

# **Reproductive Health Conference: Sexual and Reproductive Health, Our Mutual Responsibility, October, 26-28, 2006**

## **Panel Discussion:**

**Economic, Social, Political and Environmental Implications for Sexual and Reproductive Health in the global Community, Knutsford Court Hotel, October 28, 2006 at 9:00 a.m. Grand Caribbean Suite**

## **Policy and Planning Implications**

Mr. Moderator, fellow panelists, distinguished guests, friends, please accept apology for Dr. Pauline Knight, my boss, who is unavoidably absent and who I represent on the panel. For myself, I am greatly honoured to sit among these distinguished panelists. My thoughts on the topic for policy and planning will be covered under five broad areas. These relate to the need for: (i) A comprehensive policy on sexual and reproductive health; (ii) Incorporating the effects of HIV/AIDS in development and development planning; (iii) Integrated training in sexual and reproductive health; (iv) Integrated research and database on sexual and reproductive health; and (V) Allocation of greater resources to sexual and reproductive health.

### **I. Comprehensive Policy on Sexual and Reproductive Health**

One of the fundamental weaknesses in the area of sexual and reproductive health is the lack of a comprehensive policy to guide integrated planning, decision-making and service delivery. In Cairo, consensus was reached on the need for integrating family planning, maternal and child health and sexually transmitted infections including HIV/AIDS under the rubric of sexual and reproductive health and rights. The Cairo Programme of Action (POA) also stipulates that the constellation of services in these areas should be integrated and delivered through the primary health care system.

Jamaica has made some progress in health reform which supports the provision for better services in sexual and reproductive health. However, the reforms, to a large extent, fall short of the vision of Cairo. The decentralization of health administration and the formulation of an adolescent reproductive health policy as well as the policy guidelines for

health personnel in the provision of reproductive health services to minors under the age of consent have been notable achievements.

The establishment of “baby friendly” and “mother friendly” clinics and the partial integration of reproductive health and family planning services in these clinics are also noteworthy. The National HIV/AIDS Strategic Plan and the development of agency specific policies on HIV/AIDS have also been positive. However, the lack of a comprehensive policy to establish the normative framework and facilitate complete integration of the various programme components and service delivery has resulted in the perpetuation of programmes and services which, in my view, are still only partially integrated and coordinated. It should be noted that the integration of sexual and reproductive health and the family life cycle approach in health planning are not mutually exclusive modalities.

## **II. Incorporating the Effects of HIV/AIDS in Development and Development Planning**

This broad area will be discussed under two sub-sections. These are: (a) Incorporating the effects of HIV/AIDS in policy and planning; and (b) Impact of HIV/AIDS on the achievement of the Millennium Development goals.

### **(A) Incorporating the Effects of HIV/AIDS in Policy and Planning**

As you are aware, demographic parameters provide the framework for policy and planning at all levels. Under normal conditions, the effects of changes in births, deaths and migration on the structure of the population can be predicted fairly accurately. However, with the advent of the HIV/AIDS pandemic and the paucity of data particularly of the infection levels by age and sex, it has become much more difficult to project with any certainty the future impact of the disease on the structure of the population.

In the case of Sub-Saharan Africa, the prevalence rate of HIV/AIDS is estimated at over 6 per cent of the adult population 15 years and over. This has resulted in a dramatic reduction of the working age population relative to the child and elderly age groups. One of the consequences is an increase in the dependency ratios. In addition, these countries have also experienced

significant reductions in life expectancy, labour productivity, GDP and human capital.

In the Caribbean, the prevalence rate is generally below 2.0 per cent. In order to prevent the Caribbean from having a Sub-Saharan Africa experience, the region needs to mobilize greater resources and strengthen its intervention programmes in sexual and reproductive health at all levels to arrest the spread of the pandemic. The region also needs to incorporate explicitly the effects of HIV/AIDS not only in population projections but in the formulation of all other policy and planning tools. The promotion of HIV/AIDS as a cross-cutting issue needs to take centre stage in all national development policy and planning.

## **B. Impact of HIV/AIDS and the Achievement of the Millennium Development Goals**

The general presumption is that Sub-Saharan Africa will not achieve most, if not all, of the goals of the Millennium Development Summit by 2015. The HIV/AIDS pandemic has effectively undermined most of the gains achieved, particularly in the health related goals. In some countries, life expectancy at birth has fallen by as much as 30 years.

For the most affected countries in the Caribbean sub-region, indications are that life expectancy at birth has started to decline and/or that the rate of increase in life expectancy has slowed. Preliminary results from the UN for Jamaica suggest that HIV/AIDS has reduced life expectancy at birth by at least 2 years over the period, 2000–2005 (unpublished).

The first five-year assessment of Jamaica's status for achievement of the Millennium Development Goals revealed that the country was not on track for reaching the targets related to infant, under- five and maternal mortality. The situation in most other countries in the region is not considered fundamentally different. Greater efforts, therefore, are needed by our region for conducting comprehensive assessments of the impact of HIV/AIDS and other sexual and reproductive health matters on the achievement of the millennium development goals and to take the necessary steps for remedying the deficiencies.

### **III. Training in Sexual and Reproductive Health**

The curricula for the training of health professionals in Jamaica and the English speaking Caribbean have not undergone the changes necessary to reflect the true essence and meaning of the concept of sexual and reproductive health integration. Training, to a large extent, remains predominantly discipline bound. Substituting the newer concepts, such as, sexual and reproductive health for family planning, sexually transmitted diseases and maternal and child health are inadequate if presented in the same discipline bound packages. Training in both concepts and service delivery processes should reflect the vision of integration as exemplified in the ICPD Programme of Action.

It seems evident therefore that health professionals are currently not adequately prepared by local training institutions to undertake the reform towards an integrated sexual and reproductive health system. The proposed collaboration between the University of the West Indies and Johns Hopkins University for training in reproductive health seems to me to provide a step in the right direction. This initiative should be welcomed and enhanced.

### **IV. Integration of Research and Databases on Sexual and Reproductive Health**

Just as full integration is lacking in service delivery, so are existing data and systems for collection, processing and dissemination of data uncoordinated and un-integrated. Data on family planning and contraception, maternal and child health, HIV/AIDS and other sexually transmitted infections and mortality are currently categorized into separate silos and reside in different ministries and agencies. Some of these data may also exist in separate silos in the same ministry/agency.

Monitoring and evaluation of sexual and reproductive health programmes and projects are sometimes hampered by the quality, availability and adequacy of data in these areas. For multi-lateral and bi-lateral development agencies, it is revealed that some have different estimates of the same variables in their databases for Jamaica. Estimates for maternal mortality, HIV/AIDS prevalence and infant mortality are notable examples.

These estimates are used routinely to classify countries for development assistance. In the past, Jamaica has faced the indignity of being misclassified. Although we protested, the categorization was not adjusted and we bore the consequences of a lower level of assistance.

Databases, data collection instruments and surveys, at best, reflect very limited levels of integration of sexual and reproductive health issues. Attempts have been made in the past to develop integrated profiles of social and economic indicators for monitoring of development programmes. However, these have been largely ineffective due to: (a) lack of institutional ownership and commitment of requisite resources; and (b) absence of good quality data, particularly mortality and cause of death data. The recently introduced JAMSTATS programme is an instrument which could be used to provide the basis for the development of an integrated database on sexual and reproductive health. This option is to be explored with the JAMSTAT Secretariat.

## **V. Allocation of Greater Resources to Sexual and Reproductive Health Programmes**

The countries in the Caribbean, except Haiti, are classified as middle income and are ranked highly on indicators of social development. Statistics on fertility, maternal and child health and contraception reflect relatively high levels of achievement. Prevalence of HIV/AIDS, however, is one of the highest in the world.

In response to the success, both multilateral and bilateral development partners have scaled down funding. Family planning, maternal and child health programmes have mostly been affected. Funding, on the other hand, for HIV/AIDS programmes has experienced significant inflows. The level of inflows for the HIV/AIDS programme, however, is also at risk of being significantly scaled down in the future.

In light of the prospect for reduction in development funding for the HIV/AIDS programme, innovative strategies including alliances with the private financial sector and NGOs should be designed and implemented. These should be done for ensuring the viability for sustained funding.

Thank you.