

Management of the politics of evidence-based sexual and reproductive health policy

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The urgent need to address sexual and reproductive ill health is well established, and since the mid-1990s relevant policies and programmes have been expanded substantially.¹ International commitment to improving sexual and reproductive health has been formulated in several forums, including the International Conference on Population and Development (1994) and the Millennium Development Goals (2000). Moreover, the cost-effectiveness of several interventions has prompted the World Bank to recommend that such interventions be provided as part of an essential package of health-care services—even in the most resource-constrained settings.²

Nonetheless, international commitment for the introduction or scaling-up of sexual and reproductive health interventions has generally been insufficient to guarantee policy change and implementation at the national level, despite evidence for the effectiveness of such interventions.³ For sexual health in particular, political and legal frameworks nationally have been largely determined by perceptions of cultural norms and moral standards.⁴ Such policies have met both passive and active resistance. We need to analyse the political dimensions associated with these policy processes, and to manage them strategically to counteract resistance to evidence-based policies from constituencies who might be more politically adroit.

Political factors are often pivotal in the policy process. They can determine which sexual and reproductive health issues are included in national policy agendas, which evidence is examined (or excluded), which policy alternatives are considered (and ultimately adopted), and the degree to which they are implemented.

Competition to include issues on political agendas can be strenuous. Opportunities can arise when problems become widely recognised and when decision-makers become aware of feasible solutions. But agenda items can be set only when the politics of the situation are right—ie, when decision-makers want to be seen to be taking action, and the probable political costs are much lower than the potential benefits.

We might hope that health agendas would be set mainly on the basis of evidence. But experience shows that evidence has not always been sufficient,⁵ especially if a subject is culturally taboo (eg, adolescent sexual and reproductive health services in Cameroon⁶ or the promotion of condom use in Indonesia⁷); if an intervention could adversely affect some interest groups (eg, the restriction of the role of midwifery by obstetricians in rural areas in Latin America⁸); if the intervention is perceived to be difficult to administer (eg, the complexity of sexual and

reproductive health care services being used as an argument against integration of such services⁹); or if the benefits would accrue mainly to those with little political influence, such as poor people, women, and girls.

Evidence of the technical feasibility of affordable, cost-effective interventions to address a health problem might not be sufficient to ensure that relevant policies are formulated or adopted. Indeed, in some cases policies have been adopted in the absence of sufficient evidence, in contradiction to the evidence, or even when the data suggest that the proposed intervention might not work—because political factors have outweighed the available scientific evidence. For example, reviews of interventions that focus on the promotion of abstinence for reduction of unintended pregnancies, sexually transmitted infections, and HIV risk in young people have shown that when abstainers become sexually active they are less likely to use condoms¹⁰ than those who have not taken part in such programmes. Nonetheless, abstinence-only programmes have been widely adopted in international development cooperation—often as a result of influence and funding that stem from consideration of domestic political interests.¹¹ Conversely, sexuality education has been stigmatised by the perception that it promotes early initiation of sexual behaviour—despite evidence to the contrary.¹² Similarly, interest groups have also manipulated evidence about emergency contraception, and access to such contraception remains subject to legal and policy barriers in some countries.¹³

Implementation of policies can be hindered by costs or other barriers, religious or cultural norms, lack of political or commercial support, or inertia. For example, although the 1993 World Development Report recommended implementation of an essential package of services for sexual and reproductive health,² many countries have been forced to sacrifice some components because of cost and other barriers to service delivery. As a result, some countries implemented maternal health policies such as antenatal care and family planning, but not delivery care or treatment for sexually transmitted infections.¹⁴ In another instance, although most countries in sub-Saharan Africa have adopted universal screening of pregnant women for syphilis, these policies have not been effectively implemented, and rates of congenital syphilis remain unacceptably high.¹⁵ The scarcity of champions or supportive coalitions for this feasible, cost-effective intervention has hampered implementation in settings where need is greatest.¹⁶ Similarly, magnesium sulphate, which is recommended to prevent and treat eclamptic seizures and which could prevent as many as 50 000 maternal deaths yearly at low cost, remains underused.

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Poor uptake of this treatment could be explained by the fact that it “has no industrial advocate to facilitate licensing, production and distribution”¹⁷ and by the reluctance of providers to change their practices.

In Zambia, although policies to reduce maternal mortality and morbidity by liberalising abortion laws have been adopted, abortion is difficult to access in practice. Zambian law requires three doctors to certify that a woman meets the legal requirements to obtain an abortion. Evidence suggests that women seeking abortion are turned away by health workers, because hospitals do not have three physicians, physicians are reluctant to sign for religious reasons, or crowded hospitals make appointments difficult.¹⁸ In other situations, political support for a policy might be tacit rather than explicit—eg, in countries where abortion is illegal but might be unofficially endorsed.¹⁹ This situation emphasises the reality that service delivery is a function of several factors, including the interests and ideas of those tasked with implementing policy.

In view of the central role of political factors in health policy, and attempts by conservative groups to affect policies for sexual and reproductive health, we argue that the political dimensions of policies for sexual and reproductive health have to be understood. Interest groups that aim to improve sexual and reproductive health should adopt a more deliberate and systematic approach to gathering political intelligence and making use of it to inform strategies and tactics to get neglected issues onto the policy agenda and to ensure that evidence-based policies are formulated and implemented.

To call for political will, promote policy dialogue, or identify policies that have worked in the past is not enough.²⁰ Without strategic management of the political terrain, the strength of the evidence might not necessarily result in the implementation of evidence-based policy. Shortcomings in understanding and management of the political aspects of policies for sexual and reproductive health are now being recognised.²¹ For example, women’s health advocates have organised analytical exercises such as the rights and reforms initiative.²² Courses run by WHO and the World Bank Institute have attempted to improve understanding of the management of the politics of intervention strategies for sexual and reproductive health.^{23,24} These efforts, however, could remain isolated unless there are firm and sustained linkages to policy processes at country level.

What is needed is a continuing approach to collection of information and development of understanding on four elements central to policy-making: opportunities and constraints within the policy context of a specific sexual and reproductive health issue; the formal and informal processes by which decisions are made; the stakeholders who might be affected by a proposed reform; and the influence, interests, positions, and degree of commitment of various stakeholder groups in relation to a specific policy for sexual and reproductive health.

On the basis of political intelligence, the feasibility of various policy outcomes can be assessed. Strategies can then be devised to determine the influence, perspectives, and positions of key players in the policy process; manage or split key bodies of opposition; or bring unmobilised groups into the policy community. The objective would be to overcome the perverse effects of the balance of power that provides the political context for the proposed reform, enabling large groups that might be less powerful politically to prevail over the vested interests of those with power. Shifting the balance of power might mean agenda-setting activities (eg, manipulation of the public debate through strategic communications), initiation of pilot interventions to demonstrate technical feasibility, identification of opportunities for policy change, development of consensus and coalitions, and assistance for champions of reform to expand their support bases.²⁵

We propose an action-research intervention to improve the prospects of evidence-based interventions in sexual and reproductive health by calmly and deliberately tackling the political circumstances that make the difference between success and failure. We envisage that analysis and corresponding action will be undertaken by national policy-specific networks, such as advocacy coalitions²⁶ composed of diverse advocates, politicians, civil servants, pressure groups, journalists, think tanks, and academics.

The women’s movement and civil society groups have used explicitly strategic political approaches to achievement of policy successes in various contexts;²⁷ these include, for example, elimination of targets for population control in India and their replacement with a framework of reproductive choice and rights,²⁸ decriminalisation of abortion in Nepal,²⁹ and the continued fight to ensure access to antiretroviral drugs in South Africa.³⁰ In Indonesia, a public denouncement of human rights abuses against women was stimulated by the engagement of religious and political leaders, and led to legal action to prevent such abuses.³¹ Women’s groups in Indonesia then effectively campaigned to link violence issues with a broader sexual and reproductive health agenda. This type of analysis and action has been applied too rarely to policies for sexual and reproductive health.

Strategic use could be made of external resources to support proreform coalitions and to combat opposition during the policy process. For example, the Inter-American Development Bank financed consultants who worked with the health reform group of the Dominican Republic’s Ministry of Health to undertake applied political analysis and propose alternative political strategies.³²

Conclusions

It is possible to influence policy for sexual and reproductive health. Yet health researchers and programme managers should not assume that facts will speak for themselves. We need to undertake political analysis; to understand the ideas, interests, and institutions operating within a particular policy context; and to choose

appropriate strategies and tactics to ensure the implementation of evidence-based health interventions. Such tasks should not be seen as peripheral additions to the enterprise of evidence generation but rather as fundamental to advancement of sexual and reproductive health. This undertaking calls for investigators, programme managers, or their supporting funding agencies, to disseminate best practice through advocacy coalitions that are broadly constituted. However, for research to achieve maximum effect, policy networks need the means and capacity to understand the decision-making environments. Support for such political work should be viewed as a new priority for donors—one that will probably require some skilled political management in its own right.

Conflict of interest statement

We declare that we have no conflict of interest.

References

- UNFPA. Investing in people: National progress in implementing the ICPD programme of action 1994–2004. New York, USA: United Nations Population Fund, 2004.
- World Bank. World development report 1993: investing in health. New York, USA: Oxford University Press, 1993.
- WHO. World health report 2005: Make every mother and child count. Geneva, Switzerland: World Health Organization, 2005.
- Cook RJ, Dickens BM, Fathalla MF. Reproductive health and human rights: integrating medicine, ethics, and law. Oxford, UK: Clarendon Press, 2003.
- Shiffman J. Generating political will for safe motherhood in Indonesia. *Soc Sci Med* 2003; **56**: 1197–207.
- Tantchou J, Wilson E. Post-Cairo reproductive health policies and programs: a study of five francophone African countries. Washington, USA: The POLICY Project, 2000.
- Bennett LR. Single women's experiences of premarital pregnancy and induced abortion in Lombok, eastern Indonesia. *Reprod Health Matters* 2001; **9**: 37–43.
- Nelson JM. The politics of health and education reforms: themes from Latin American experience. Washington, USA: Woodrow Wilson Centre, Smithsonian Institution, 2004. <http://www.hse.uri.edu/ic5/45.pdf> (accessed Jan 31, 2006).
- Oloff M, Mayaud P, Brugha R, Semakafu AM. Integrating reproductive health services in a reforming health sector: the case of Tanzania. *Reprod Health Matters* 2003; **11**: 37–48.
- Bruckner H, Bearman P. After the promise: the STD consequences of adolescent virginity pledges. *J Adolesc Health* 2005; **36**: 271–78.
- Santelli J, Ott MA, Lyon M, Rogers J, Summers D, Schleifer R. Abstinence and abstinence-only education: a review of US policies and programs. *J Adolesc Health* 2006; **38**: 72–81.
- Kirby D. Emerging answers: research findings on programs to reduce teen pregnancy. Washington, USA: National Campaign to Prevent Teen Pregnancy, 2001. http://www.teenpregnancy.org/resources/data/report_summaries/emerging_answers/default.asp (accessed on Jan 31, 2006).
- Grimes DA. Emergency Contraception: politics trumps science at the US Food and Drug Administration. *Obstet Gynecol* 2004; **104**: 220–21.
- Wyss K, Lorenz N. Primary health care in sub-Saharan urban areas. Bern, Switzerland: Swiss Development Corporation, 2002.
- Gloyd S, Chai S, Mercer MA. Antenatal syphilis screening in sub-Saharan Africa: missed opportunities for mortality reduction. *Health Policy Plan* 2001; **16**: 29–34.
- Hawkes S, Miller S, Reichenbach L, Nayyar A, Buse K. Antenatal syphilis control: people, programmes, policies and politics. *Bull World Health Organ* 2004; **82**: 417–23.
- Roberts JM, Villar J, Arulkumaran S. Preventing and treating eclamptic seizures. *BMJ* 2002; **325**: 609–10.
- Ngwenya C. An appraisal of abortion laws in southern Africa from a reproductive health rights perspective. *J Law Med Ethics* 2004; **32**: 708–17.
- Ahmad K. UN study expresses concern over national antiabortion policies. *Lancet* 2002; **360**: 64.
- Gay J, Hardee K, Judice N, et al. What works: a policy and program guide to the evidence on family planning, safe motherhood, and STI/HIV/AIDS interventions. 2003. Washington, USA: The POLICY Project, 2003. http://www.policyproject.com/pubs/generalreport/SM_WhatWorksps2.pdf (accessed on Jan 30, 2006).
- Berer M. Health sector reform: implications for sexual and reproductive health services. *Reprod Health Matters* 2002; **10**: 6–15.
- Ravindran TKS, de Pinho H, eds. The right reforms? Health sector reforms and sexual and reproductive health. Johannesburg, South Africa: Women's Health Project, University of Witwatersrand, 2005.
- WHO. Transforming health systems: gender and rights in reproductive health. Geneva, Switzerland: World Health Organization, 2001.
- World Bank Institute. Health outcomes and the poor. http://siteresources.worldbank.org/HNPLP/Resources/461053-1111420694250/HOPbrochure2_text.doc (accessed on Jan 31, 2006).
- Buse K, Mays N, Walt G. Making health policy. Milton Keynes, UK: Open University Press, 2005.
- Sabtier PA, Jenkins-Smith HC. Policy change and learning: an advocacy coalition approach. Boulder, USA: Westview Press, 1993.
- Sen G, Germain A, Chen L, eds. Population Policies Reconsidered: Health Empowerment and Rights. Harvard Series on Population and International Health. Boston, USA: Harvard University Press, 1994.
- Donaldson PJ. The elimination of contraceptive acceptor targets and the evolution of population policy in India. *Popul Stud* 2002; **56**: 97–110.
- Thapa S. Abortion law in Nepal: the road to reform. *Reprod Health Matters* 2004; **12** (suppl 24): 85–94.
- Schneider H. On the fault line: the politics of AIDS policy in contemporary South Africa. *Afr Studies* 2002; **61**: 145–67.
- ARROW. Taking up the Cairo Challenge: Country Studies in Asia Pacific. Kuala Lumpur, Malaysia: Asian–Pacific Resource & Research Centre for Women (ARROW), 1999.
- Glassman A, Reich MR, Laserson K, Rojas F. Political analysis of health reform in the Dominican Republic. *Health Policy Plan* 1999; **14**: 115–26.