in sub-Saharan Africa.

The players in priority setting

In her discussion on SRHR and HSR, Olowu (2003) claims that there is a disparity in Africa between political power and technical capacities. As a result, HSR has been led by forceful research institutes that are, on the whole, external to the continent. The policy making around HSR relies heavily on the research of WHO Africa Region, the United Nations Economic Commission for Africa, the African Development Bank and sub-regional bodies such as the Southern African Development Community and the Economic Union of West African States (ECOWAS). The African Union (AU) and New Economic Plan for African Development initiatives envisage control shifting to Africa. In particular, there are plans for the AU – like the European Union – to have a health commissioner with a research unit and technical capacity. However, these developments are still in the early stages. It thus remains to be seen whether research will begin to evolve within the continent and how this may alter priority setting.

Within each country, the key players in the process of priority setting include the Minister of Health, the Ministry of Health (MoH), the Ministry of Finance (MoF), and advocacy groups. Although Health ministers and ministries play an important role in the process of priority setting, they are often constrained by their lack of technical capacity. As such, the MoF tends to overshadow the MoH because of its stronger economic capacities and control over the purse-strings and because it exerts a stronger influence over the priority making process in general.

Thus the process of priority setting is multi-layered and complex. It is influenced by the agendas of multilateral agencies, donor agencies and national governments, by budgetary requirements and human and gender equity concerns, by western values and local cultures. As a result, the process of deciding what is important around SRRH is not always consistent.

The next section of the chapter explores some of the dynamics operating in three African countries around priority setting and SRHR. The African continent is large and it is not possible to cover every country within a review of this scope. The chapter thus compares the similarities and differences in the processes in Ghana, Uganda, and Kenya. In addition, the
description of each case is heavily influenced by the information available and the interpretation of this information provided in the literature.

Country case studies

Ghana
Much of the information presented in this section is drawn from Gulaid's (2001) report prepared for the World Bank.

Challenges facing the reproductive health of women
In Ghana, the fertility rate declined from an average of six births per woman in the mid-eighties to 4.6 births per woman in the 1990s. The Ghana Statistical Services also reports a significant trend towards marrying later over this period. Knowledge of contraception is high in that it is estimated that 93% of married women are aware of at least one modern method. Nevertheless, contraceptive use remains low. In 1998 it was estimated that only 13% of married women used contraception. Teenage pregnancy is seen as an important social and health issue and is related to early initiation into sexual activity and non-use of contraception. A survey by Aygei et al (2000) suggested that nearly half of the teenage female population in Ghana had terminated a pregnancy, despite the fact that abortion is illegal in Ghana except in the cases of rape, incest, or health risk to the mother (Luke cited in Gulaid 2001). Despite, or because of, the illegality of abortion, unsafe abortion is considered to be the most significant contributor to the high maternal mortality rate (Ostea et al cited in Gulaid 2001).

HIV/AIDS is also a growing health problem. In 2001, between 4 and 5 percent of the population was infected with HIV and the rates for women were twice as high as they were for men. While awareness of the disease is widespread (97% of women and 99% of men), knowledge of preventive strategies is poor in the three northern regions of the country.

Even this cursory glance suggests that Ghana's women do not experience the levels of freedom of choice around their sexual and reproductive health and rights articulated at the ICPD.

Governmental reforms
Gulaid reports that the MoH in Ghana embarked on a series of reforms between 1992 and 2002. The reforms evolved through a range of strategies: ten years of institutional development, four years of major policy and strategy work, three years of strengthening management functions and two years of negotiations, planning and design. The reform plan was developed as a joint initiative by outside donors and the MoH (Asamoa-Baah & Smithson cited in Gulaid 2001).

HSR in Ghana has been informed by sector-wide reviews and extensive consultations with a range of stakeholders, including public, private and international donors. The focus on sectoral research as well as consultations with stakeholders led to the development of a Five-year Programme of Work (5YPOWER) covering the period 1997-2001. The 5YPOWER described the vision of the health sector, the national priorities and key strategies for the sector. A package of priority services was defined which included reproductive health, immunisation and some disease-specific interventions. Reproductive health was named as one of seven
priorities, and focused on family planning services and essential and emergency obstetric care.

In terms of institutional reforms, the Ghana Health Service Bill of 1996 entrusted the delivery of health services to the Ghana Health Service, allowing the MoH to focus on advisory and regulatory functions.

While donors work with the MoH in developing the priorities, unlike in many other African countries, much of the HSR in Ghana has been based on internally driven research. In 1992, when the reforms were being initiated, the parastatal National Population Council (NPC) was established. The function of the NPC is to advise government on population issues and to provide a framework for inter-sectoral collaboration and coordination of reproductive health. In the year it was founded, 1992, the NPC adopted the ICPD’s definition of reproductive health.

Today the main objectives of the reproductive health programme in Ghana are to reduce maternal mortality rates and increase birth intervals. To achieve these objectives, the programme relies heavily on PHC, community based-activities, health education, promotion of appropriate technology and collaboration.

The reproductive health service policy in Ghana was developed in 1996 and received support from various stakeholders, including NPC, USAID, the UK’s Overseas Development Agency (now the Department for International Development (DFID)) and UNFPA. One of the important programmes that emerged from this consultation process in 1993 is the Safe Motherhood (SMH) Initiative. With assistance from the World Health Organisation (WHO) and other donor agencies, in 1995 the MoH developed a SMH skills handbook which it used to start systematic training of midwives and doctors. Among the objectives of the SMH are to reduce maternal mortality and morbidity, to make childbearing safe for all women and to assist in reducing infant morbidity.

While research seems to have been emphasised in Ghana over a long period of time, Adjei (1999) argues that the link between research and policy formulation remains weak. For example, research projects such as the Danfa Comprehensive Health and Family Project (1970-1999) aimed to improve rural primary health care and family planning. However, the findings do not seem to have been taken into account by decision makers. In contrast, in 1987 a research project of the MoH explored the use of traditional birth attendants or family planning and midwifery services. With this project there was much interaction between researchers and policy makers and the outcome was a national traditional birth attendant programme.

Lessons learned
The development of HSR in Ghana and the setting of its health sector priorities have been closely informed by collaboration between Ghana’s parastatal research agencies, donor agencies and policy makers. It seems that international donors influenced the setting of reproductive health as a priority in Ghana but did so through working with agencies endogenous to Ghana. More importantly, Ghana’s experience suggests that research will only have impact if the research is carried out in collaboration with policy makers.
At least some of Ghana’s successes can be attributed to the fact that the research which informed the priority setting has been internally driven and developed. This chapter does not aim to suggest that external donor agencies necessarily serve as obstructions to the process of meaningful HSR. However, the Ghana case suggests that when research is internally driven by parastatal agencies and when a broader base of groups are included in the research and collaborative process, widespread and long-term goals can be set. Realisation of these goals nevertheless remains difficult.

Uganda

Challenges facing the reproductive health of women
The average fertility rate in Uganda is 7.4. The contraceptive prevalence rate is, on average, 10% although there is significant variation across districts. The culture in Uganda values large families. Male children, in particular, are a source of status and provide income through additional labour. Women’s access to family planning is sometimes constrained by men because of the patriarchal culture. At the more practical level, there is often a great distance to travel in order to access services.

Abortion under the law is prohibited in Uganda except on medical grounds to save the life of the mother. Many women seek illegal abortions. However, they tend to delay seeking proper medical care in the case of complications because abortion is illegal. As a result, 20% of maternal deaths in Uganda are due to unsafe abortions.

The government is responsible for promotive and preventive health care in Uganda. However, in the area of maternal health care, most women access services outside the formal health care system. A 1993 study which looked at the reasons why some women in Uganda did not use health services found that it was due to inadequate financial resources and high unofficial fees for poor services.

Governmental reforms
Uganda’s health sector is dependent on donor contributions both for capital investment such as the rehabilitation of health facilities and for other costs. The funds available to government thus include those from the government’s own resources, donor funds and debt relief. In 1990/91, 61% of the total expenditure in the health sector came from external assistance (UNFPA 1995).

In 1996, the Ministry of Finance, Planning and Economic Development (MOFPED) introduced the medium term expenditure framework (MTEF), and sector budget framework papers. The MTEF gave each sector a budget for a three-year period. It was accompanied by efforts to assist in the choice-making process and has proved to be a useful tool in priority setting.

In 2000, the MoH introduced a Health Sector Strategic Plan. For the financial year 2000/01, the priority focus was on programmes in respect of malaria and childhood immunisation. For 2001/02, an emphasis on reducing maternal morbidity and mortality and strengthening the public health presence was added.
To address challenges resulting from severe budget constraints, the abolition of user fees and the winding up of some donor aid, Uganda developed the National Service Delivery Programme for the financial year 2001/02. This Programme prioritised various projects which had been left out of the main budget and which required funding from the Poverty Action Fund (PAF), i.e. the money released through the Highly Indebted Poor Country Initiative. Reproductive health and contraceptive supplies were included in the National Service Delivery Programme.

In recent years Uganda has opened up the decision making process around priorities at both the central and local levels of governments. The priority sectors to be funded are determined by government policy as articulated in the Poverty Eradication Action Plan. Health is one such priority sector. At the central level discussions are held between the ministries, MOFPED, development partners, the private sector and civil society organisations. At least some of these discussions are sector-based. This, in theory, allows non-government players with specific knowledge, experience and interests in a sector to influence the agenda. Participants have included civil society organisations, such as the Forum for Women in Democracy, with an explicit focus on gender issues. Nevertheless, MOFPED and the relevant ministry the MoH in the case of Health dominate the process.

Because of Uganda's poverty, budgetary considerations dominate the priority setting agenda. Nevertheless, there have been attempts at using other factors to determine priorities. In 1970 the National Research Council was established. It had six committees made up of medical experts who assisted in setting research priorities. However, they tended to use BOD to decide on priorities. As a result, the research did not include the entire health sector and was clinically based (Owor et al 2000).

In 1991 Uganda established the Essential National Health Research Strategy (ENHR). Thereafter a national ENHR plan was developed for the period 1993-1996. The plan was reviewed in 1997 and a new five-year plan was proposed. The review included consultations with research scientists, policy and decision makers, and district health management teams, a review of health statistics, a review of relevant literature and a national consultative conference. The following broad research priority areas were outlined: maternal child health and nutrition; water, sanitation and environment; communicable diseases; non-communicable diseases; health policy and health systems; and drug use studies. Recently the Uganda National Health Research Organisation was established under the MoH, and took over the management of the ENHR (Owor et al 2000).

The ad hoc committee established in terms of the ENHR consulted with policy makers and decision makers, health researchers and communities in order to develop national research priorities. Based on this process of research and consultation [and the outcomes of the BOD analysis, in 1995 the MoH adopted a National Population Policy which incorporated many elements of the ICPD into the national reproductive health programme. Priorities included safe motherhood and child survival, family planning, adolescent health, capacity building, infrastructure development, information, education and communication.

In 1997 Uganda formulated a National Gender Policy which aimed to integrate gender into development efforts at all levels of planning, resource allocation and implementation of development programmes. From 1998, the government initiated a population programme
that is being implemented by the Population Secretariat under the MOFPED. With this increase in focus on reproductive health, the contraceptive prevalence rate among married women increased from 3% in 1988 to 8% in 1995 and to 15% in 1997. Rates of fertility and mortality remain high, although they are declining. In 1999, a National Health Policy and five year Health Sector Strategic Plan was put into place. The aims include decreases in mortality, morbidity and fertility. In the setting of priorities, the criteria include not only budgetary concerns and burden of disease, but also feasibility, the avoidance of duplication, political acceptability, capability, urgency and ethical acceptability.

As noted, in 1995 Uganda incorporated many elements of the ICPD programme of action into its policy. After the ICPD, the MoH has selected promotion of safe motherhood, family planning and reproductive health advocacy as reproductive health priorities (Mirembe & Sengooba 1998).

In an effort to reduce high levels of maternal and neonatal morbidity and mortality in the country, in 1999 the Ugandan government established Uganda’s Safe Motherhood Programme. The programme aimed to reduce maternal mortality by 20% by the year 2001. The programme elements included training for health care providers, improving the quality of and access to maternal care, instituting a referral system for emergency obstetric care and family planning services. The government collaborated with donors, non-governmental organisations (NGOs) and the private sector (including traditional birth attendants) in implementing the programme (Partners in Population Development 1999).

**Lessons learned**

It has been a long road for Uganda in trying to develop and realise an effective model for HSR. Several factors stand out as contributing towards the steady, if slow, improvement of services in Uganda. One factor is the introduction of the MTEF. Instead of the MOFPED retaining control of all ministerial allocations, budgets were given to the respective ministries for a three-year period, accompanied with advice and suggestions.

Uganda’s establishment of the ENHR (subsequently the Uganda National Health Research Organisation) impacted positively on the process of policy formation in general and reproductive health in particular. It remains to be seen whether the focus on BOD analysis will be extended to include concerns such as gender equity and ethical acceptability. However the importance of endogenous research in determining the successful implementation of an intervention is not to be under-estimated. When countries are able to assume national responsibility for research, instead of leaving it all in the hands of the donors, a policy can be created which is potentially more far-reaching in its impact.

Another related lesson from Uganda is the danger in relying purely on a BOD model. The quantitative method of BOD leaves many of women’s sexual and reproductive health problems in the interstices, untouched. It was only when the Ugandan government expanded their measures to include other factors that priorities for women in Uganda broadened and expanded.

In considering the Ugandan experience from a political level, or gendered perspective, one can observe how initially the definition of reproductive health was narrow and, as in many other African countries, concerned only with birth control, fertility, mortality etc. As
Uganda's research efforts broadened and deepened, so did its definition of reproductive health and its concern with gender, so much so that it came to include the ICPD principles. This experience suggests that there is a link between broader and more inclusive research methodologies and practices and a more progressive and equitable approach towards women and gender.

Kenya

Challenges facing the reproductive health of women
The Reproductive Health Needs Assessment Report of 1999 states that maternal mortality in Kenya remains high at 590 per 100 000 live births. The high maternal mortality rate is associated with obstructed labour, unsafe abortion, haemorrhage, hypertension during pregnancy, sepsis, anaemia, malaria, STIs and HIV/AIDS. According to the Kenya Demographic Health Survey of 1998 (quoted in Muga, 1999), maternal deaths account for 27% of all deaths in women aged 15-49. The survey revealed that almost a quarter (24%) of women in Kenya have an unmet need for family planning. However, achievements have been made with regard to reducing the total fertility rate and increasing contraceptive prevalence rate. These stood at 4.7 and 39% respectively in 1998. However, in that same year only 42.5% of births were taking place in health facilities.

When the men and women groups in the Kenya Demographic Health Survey were asked about FGM, they all reported that that it is practised in their communities on young girls between the ages of 10 and 16 years. The survey indicated that in all ethnic groups the prevalence was lower amongst the daughters than the mothers. Nevertheless, amongst the Kisii and Masai FGM is still commonly practised.

Governmental reforms
Kenya adopted a population policy in 1967 when it launched its first family planning programme. Following this, in 1978, the government endorsed the PHC strategy for providing health services to the Kenyan population with an emphasis on interventions in the rural areas. Since then the government has sought to shift the responsibility of cost so that the beneficiaries also contribute.

According to the Reproductive Health Needs Assessment Report (1999), before the Alma Ata declaration, health services were mainly curative and there was little focus given to obstetrics, and maternal and child health services. However, with the introduction of the Alma Ata Declaration (1978), PHC was introduced in order to assist in health service delivery. Maternal and child health were a major component of the PHC strategy. A decade later and progress in the reduction of perinatal and maternal morbidity and mortality was slow. Therefore, in 1987, the SMI or Global Safe Motherhood Initiative was launched in Nairobi. The SMI introduced a number of different approaches to Maternal/Child Health and Family planning, namely an increased political commitment, an emphasis to strengthening systems and re-addressing social disparities confronting women in particular. From this, Kenya adopted the Safe Motherhood Initiative Strategy.
Many NGOs in Kenya have promoted community-based health care. To date, however, there has not been consistent, close collaboration between NGOs and government. In 1982, the government established the National Council for Population and Development. However, it was the Kenya Health Policy Framework of 1994 which clearly presented the MoH's vision. The goals of this framework included the reduction of population growth, equitable allocation of resources, increased cost effectiveness, and the creation of an environment of collaboration among the private sector, NGOs and the community.

After the ICPD in 1995, Kenya significantly changed its concept of reproductive health. The emphasis shifted from maternal and child health/family planning with the establishments of the Reproductive Health Programme in the Division of Primary Health Care of the MoH. This programme then developed the Kenya National Reproductive Health Strategy (KNRHS), (1997-2010) where, according to the Reproductive Health Needs Assessment Report, the following components were included.

- Safe motherhood and child survival;
- Management of STDs/HIV/AIDS;
- Promotion of Adolescent and youth health.
- Family planning
- Management of infertility;
- Cervical cancer;
- Gender issues and Reproductive Rights

In 1998, the KNRHS was distributed at a National District Forum for district health managers. Safe motherhood was given the highest priority by the Forum.

For the period 1999-2004, Kenya's health policy is still guided by the Kenya Health Policy Framework of 1994. Women's health status is regarded as of significant importance especially at family and household levels. It is understood that women's role in health development is to provide care to children and adults in the community and it is therefore in the country's interests to promote the health of women. However, while government and NGOs recognise this fact, women's health status has not really changed due to unfavourable and inadequate policies, negative socio-cultural practices, political barriers, inequity in gender relations and poor quality of care.

The African Medical Research Foundation (AMREF) (2000) reports that research into the impact of gender on health development in Kenya is lacking and there has not been collaboration and sharing of material. AMREF suggests that a community-based health model seems to be most effective in dealing with reproductive health. For example, experience in Western Kenya has shown that by using people from the community as a resource, awareness can be raised about rapid population growth, condom distribution and oral contraceptives. This then contributes towards a reduced number of children per family and increased birth intervals.

AMREF's claim that the prioritisation of RH in policy is not being translated into practice is supported by The Reproductive Health Needs Assessment Report (Muga, 1999). The report notes the concern of the MoH about high maternal and perinatal mortality, a deterioration of health delivery systems in terms of quality of care, and policies which do not provide an enabling environment for health sector reforms. It proposes that there is a need to conduct a
situational analysis to guide policy review, especially in areas such as human resource development and the equitable distribution of services.

Reproductive health programmes in Kenya receive a lot of external aid. They are supported by United Nations Population Fund, the German Technical Cooperation, the United Nations Children Fund, the World Health Organisation, the World Bank, Swedish International Development Cooperation Agency, United States Agency for International Development, the Department for International Development, the European Union and the Netherlands. The government of Kenya has adopted a strategy of pooling of funding from different sources so as to avoid a situation where interventions are driven by a particular donor.

Community perceptions of reproductive health
The government provides over 40% of health services in Kenya. Traditional health and birth attendants play a vital role, as do providers of herbal medicine. The government has expressed a commitment to providing an enabling environment for the promotion of the participation of NGOs and community-based providers so as to be able to address the increased demand for services. HSR has also highlighted the importance of the community in terms of identifying problems and naming priorities. Interviews were conducted with men and women.

As such, in 1999, the government organised a study which included interviews with members of communities and community focus group discussions as input for the Reproductive Health Needs Assessment Report. Both men and women said that the main reproductive health problems were sexually transmitted infections, unwanted teenage pregnancies associated with abortion and lack of delivery services. In addition to being asked about family planning, abortion, maternal health, sexually transmitted infections, infertility and reproductive health cancers, men and women were questioned about violence against women. Both men and women said that violence against women is a common problem in their communities. Factors which were said to contribute to violence against women included domestic quarrels, economic hardships, alcoholism, drug abuse and failure of women to adhere to customs such as cattle keeping. The men's proposed interventions to curb violence against women included promotion of dialogue and understanding between couples, educating of communities and a reduction in beer brewing.

As noted above, both men and women said that FGM is practised in their communities, primarily on young women between 10-16 years. They explained that the advantages of FGM are respect from the community, preservation of cultural norms, and reduced libido which can assist in preventing unwanted pregnancies. Over half (53%) of the members in the men's group and nearly two-thirds of the women (65%) felt that FGM should stop while 26% of the men and 35% of the women said that FGM should continue because it reduces promiscuity among young women.

The interviews with the community were valuable as a research tool because they revealed some disparities between priorities set at the level of government and what occurs on the ground. Neither violence against women nor FGM are listed in the Kenyan National Health Reproductive Strategy (1999) as high concerns. This suggests that government
priorities do not cover the full gamut of what occurs on the ground. A situational analysis might assist in expanding governmental priorities.

**Lessons learned**

Perhaps the most valuable lesson to be drawn from the Kenyan experience is the disparity between the priorities as outlined by the Kenyan National Health Reproductive Strategy and concerns that emerge in interviews conducted at a grassroots level. This disparity is almost certainly not unique to Kenya. This results in many priorities being set that are not concordant with the needs of women (or men!) in the community.

Another issue that the case study raises is the limited collaboration between government and NGOs in Kenya. The reason for this lack of collaboration is not clear.

On a positive note, in Western Kenya the community was used to promote awareness around reproductive health and this resulted in a marked improvement in levels of awareness and use of contraception in the region. This suggests that creative use of members of the community can have a significant impact even when the resource envelope is small. It should, of course, not be assumed that women’s health concerns will automatically be addressed through the community. However, women tend to be involved in community affairs and may, through their informal leadership roles in their communities, impact positively on women’s reproductive health.

As with the other countries, Kenya’s priorities suggest a tension between patriarchal approaches to reproductive health which regard women simply as mother and are therefore concerned only with fertility, mortality and morbidity, and a more progressive gendered approach to reproductive health as espoused at the ICPD. As the definition of reproductive health expands, so the priorities around reproductive health are broadened.

The community research of Kenya points to the importance of consultation and participation in the process of priority setting. This chapter has described the problems encountered when a country’s research is defined, conducted and financed by external agencies. To be appropriate, priority setting requires horizontal and vertical inclusiveness in terms of participation. In addition, accountability mechanisms need to be set in place. These issues are discussed in other chapters of this report but they affect the process of priority setting and so need to be mentioned here too.

**Comparison and contrast**

The three countries presented in this chapter share some interesting commonalities. Firstly, high fertility, maternal mortality, STIs, HIV/AIDS as well as general prejudicial patriarchy seem to be women’s burden across all the countries, although in the case of STIs, and HIV/AIDS they are not women’s burden alone. The case studies suggest that there is a slightly more open attitude towards women in Ghana. Ghana has the lowest fertility rate (4.6) and 93% of the population are aware of at least one form of contraceptive, although use remains low. Of the four countries, Ghana’s research and priority setting seems to have had the most impact on long-term changes in women’s reproductive health although there have been smaller triumphs in the other countries. This could, at least partly, be the result of Ghana’s collaborative research process which was internally driven but worked in tandem
with international agencies. This contrasts with Kenya where the difference between the findings of quantitative research done at a national level and conclusions drawn from grassroots qualitative interviews remains stark.

All four countries have established research agencies to assist the priority setting process. In some cases (e.g. Ghana), the research is comprehensive and inclusive, while in others (Uganda) this is less the case. Despite the fact that African countries tend to share many of the same problems around reproductive health, cross-country collaboration appears minimal. As a result, research may be duplicated unnecessarily. More collaborative work across the continent might help to come up with more effective means of determining and addressing priorities. For example, countries could publish and distribute papers on their successes as well as their challenges.

**In conclusion: A gendered critique of priority setting**

This chapter has attempted to report on some of the ways in which African countries have engaged in priority setting around reproductive health. The first sections explored the ways in which priority setting has been influenced by forces exogenous to the continent. In particular, it discusses the research methods, such as CEA, BOD and DALYS, which have been harnessed in the process. For the most part, these methods were developed externally by donors and, Reichenbach suggests, exclude important factors when assessing health.

The next section of the chapter explored the ways in which reproductive health as a term has expanded in meaning over time. This change in meaning has affected what is included in the scope of reproductive health when defining priorities. However, it does not appear to have been fully incorporated into the methods used in priority setting.

After these introductory sections, the main body of the chapter explores the experience of three countries. The case studies describe the status of women’s health in each country and look at what interventions the governments have made in reproductive health and what informed their priority forming process. All three countries are heavily influenced by external aid. All have also been influenced by the ICPD’s definition of reproductive health, at least in theory. All list reproductive health as a priority in one way or another. Nevertheless the disparity between theory and practices and between abstract policy and material outcomes remains wide. Overall, women in Africa, as a group, remain disadvantaged.

As Reichenbach’s critique of normative measures argues, it is impossible to understand the full scope of what women face in each country through a quantified measure of their morbidity or fertility rates. Nevertheless, in most countries the focus remains on maternal health, neonatal care and fertility rates. The reproductive and sexual health of women is thus still confined largely to the space of ‘woman as mother’. This approach does not sit easily with the more inclusive definition of women’s reproductive health developed in Cairo. However, it does fit in well with a patriarchal society which, on the one hand, honours the mother as the bearer of the progeny but, on the other hand, does not accord women much space beyond this domain. As long as the priority setting process continues to emphasise women as mothers rather than as human beings and as sexually active adults with concerns
other than child-bearing, the priority setting process will reflect and reinforce a patriarchal bias that is endemic to the continent.

Another common thread is that the bulk of the research on reproductive health is driven by external international organisations. As long as the research continues to be externally and donor-driven, the priorities accorded to reproductive health will change as the fashion in particular agencies changes. At the same time, African women need to be challenged to develop their own sense of feminism, one which critiques practices such as FGM from the inside. Trible (1978: 1967) notes that currently a man’s world tells a woman’s story. The challenge is for women, even in a man’s world, to write their own story!

References


**Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>5YPOW</td>
<td>Five-year Programme of Work</td>
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<tr>
<td>AMREF</td>
<td>African Medical Research Foundation</td>
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<td>AU</td>
<td>African Union</td>
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<td>BOD</td>
<td>Burden of disease</td>
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<td>CEA</td>
<td>Cost-effectiveness analysis</td>
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<td>DALY</td>
<td>Disability-adjusted life year</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>ECOWAS</td>
<td>Economic Union of West African States</td>
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<td>ENHR</td>
<td>Essential National Health Research</td>
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<td>FGM</td>
<td>Female genital mutilation</td>
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<td>HSR</td>
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<td>ICPD</td>
<td>International Conference on Population Development</td>
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<td>Kenya National Reproductive Health Strategy</td>
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<td>MTEF</td>
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<td>NPC</td>
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<td>PAF</td>
<td>Poverty Action Fund</td>
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<td>PHC</td>
<td>Primary health care</td>
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<td>SRHR</td>
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<td>TGNP</td>
<td>Tanzania Gender Networking Programme</td>
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