# Ensuring Access to Sexual and Reproductive Health: How Foreign Aid Can Be Undermined

## I. Introduction

The establishment of the Millennium Development Goals (MDGs), a set of eight targets to advance human development by the United Nations (UN) in 2000, was a turning point for the world in putting a focus on women's health (Hill, Huntington, Dodd & Buttsworth, 2013, p. 113). Specifically, the belated Target 5B, which came in 2007, focused on providing "universal access to reproductive health" (UN, n.d.). Although the MDGs were to be achieved by 2015, there is still significant progress to be made, considering the fact that 10% of women worldwide do not have access to an effective method of contraception (World Health Organization, 2015). Reexamining the progress made toward this goal is necessary in order to achieve Goal 3 of the UN's new Sustainable Development Goals (SDGs), which have the same objective of providing reproductive health care for all.

Whilst noted economists, including Jeffrey Sachs of Columbia University, claim that simply "fulfilling the funding for access to sexual and reproductive health services" (Sachs, 2015, p. 304) would help to achieve these goals, there are factors on both the donor and recipient sides that may erode the aid's efficacy. The failure to achieve access to reproductive health for all can be attributed to donors' incentives, partisan politics based on ideology, and the lack of an active civil society, which all work to undermine the effectiveness of the aid for developing countries. This paper will discuss how these three factors have affected the beneficiaries of foreign health aid and how they impede the road to providing access to sexual and reproductive health for all women.

## II. Donors' Incentives

The complications with foreign aid start from the donor side, where a growing number of diverse stakeholders with individual incentives have transformed the aid scene and hindered efforts to provide a comprehensive sexual and reproductive health agenda. Esser (2009) claims that "the past decade will likely come to be viewed in the history of international affairs as a period characterized by unprecedented activism for global health by national governments, multilateral agencies, corporations, nongovernmental organizations (NGOs), and private foundations" (p. 225), as shown in Table 1 below.

Table 1. Major Donors to Global Health

| Player category | Examples | |
|---|---|---|
| States | Great powers | United States, China |
| | Emerging powers | India, Brazil |
| | Developed states | Britain, Canada, Germany, Japan, Norway |
| | Developing countries | Bangladesh, Indonesia, Kenya, Venezuela |
| | Failing or failed states | Congo, Haiti, Zimbabwe, Somalia |
| IGOs | Multilateral | ILO, UN, UNAIDS, UNICEF, World Bank, WHO, WTO |
| | Regional | African Union, ASEAN, European Union |
| PPPs | Mechanisms to increase access to health technologies | AMCV; GAVI Alliance; Global Fund; IFFIm |
| | Drug and vaccine development partnerships | Drugs for Neglected Diseases Initiative, International AIDS Vaccine Initiative, Medicines for Malaria Venture, Malaria Vaccine Initiative, TB Alliance |
| Nonstate actors | Philanthropic foundations | Bloomberg Initiative, Carter Center, Clinton Foundation, Gates Foundation, Rockefeller Foundation |
| | NGOs and civil society groups | Amnesty International, Doctors Without Borders, Human Rights Watch, Oxfam |
| | Multinational corporations | Food and beverage, pharmaceutical, and tobacco companies |

*Note*: Retrieved from "The challenges of global health governance," by Fidler, D. P., 2010, 10. Copyright 2010 by Council on Foreign Relations.

For example, businesses have become leading players in the field; there is a "growing sense among transnational companies that their economic fate is linked to the improvement of their

public image in the countries where they invest" (Severino & Ray, 2009, p. 5), highlighting their own corporate social responsibility agendas. For many of these entities, "organizational self-preservation" is often their priority to ensure their financial survival, so safeguarding their own mandate comes before collaboration and cooperation with other organizations (Esser, 2009, p. 228). This can result in duplications in the allocation of resources, causing holes and missing spots in health governance (Fidler, 2010, p. 3). Despite the fact that more money is being poured each year into global health, it has become more difficult than ever to ensure the "equitable and efficient use of these new resources" (Esser, 2009, p. 226).

This has had a profound impact on aid for sexual and reproductive health; according to a series of interviews conducted by Hill, Huntington, Dodd, and Buttsworth (2013), "UN country offices expressed concern that the plethora of new actors, each with their own modus operandi, was complicating country development processes" (p. 116). Specifically, workers in the Ministry of Health in Senegal responded that there were multiple donors with their own reproductive health interests, but this was "failing to achieve comprehensive coverage of sexual and reproductive health" (Hill et al., 2013, p. 116). Although local workers in the health sector oversee the coordination of donor efforts, having to balance numerous projects and maintaining separate policies has hindered efforts of alignment and harmonization in implementation (Hill et al., 2013, p. 118). Furthermore, the researchers found that in Senegal, despite the fact that sexual and reproductive health and rights (SRHR) had been a priority in the 2005 country studies, by 2011, it had lost its prominence and no longer was integrated in the country's poverty strategy or national health plans; this reflects the "uncertain staying power of these issues in . . . political arenas" and the unpredictability of priorities (Hill et al., 2013, pp. 119-120). Indeed, of the thirteen goals of the Paris Declaration on Aid Effectiveness organized by the Organisation for

Economic Co-operation and Development (OECD), which aimed to harmonize aid delivery as an effort to help achieve the MDGs, only one was met by its deadline in 2010 (OECD, 2011, p. 1). The results showed that donors' progress in coordinating joint missions and analyses had been slow, and that aid remains unpredictable in developing countries because "donor communication of information on future aid to individual developing country governments remains isolated rather than being the norm" (OECD, 2011, pp. 1-2); in fact, the predictability of aid, the 7th target, had gone up from 42% to only 43%, far from its target of 71% (Overseas Development Institute, 2011, p. 6). Ultimately, according to Esser (2009), even though "unparalleled amounts of financial capital" (p. 225) are being poured into global health aid, a comprehensive sexual and reproductive health agenda depends on the donors' willingness to use those resources effectively and to coordinate their efforts, instead of acting purely on their individual interests and incentives.

## III. Political Agendas

Amongst the array of donors, countries themselves—specifically the United States—can have political agendas behind overseas health aid that have direct effects on the beneficiaries. Although the United States has been providing family planning aid to developing countries for 50 years, most of it has been entangled in abortion politics (Barot & Cohen, 2015, pp. 27-28). At the root of this is the Mexico City Policy, which was devised in 1984 by President Reagan's administration and rescinds federal funding (from the United States Agency for International Development, or USAID) for foreign NGOs that perform, endorse, mention, or educate women about abortion as a way of family planning. It stems primarily from socially conservative ideology and the "conviction that taxpayer dollars should not be used to pay for abortion or abortion-related services" (Bendavid, Avila, & Miller, 2011, p. 873), and it has been strictly

partisan since its conception, as Democratic presidents have rescinded it and Republican presidents have reinstated it, reflecting deep domestic struggles between the pro-life and pro-choice factions and the Republican and Democratic parties (Crane & Dusenberry, 2004, p. 129). The effect that the Mexico City Policy has had on abortion is surprising: although President George W. Bush proclaimed in a 2001 press briefing that it would make abortion more rare, a study by Stanford researchers has shown the opposite. In 2011, Bendavid, Avila, and Miller conducted a research study to determine whether the Mexico City Policy had any relation to the induced abortion rate in sub-Saharan Africa, as health programs in the region receive substantial foreign assistance (pp. 873-874). They discovered that the overall induced abortion rate was stable from 1994 and 2001 at 10.4 per 10,000 woman-years, but then increased significantly between 2002 and 2008 to 14.5 per 10,000 woman-years, consistent with President Bush's reinstatement of the Mexico City Policy in 2001, as shown in Figure 2 below (Bendavid et al., 2011, p. 876).

Figure 2. Rate of Induced Abortions From 1994 to 2008 Across 20 Sub-Saharan Countries

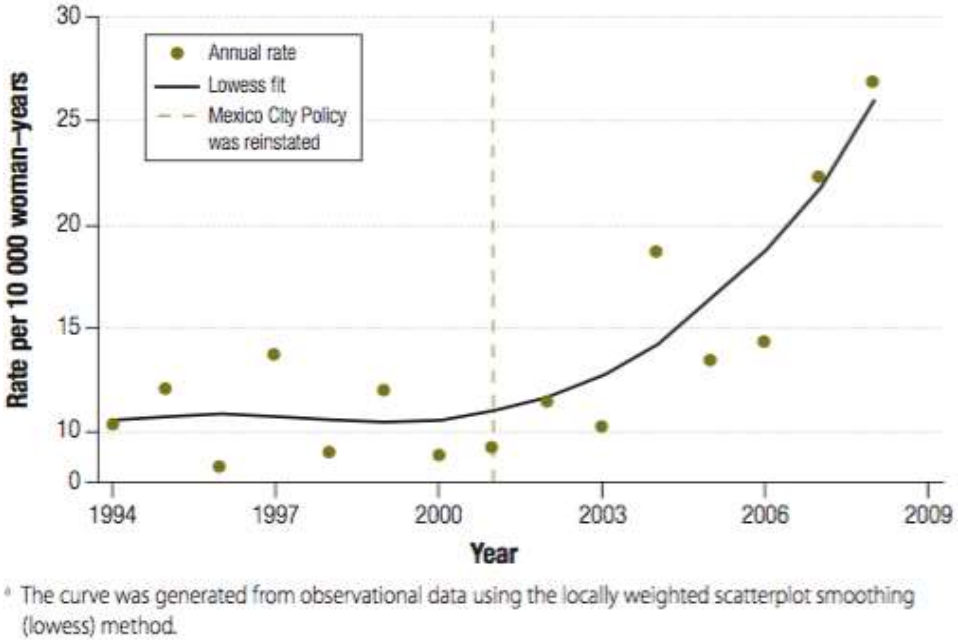
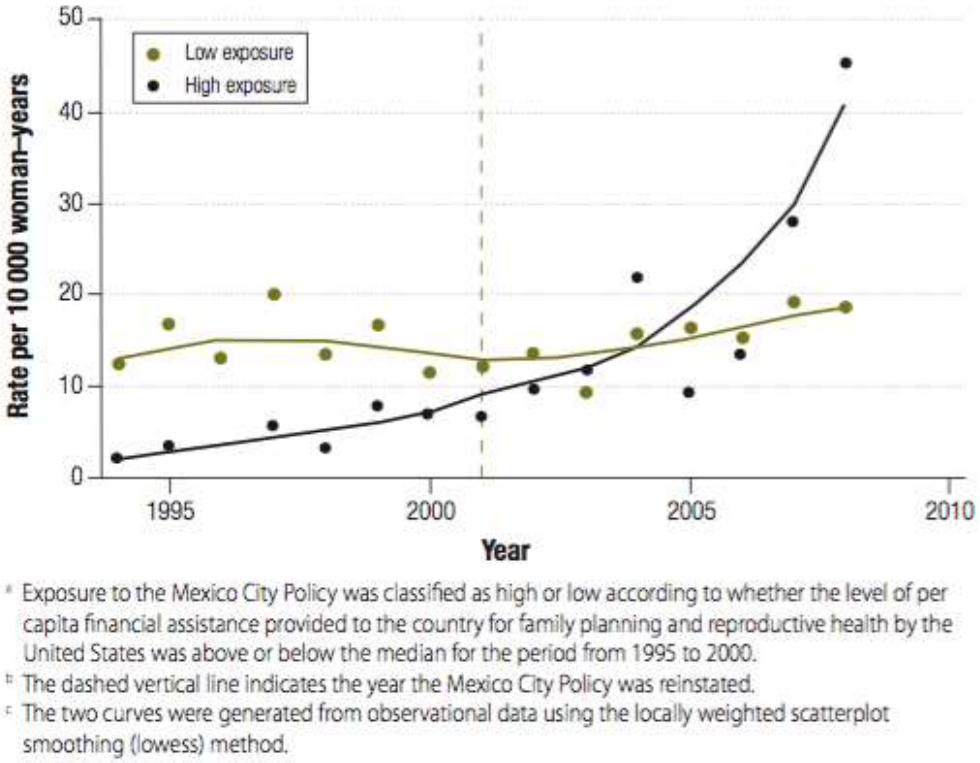



*Figure 2*. Rate of induced abortions from 1994 to 2008 across 20 sub-Saharan Countries. Adapted from "*United States aid policy and induced abortion in sub-Saharan Africa*," by Bendavid et al., 2011, *Bulletin Of The World Health Organization*, *89*(12), 875. Copyright 2011 by Bulletin of the World Health Organization.

Furthermore, as shown in Figure 3, high-exposure countries, or "countries that received a higher level of financial assistance from the United States for family planning and reproductive health" (Bendavid et al., 2011, p. 874), had a much higher induced abortion rate compared to low-exposure countries, showing the direct impact the policy has on poor countries dependent on aid.

Figure 3. Rate of Induced Abortions From 1994-2008 Across 20 Sub-Saharan Countries, by Exposure to the Mexico City Policy




[a] Exposure to the Mexico City Policy was classified as high or low according to whether the level of per capita financial assistance provided to the country for family planning and reproductive health by the United States was above or below the median for the period from 1995 to 2000.
[b] The dashed vertical line indicates the year the Mexico City Policy was reinstated.
[c] The two curves were generated from observational data using the locally weighted scatterplot smoothing (lowess) method.

*Figure 3*. Rate of induced abortions from 1994-2008 across 20 sub-Saharan Countries, by exposure to the Mexico City Policy. Adapted from "*United States aid policy and induced abortion in sub-Saharan Africa,*" by Bendavid et al., 2011, *Bulletin Of The World Health Organization*, *89*(12), 876. Copyright 2011 by Bulletin of the World Health Organization.

One possible explanation for this is that when the Mexico City Policy was imposed, reproductive health and family planning services were disrupted as the variety of available services was reduced and the clinics unwilling to accept the rule were closed, which led to a loss of access to "trusted local providers—sometimes the only provider of these services in their community—putting [women] at risk of unintended pregnancy and unsafe abortion" (Barot &

Cohen, 2015, p. 29). Furthermore, according to research by Population Action International (PAI), the reinstatement of the rule caused the cease of shipments of American-funded contraceptives to 16 developing countries, which led to the inability to prevent unintended pregnancies; accordingly, Bendavid, Avila, and Miller (2011) found that the use of contraceptives in the sub-Saharan countries became lower under the policy (p. 877). Barot and Cohen (2015) conclude that "placing legal barriers between women's reproductive health needs and desires and their access to safe abortion services only leads to unsafe abortion" (p. 30), and thus the impact of the policy is that it has only made the procedure "more likely and unsafe"; the vast majority of these abortions are performed by an "untrained person" or in "an environment that does not meet minimum medical standards" (p. 29).

According to Crane and Dusenberry (2004), the Mexico City Policy was significant in the aid scene in that the American government exercised its "power of the purse" to the point of manipulation, harming rather than helping the recipients who were virtually powerless in raising their voices (p. 133). Bendavid, Avila, and Miller (2011) argue that it is vital to recognize the unintended implications the policy and the volatile politics behind it have, regardless of one's opinion on abortion (p. 877).

## IV. Civil Society

Even amongst donors who are steadfast supporters of SRHR, the lack of the participation of civil society among recipients can reduce the impact of aid. According to Seims (2011), the seven European countries of Denmark, Finland, Germany, Netherlands, Norway, Sweden and the U.K. "stand alone in being willing to embrace the controversial elements of SRHR, such as promotion of safe abortion . . . as well as . . . the unmet need for contraception" (p. 129). However, because these donor countries place strong value in country ownership, they have left

the responsibility of decision-making with developing country governments to foster autonomy (Seims, 2011, p. 129), essentially giving them the freedom in the area in which to allocate the aid (such as to reproductive health, or malaria prevention) (p. 130). However, Seims (2011) found that during the negotiations, civil society plays a significantly weak role in affecting decisions regarding the allocations (p. 130). The World Health Organization (WHO) (2001) suggests that civil society plays a vital role in health services in that they can facilitate communication between the government and citizens and provide services "in response to community needs", and strengthen health service by giving "powerful additional pressure for the recognition of public interests within the health sector" (pp. 7-8). In terms of SRHR, it is in fact civil society that often leads the way for safe abortions and sexual rights, rather than the countries' governments, but because funding that is allocated for NGOs that promote SRHR is minimal, failures have occurred as a result, such as frequent stock outs of contraceptives and the availability of only a small number of trained personnel (Seims, 2011, pp. 130-134).

This misalignment extends even further down to the individual beneficiaries, who are even more excluded. A series of interviews were conducted in East African countries with three groups of participants (individuals, health care workers, and policy makers) by Lövgren, Taro, and Wipfli in 2014, where they were asked if they thought their country should get less or more foreign aid. In the results, individuals responded that they should receive significantly more aid, whilst health care workers responded they should receive some more aid, and lastly policy makers responded that they should receive less aid (pp. 332-333), as seen in Figure 4 below.

Figure 4: Responses to the question, "Do you think your country should get less foreign aid or more foreign aid?" by policy makers, health care workers, and individuals

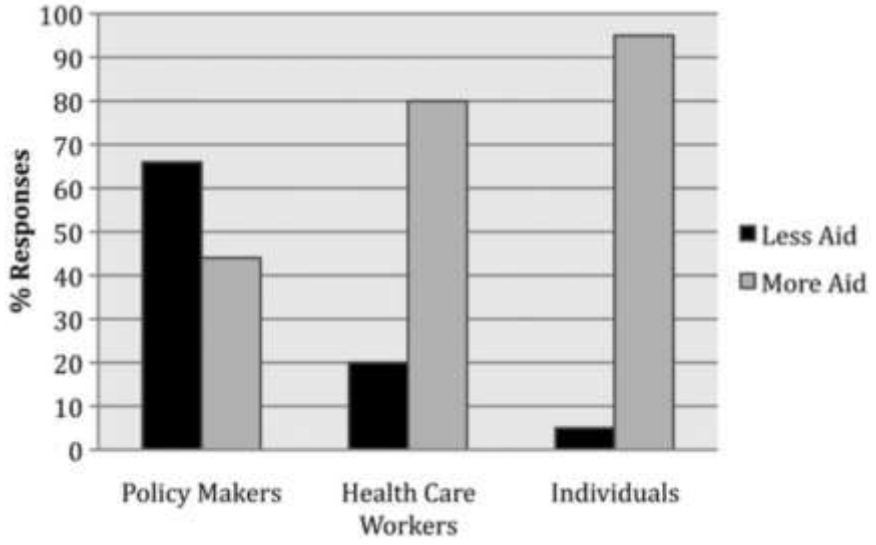



*Figure 4*. Responses to the question, "Do you think your country should get less foreign aid or more foreign aid?" by policy makers, health care workers, and individuals. Adapted from "*Perceptions of foreign health aid in East Africa: an exploratory baseline study,*" by Lövgren et al., 2014, *International Health*, *6*(4), 334. Copyright 2014 by International Health.

The groups' perception varied greatly depending on their involvement with aid administration, with policy makers, the group most involved, perceiving the aid to be generous, and health care workers and individuals, who have significantly less power and a much weaker role in negotiations, responding that they did not receive enough (Lövgren et al., 2014, p. 335). This reflects a "lack of transparency to beneficiaries" and a need for the inclusion of all levels of stakeholders (Lövgren et al., 2014, p. 335). According to Seims (2011), in order to make foreign aid as effective as possible, civil society must hold governments and donors accountable to make progress in providing universal access to sexual and reproductive health (p. 134).

## V. Analysis and Conclusion

Although economists such as Sachs suggest fulfilling funding for SRHR will lead the way for providing access to reproductive health, there are incentives, political agendas, and power imbalances on both the donor and recipient sides that ultimately hinder the effectiveness of the aid itself. Ultimately, the MDGs were not achieved, and women in developing countries are far from having universal access to sexual and reproductive health services. Simply continuing the way that foreign aid is distributed is not sustainable because it reflects neither the changes in the aid scene nor the underlying issues that may have led to the failures of the MDGs in the first place. With the reinstatement of the Mexico City Policy by President Trump on January 23, 2017, for instance, increasing or even sustaining the current level of aid is impossible if a major donor like the U.S. government unilaterally decides to cut it off. Research led by PAI has shown that when the policy is in place and shipments of U.S.-funded contraceptives are cut off, there are far-reaching consequences; for example, the Lesotho Planned Parenthood Association had received over 400,000 condoms during the course of two years during the Clinton administration via USAID, but after shipments were cut off when the rule went into effect, one out of every four women in the country was infected with HIV, as the Planned Parenthood Association was the sole provider of condoms in Lesotho (as cited in Barot & Cohen, 2015, p. 29).

In order to provide effective and modern contraceptives and family planning assistance to women in developing countries dependent on foreign assistance, policies and priorities must channel that money directly to the women's needs, independent of incentives or ideologies and with the inclusion of NGOs and CSOs. It is vital to fix the current impediments that undermine

foreign aid in order to achieve the SDGs and provide access to sexual and reproductive health for all women.

References

Barot, S., & Cohen, S. A. (2015). The Global Gag Rule and Fights over Funding UNFPA: The Issues That Won't Go Away. *Guttmacher Policy Review, 18*(2), 27-33. Retrieved December 28, 2016, from https://www.guttmacher.org/sites/default/files/article_files/gpr1802715.pdf

Bendavid, E., Avila, P., & Miller, G. (2011). United States aid policy and induced abortion in sub-Saharan Africa. *Bulletin Of The World Health Organization, 89*(12), 873-880C. Retrieved December 25, 2016, from http://www.who.int/bulletin/volumes/89/12/11-091660/en/

Crane, B. B., & Dusenberry, J. (2004). Power and Politics in International Funding for Reproductive Health: the US Global Gag Rule. *Reproductive Health Matters*, *12*(24), 128-137. Retrieved December 27, 2016, from https://www.jstor.org/stable/3776588?seq=1#page_scan_tab_contents

Esser, D. E. (2009). More Money, Less Cure: Why Global Health Assistance Needs Restructuring. *Ethics & International Affairs*, *23*(3), 225-234. Retrieved November 13, 2016, from http://www.carnegiecouncil.org/publications/journal/23_3/essays/001

Fidler, D. P. (2010). *The challenges of global health governance*. Retrieved December 28, 2016, from http://www.cfr.org/global-governance/challenges-global-health-governance/p22202

Hill, P. S., Huntington, D., Dodd, R., & Buttsworth, M. (2013). From Millennium Development Goals to post-2015 sustainable development: sexual and reproductive health and rights in an evolving aid environment. *Reproductive Health Matters*, *21*(42), 113-124. Retrieved November 29, 2016, from https://www.researchgate.net/publication/259245539_From_Millennium_Development_

Goals_to_post2015_sustainable_development_sexual_and_reproductive_health_and_rights_in_an_evolving_aid_environment

Lövgren, S. L., Taro, T. B., & Wipfli, H. L. (2014). Perceptions of foreign health aid in East Africa: an exploratory baseline study. *International Health*, *6*(4), 331-336. Retrieved November 27, 2016, from https://www.researchgate.net/publication/263477153_Perceptions_of_foreign_health_aid_in_East_Africa_An_exploratory_baseline_study

Overseas Development Institute. (2011). *Progress in implementing the Paris Declaration on aid effectiveness: what does the evidence tell?* Slideshow presented at the 4th High Level Forum on Aid Effectiveness, Busan, Korea. Retrieved November 21, 2016, from https://www.odi.org/sites/odi.org.uk/files/odi-assets/events-presentations/953.pdf

Organisation for Economic Co-operation and Development. (2011). *Aid effectiveness 2005-10: progress in implementing the Paris Declaration*. Summary presented at the 4th High Level Forum on Aid Effectiveness, Busan, Korea. Retrieved December 10, 2016, from http://www.oecd.org/development/effectiveness/48734301.pdf

Population Action International. (n.d.). Worldwide access denied. Retrieved December 11, 2016, from http://pai.org/gag-rule/

Sachs, J. (2015). *The age of sustainable development*. New York, NY: Columbia University Press.

Seims, S. (2011). Improving the impact of sexual and reproductive health development assistance from the like-minded European donors. *Reproductive Health Matters*, *19*(38), 129-140. Retrieved December 13, 2016, from http://www.rhm-elsevier.com/article/S0968-8080(11)38578-3/pdf

Severino, J. & Ray, O. (2009). *The end of ODA: death and rebirth of a global public policy*. Retrieved from December 10, 2016, from http://www.cgdev.org/files/1421419_file_End_of_ODA_FINAL.pdf

United Nations. (n.d.). Goal 5: improve maternal health. Retrieved December 10, 2016, from http://www.un.org/millenniumgoals/maternal.shtml

World Health Organization. (2001). *Strategic alliances: the role of civil society in health*. Retrieved December 11, 2016, from http://www.who.int/civilsociety/documents/en/alliances_en.pdf

World Health Organization. (2015). MDG 5: improve maternal health. Retrieved November 13, 2016, from http://www.who.int/topics/millennium_development_goals/maternal_health/en/