

Share-Net
Netherlands network on
sexual & reproductive health and aids



REPORT

Expert Meeting 'Healthy Nations, Wealthy Economies' May 30, 2011 at KIT in Amsterdam

The expert meeting 'Healthy Nations, Wealthy Economies' organized by the two networks *MDG5 Meshwork for Improving Maternal Health* and *Share-Net* took place at the Royal Tropical Institute (KIT) on 30 May 2011. The afternoon was organized around the question why and how the Netherlands should continue investing in Sexual Reproductive Health and Rights (SRHR) and HIV/AIDS.

The meeting was organized as a response to current developments in Dutch international development policy. Recently, the Dutch government has decided to scale back Official Development Assistance (ODA) from 0.8% to 0.7% of GNI. Stimulating *economic* development will drive support and investments of Dutch international development aid. Although SRHR remained one of the four focal areas this field will be affected as well. Therefore this symposium discussed and shared the economic benefits of investing in SRHR and HIV/AIDS.

Experts from India, Washington and the Netherlands and an audience of more than 40 people from Dutch non-profit organizations, universities, research institutes and the Ministry of Foreign Affairs gathered in the reading room of KIT.

13.00 Moniek van der Kroef, Policy Advisor at Aids Fonds/Stop AIDS Now!

Moniek van der Kroef introduces Share-Net and MDG5 Meshwork for Improving Maternal Health, the two organizers of the meeting. Share-Net (www.share-net.nl) is a network of Dutch development organizations and individual consultants working in the field of sexual & reproductive health and rights, and HIV; MDG5 Meshwork (www.mdg5-meshwork.org) is a collaborative network of more than 30 organizations from the Netherlands, Sierra Leone and Afghanistan who have joined forces to develop and implement innovative projects to reduce maternal mortality worldwide.

13.10 Korrie de Koning, Senior Advisor SRHR at the Royal Tropical Institute (KIT)

Korrie de Koning was originally on the agenda and willing to introduce the current situation of sexual and reproductive health globally, and what is now in the literature on the economic benefits of investing in SRHR. Unfortunately she was unable to attend the meeting. The background paper on which this presentation was build is available on both the Share-Net and MDG5 Meshwork websites.

13.15 Jeroen de Lange, Head of Strategy, Knowledge and Innovation at Cordaid

The meeting started with a presentation by Jeroen de Lange. Before giving an overview of the recent developments of Dutch international development policy, he points out that investing in health proves to stimulate economic development. There is however a weak link between aid invested in health and economic growth in the short term. On the longer term there is stronger evidence that investing in health results in a more healthy workforce which pushes economic growth. A stronger link exists between investments in health and health systems in case of strong institutions.

As one of the contributors to the Scientific Council for Government Policy (WRR) report on international development, De Lange is critical on its translation into current policy directions. Where the report underlines the need of a good analysis of the needs and demands of developing and partner countries and forming policies accordingly, he states that the current intended policy all but based on good context specific analyses. Dutch international development will be narrowed down to four specific areas: food security, water, security and the rule of law in fragile states, and SRHR. A strong focus will be on developing the economy and promotion of entrepreneurship within these themes. Although SRHR has been chosen as one the priority areas, 'health' on itself has been dropped of the agenda. Doing so, De Lange argues, the current government is not taking the need for sexual and reproductive health seriously. 'It is impossible to have SRHR as one of your focal points, while not investing in health more broadly. Can a government contribute to SRHR without investing in health systems?'

De Lange argues that we should start focusing on what works and indeed as the title of the WRR report says have 'less pretension but more ambition'. He questions whether strengthening *states* is the way forward and we might have to look more into cooperation and collaborations with the private sector. Also he argues to continue investing and spreading technologies as overall dramatic global improvements, last century in public health, were mainly achieved through spread of ideas and technologies.

Finally, De Lange argues, Dutch international development in health can only be efficient and effective if we build a strong professional coalition or network of all organizations that deal with health.

13.55 Suneeta Sharma, Country Director at Futures Group India

Suneeta Sharma was invited to talk about the integration of SRHR and HIV/AIDS from a health systems perspective. According to Sharma there are many arguments why SRHR and HIV/AIDS services should be integrated: they share the same root causes, they

address human sexuality, serve similar target groups, promote safe responsible sexual behaviour, treat sexually transmitted infections, rely on effective prevention, distribute condoms, use similar medical skills and facilities, rely on community participation, and need a multi-sectoral response. Key linkages between promoting SRH and preventing and treating HIV and AIDS are informing about HIV status, promoting safe sexual behaviour, optimizing the connection between HIV and STI services, and integrating HIV with maternal and infant health. Sharma points out that there are numerous recent reports stating the advantages of linking the two services such as improved access and uptake of services (including HIV testing), health outcomes, condom use, HIV and STI knowledge, overall quality of services. Moreover integration promoted increased efficacy of sexuality counselling and cost-effectiveness studies reported net savings and positive outcomes. Unfortunately there are still many factors impeding linking the two domains such as lack of commitment, non-sustainable funding, staff shortages and high turnover, lack of capacity development, women being insufficiently empowered to make SRH decisions, and adverse social events (e.g. domestic violence) and stigmatizing attitudes. In order to promote integration Sharma advises that there should be more focus on health outcomes rather than inputs and utilization of financial and human resources should be maximized (e.g. by sharing facilities, rationalizing staff responsibilities, training workers to perform multiple tasks, etc.). Also accountability, transparency, and management at the operational levels should be improved.

Sharma continues to underline that even if services are integrated, inequitable access and availability remains an issue. Supply side barriers could be reduced by creating publicly-owned supply models (e.g. social/health insurance), institute equitable resource allocation and targeting mechanisms, or contracting out or subsidizing the private sector to create publicly financed supply. Improving equitable access from the demand side could entail providing information to helping change behaviour, providing purchasing power (e.g. by vouchers), or providing incentives to change behaviour (e.g. conditional cash transfers). Lastly, Sharma argues that scale up of donor-funded single disease-specific interventions should be limited. Instead investments should be made in designing, testing, costing, evaluating and scaling up public-private partnership models and community based interventions. Examples of such interventions are social franchising, contracting, social marketing, mobile health vans, involvement of the corporate sector, capacity building of private providers.

15.00 Kees Kostermans, Lead Public Health Specialist, South Asia Region at World Bank

Kees Kostermans gave a presentation about why the Dutch should keep investing in SRHR. First of all he argues too that HIV/AIDS should be linked to SRH for efficiency and effectiveness: 'the large majority of HIV infections are sexually transmitted and both HIV/AIDS and many illnesses linked to SRH have the same root causes'. Also he states that the greater proportion of paediatric HIV infections is spread from mother to child in the process of pregnancy, birth and breastfeeding. Although it seems difficult to introduce at the operational level, internationally countries have largely committed to

this integration through the ICPD in 1994, which said that effective prevention and treatment of sexually transmitted diseases, including HIV, is an integral part of reproductive health services.

Kostermans argues that health care delivery should be patient centered and the objective of integrating HIV/AIDS and SRH services should thus be convenience to the client. Another objective is increasing coverage for both type of services and efficacy can be gained by building systems with not many narrow vertical pillars but with few pillars broad enough to provide comprehensive SRH. For example, integration of HIV/AIDS and SRH services will improve access to and use of key HIV and SRH services, will improve access of PLWHA to SRH services, will reduce HIV-related stigma and discrimination, will improve the quality of care, will provide greater support for 'dual protection' and will decrease duplication of efforts and competition for resources etc. An example which has not been discussed widely is the high HIV infection rate associated with unintended or unwanted pregnancies. However, there are situations that integration does not make sense. For example, warning against breast feeding as potential source of PTCT in Afghanistan, or advocating that IDU's attend general health services while people do not want to be confronted with IDU's all the time when visiting health services. Moreover, MSM (by definition not a reproductive activity) have very specific needs. Kostermans explains the difference between concentrated and generalized HIV epidemics and their driving forces. Funding for HIV/AIDS and SRH is still mostly separated and skewed. Kostermans then touches upon an often seen scenario these days of decreasing funds for national AIDS programs, while the number of people living with HIV/AIDS on treatment, and high risk groups with very low condoms coverage keeps increasing. Meanwhile RCH programs which were typically struggling for funding is getting increasing attention due to the global interest in Millennium Development Goal (MDG) 4 and 5. There is a sense of need to scale up the RH services, especially family planning. He advises, in order to improve the situation for both fields, to identify the win-win for both HIV/AIDS and SRH programmes in a typical country scenario.

To the question why the *Dutch* should keep investing in SRHR and HIV/AIDS, Kostermans says the following: the Dutch have a special place in the world as our policies for drug users are renowned globally, men having sex with men are accepted in the Netherlands, it is one of the first countries where gay marriage is legalized, our commercial sex policies are studied worldwide, and there is gender equality. No wonder that gender issues have been at the forefront of Dutch development policies. Improved gender equality is directly linked to the integration of SRH and HIV/AIDS services. The burden of the lack of integration falls largely on women; the women will suffer and not the men.

Kostermans continued with information about the Bank Netherlands Partnership Program (BNPP) which was established in 1998. After a restructuring, its resources are now focused on fewer key priorities (Sexual and Reproductive Health and Gender Equality amongst others). The integration of SRH and HIV/AIDS can be at all levels; at international, country and service delivery level and these levels are interlinked. Both

HIV/AIDS and SRH are keys to development: if a healthy family is not important for development then what is important?

He concluded by stating that past commitments bring future obligations (the Dutch can not say: today it is our priority but tomorrow it is not). The Dutch have been proven to be strong allies and are very much appreciated internationally and by developing countries. Although the amount which the Dutch bring in may be relatively small, when considered global aid volume, but our ideas matter a lot. However, people will only listen when we have a seat at the table which is supported by funds. The impact of the Dutch voice is likely underestimated by the Dutch themselves.

15.45 Discussion

The presenters formed the panel and several statements coming from the audience this time were discussed by the panel and the audience.

A first statement: "SRHR and HIV programmes can not be successful if the rights are not appropriately addressed" provoked much discussion. Some in the audience questioned if the rights-based argument and approach are actually helping; it was argued that international development in the health sector should be driven by evidence-based effective implementation rather than promoting human rights, because of the political realities in many developing countries. The economic argument might be more effective it is said. Others indicate that the so called 'soft factors' (gender, human rights, and stigma) are actually promoting health in developing countries and that the impact of the human rights argument is being underestimated. Advocating for women's rights, without focussing on the economic arguments contributes strongly to the development of the society. Also it was brought to the table that SRHR and HIV/AIDS are addressed more effectively if the rights-based approach is used. Moreover the importance of understanding the context when developing programmes was highlighted – looking at the needs of the target group and including the target group in all stages of the programme.

"Investing in comprehensive sexual education for young people is cost-effective" was the second statement. According to the panel this was a very complex issue: changing behaviour is most effective in gaining results, however there is little evidence that sexual education is actually effective in changing this behaviour. The evidence is overwhelming that more factors contribute to actual behaviour change, than sexuality education as an intervention alone. However, others argue that sexuality education is proving to be cost-effective, as presented in the report *Adding It Up* by the Guttmacher Institute. It was pointed out that investments should start at the basics, as often delivery channels for interventions are not yet present (for example well qualified teachers to deliver sexuality education).

The next statement proposed was: "Skip MDG 4, 5 and 6 and replace them by 1 MDG for health". It is mentioned that such an MDG could be helpful. Now specific indicators should be set, but each country should decide for its own priorities. The question came up whether the MDG should then be a public health MDG or about healthy behaviour?

A theme that came up several times was the statement that international aid is actually all about politics and not about economics because as soon as the parliament is replaced by another parliament the focus areas change. It was stated that politics are often neither rational nor evidence-based. At the moment, with a new Dutch cabinet (and thus politics), there is a liberal agenda in the Netherlands for development aid; the real change should thus come from the grassroots organisations. Others however do not want to rule out the importance of a focus on economic development as for example financial independent women are able to make a difference. It was mentioned that we should focus on the good aspects of the new liberal agenda.

Sharma again highlights that communities should be engaged in programmes. Kostermans supported this and added that the priorities of communities are often different than our priorities, which indicates a major gap.

The discussion continued about differences between investing in the middle class of a developing country or the poor. For example, it was stated a health insurance system will work for the middle class but not for the poor. It is harder to reach the real poor than the middle class in the urban areas. It was argued that when aiming for economic development, investments should be focused on the middle class. Others however counter that the choice is not between poor and middle class: every business needs to hire people and thus investments can benefit both. Moreover we should not forget that - as Peter Piot once stated - the bigger the gap between rich and poor, the bigger the HIV prevalence.