SID Policy Brief on Public-Private-Partnerships for Reproductive Health

Society for International Development (SID)

March 2006
Public-Private Sector Partnerships Working for Reproductive Health

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Introduction

This SID Policy Brief is designed to raise some important questions about private-public partnerships (PPPs) for reproductive health.

Some of the questions it addresses are:

- How to assess if PPPs are delivering benefits for women's reproductive health or causing potential harm?
- What are the true costs of PPPs to the public sector, are they supporting or fragmenting public health efforts?
- What are the governance mechanisms required to establish equitable PPPs?
- What are the potential implications of PPPs for the long-term agenda for equity and health?
- What are shared values and what are the potential areas for conflict of interest?
- What are the minimum standards and who defines and enforces them?

This SID Policy Brief recognizes that private-public partnerships (PPPs) for reproductive health are now a feature of developing health systems and have been for some time, however in order to ensure that they work for poor women within the framework of the agreements made at the International Conference on Population and Development (ICPD) in 1994 and the aims of the Millennium Development Goals in 2000, it is important to look at the inherent challenges potential hidden costs/pitfalls of such collaborations. The SID Policy Brief therefore aims to address the broader context of PPPs and the potential ramifications for national health agendas, whether they are an efficient use of scarce public sector funds and donor money and what are the values driving funding patterns for PPPs.

The message of the SID Policy Brief is that PPPs should not be seen as the way to enable the private sector to step into the space left by the dwindling resources, fragmentation and fragility of public health services. Nor should PPPs provide a safety net for political leaders who fail to provide adequately for the health of their populations. PPPs need to be about long-term solutions and longer term investments that enable poor people access to reproductive health. They need to support governments in improving health equity by building capacity in health systems, open up new opportunities to improve reproductive health, reduce maternal mortality, strengthen institutional arrangements at community level, improve prevention of reproductive health infections, reduce harmful risk factors around child birth and encourage more healthy sexual habits among women and men of all ages.

Understanding the successes and failures of PPPs for reproductive health within the framework of ICPD Programme of Action and the MDG 4 on reducing maternal mortality goes to the heart of how to ensure poor women and men's reproductive health. PPPs or Private Public Initiatives PPIs must work for poor women. In a non-for-profit framework PPPs can promote economic and social development that can strengthen the state and improves reproductive health for poor women and men.

"The sustainability of these initiatives (PPPs) is an issue, when funding comes to an end. Therefore, building capacities and skills of human resources in the public sector should be an on-going process (due to high turnovers, staff transfers, attrition), in which non-state actors can play a critical role-academic institutions." Ravi Duggal (India)
Some Working Definitions for Reproductive Health and PPPs

What are PPPs?
Public-private partnerships represent a collaborative relationship in which public and private sector actors work together on the basis of shared objectives, strategies and agreed monitoring and evaluation criteria, usually through the formation of a new joint entity for implementation. PPPs involve at least one private-for-profit and one public actor; the definition of ‘public’ being expanded to include also multilateral agencies, private also includes the not-for-profit private sector.

What is Sexual and Reproductive Health?
Reproductive health is a state of complete physical, mental and social wellbeing, not merely the absence of disease … in matters relating to the reproductive system…
Reproductive health includes:
• Capability to reproduce, and the capability to decide if, when and how often;
• Information on and access to safe, effective, affordable and acceptable methods of contraception;
• Safe pregnancy and child birth, and a healthy infant;
• Sexual health which includes not only counselling and care related to reproduction and STDs, but the enhancement of life and personal relationships;
• Life Cycle Approach, which includes reproductive health needs in adolescent as well as older women.

What does the ICPD say about PPPs?
Partnership with different sectors for expanding access to Sexual and Reproductive Health services was recommended in the ICPD Programme of Action. (Paragraph 15.5)
• ‘To strengthen the partnership between governments, international organizations and the private sector in identifying new areas of co-operation;
• To promote the role of the private sector in service delivery and in the production and distribution, within each region of the world, of high-quality reproductive health and family planning commodities and contraceptives, which are accessible and affordable to low-income sectors of the population.’

What is the position of The Millennium Declaration on PPPs?
In September 2000, the fifty-fifth session of the United Nations General Assembly adopted resolution 55/2: United Nations Millennium Declaration. The declaration among others provides a roadmap for accelerating equitable socio-economic development, poverty eradication and attainment of social justice worldwide. Of direct relevance to health, are the resolution sections that reflect on poverty and poverty mediated ill health, maternal and child health, HIV/AIDS, education and gender. The declaration also makes specific reference to the importance of developing ‘strong partnerships with the private sector and civil society organizations in pursuit of development and poverty eradication’.

PPPs and Reproductive Health in South Asia and East Africa

‘The modalities of partnerships between S.E. Asia and E. Africa- and the challenges (lack of frameworks, legislation, stewardship of government etc etc.) are surprisingly similar:’ Hulda Ouma (Kenya)

In relation to public health and sexual and reproductive health and rights South Asia and East Africa face similar situations – a shortage of funds for health, a rapid rise of privatization in the 1980s and 1990s and accompanying lack of investment in the public health sector in the 1990s along with the introduction of user fees and large and unregulated private sector providing dubious quality health care. Meeting reproductive health needs for poor women and men requires different strategies for PPPs than those that aim to meet basic health needs (such as bed nets, immunization etc.). Improving maternal health requires gender sensitive strategies for dealing with gender based violence, aftermath of abortions and the added complications other developing country diseases, social and cultural factors. In both regions, sustainability of quality health care is a major issue particularly as different approaches of the programmes generated by PRSPs and the MDGs.

‘Equity should be used as a yardstick in looking at any measures to improve reproductive health.’ T.K. Sundari Ravidran (India)

I’m going to explain Public-Private Partnerships until you feel drowsy and fall asleep!

The English daily The Island on Monday 27th February 2006 announces the SID meeting in Colombo underlining how reproductive health must be part and parcel of both the MDGs and the ICPD Programme of Action.’
Sexual and Reproductive Health in South Asia

South Asia is among the most populous regions in the world with over a billion people, most of them living in India. With the notable exception of Sri Lanka, the region has high levels of avoidable mortality. Maternal mortality ratios are extremely high, with the highest ratios of 740 registered in Nepal. Infant mortality rates range between 46 and 81 per 1,000 live births. Total fertility rates are above 3.0, and contraceptive prevalence rates range from 58% in Bangladesh to as low as 28% in Pakistan. More than 85% of births in Bangladesh, Nepal and Pakistan and 57% of births in India are not attended by a skilled professional. India has a very high burden of HIV, given its relatively higher prevalence rate and its very large population.

‘We cannot talk about PPPs and reproductive health without talking of capacity building, female literacy, female empowerment.’ Aruna Uprety (Nepal)

‘We need a body of evidence to show what has worked and what hasn’t and from there, take lessons to help us benefit to the maximum, the poor.’ Bina Pradhan (Nepal)

Safe Motherhood Plan in Nepal worked on a PPI with government, NGOs including medical practitioners, academics and other social scientists. An important inclusion in the PPP was to set as a goal poor women’s empowerment, addressing gender based violence and literacy.

‘PPPs in North East Pakistan has led to increased availability and access of different types of services, but actual skilled human resources are still over-stretched.’ Saman Yazdani Khan (Pakistan)

There are marked inequalities in health status between the poorest 20% and richest 20% of the population. For example, the proportion of births attended by a skilled professional among the richest 20% was more than 10 times that among the poorest 20% in Bangladesh, Nepal and Pakistan, and more than 5 times in India. There were three times as many infant deaths per 1,000 live births among the poorest 20% in Bangladesh, Nepal and Pakistan, and more than 5 times in India. Infant mortality rates among the poorest 20% in Bangladesh, Nepal and Pakistan, and more than 5 times in India.

Public-private interactions in sexual and reproductive health services at the country-level share most of the characteristics of public-private interactions in any health service such as contractual arrangements between the public and private sectors for direct involvement in service delivery, distribution of products or provision of technical support. However, there are also some arrangements unique to sexual and reproductive health services. For many decades, family planning programmes in many developing countries have had public-private arrangements such as social marketing of contraceptives. Franchising for service delivery is a relatively new arrangement that has gained prominence specifically in the provision of reproductive health services.

‘Government/public sector ownership is key to the sustainability of any initiative.’ Aruna Uprety (Nepal)

PPPs improving quality of care in Bangladesh

One of the few examples available on improvement in quality of care is from Bangladesh. The Bangladesh Urban PHC programme showed that in all the NGO clinics contracted (100%), more than one method of family planning was available and offered as a choice, as compared to only 19% in the control group of health facilities in the same district run by the government.

‘The private health sector in India is grossly unregulated, yet hugely subsidized by government. There are no standards of care, no accountability structures … Lack of regulation has impacted private sector investment in the health arena (i.e. health insurance companies which are in it, to make profit, not to do charity).’ Ravi Duggal (India)

Socio-demographic profile for major South Asian countries

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Bangladesh</th>
<th>India</th>
<th>Nepal</th>
<th>Pakistan</th>
<th>Sri Lanka</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GDP per capita (PPP US$: 2003)²</td>
<td>1710</td>
<td>3078.2</td>
<td>1420</td>
<td>2987</td>
</tr>
<tr>
<td>Population below income poverty line of US$ 1 per day (1990-2003)</td>
<td>36.0</td>
<td>34.7</td>
<td>37.7</td>
<td>13.4</td>
<td>7.6</td>
</tr>
<tr>
<td>Human Development Index (HDI) Rank 2005</td>
<td>139</td>
<td>127</td>
<td>136</td>
<td>135</td>
<td>93</td>
</tr>
<tr>
<td>Gender Development Index (GDI) Rank 2005</td>
<td>105</td>
<td>98</td>
<td>106</td>
<td>107</td>
<td>66</td>
</tr>
<tr>
<td>HDI rank minus GDI rank 2005²</td>
<td>+2</td>
<td>0</td>
<td>-2</td>
<td>-4</td>
<td>+7</td>
</tr>
<tr>
<td>Adult literacy: female rate as % of male rate 2003³ (age 15 and above)</td>
<td>62.5</td>
<td>65</td>
<td>56</td>
<td>57</td>
<td>96³</td>
</tr>
<tr>
<td>Population below income poverty line of US$ 1 per day (2000)</td>
<td>36.0</td>
<td>34.7</td>
<td>37.7</td>
<td>13.4</td>
<td>7.6</td>
</tr>
<tr>
<td>Life expectancy at birth (2000-2005)³</td>
<td>62.6</td>
<td>63.1</td>
<td>61.4</td>
<td>62.9</td>
<td>73.9</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births) 2003</td>
<td>46</td>
<td>63</td>
<td>61</td>
<td>81</td>
<td>13</td>
</tr>
<tr>
<td>Maternal mortality rate (per 100,000 live births) adjusted 2000⁴</td>
<td>380</td>
<td>540</td>
<td>740</td>
<td>500</td>
<td>92</td>
</tr>
<tr>
<td>Total fertility rate (2000-2005)⁵</td>
<td>3.2</td>
<td>3.3</td>
<td>3.7</td>
<td>4.3</td>
<td>2.9</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (1995-2003)¹¹,¹²</td>
<td>58</td>
<td>48¹⁰</td>
<td>39</td>
<td>28</td>
<td>70</td>
</tr>
<tr>
<td>HIV prevalence (2002-4) % in the age group 15-49 years 2003</td>
<td>0.2</td>
<td>0.4</td>
<td>1.3</td>
<td>0.3 (0.2-0.5)</td>
<td>0.1 (0.0-0.2)</td>
</tr>
</tbody>
</table>


Notes:
1. Estimates based on regression. The GDP figures in dollars have been adjusted for purchasing power parity (PPP) making data comparable across countries.
2. Based on consumption surveys.
3. The HDI rank used in this column are those recalculated for the 144 countries with a GDI value. A positive figure indicates GDI rank is higher than HDI rank, implying a relatively better status for women, and a negative value implies the opposite.
4. Data refer to national literacy estimates from census or surveys conducted between 2000 and 2004.
5. Data refer to estimates for the period specified.
6. Data refer to estimates for the period specified.
7. Data refer to the most recent year within the period specified.
8. Data refer to point and range estimates based on new estimation models developed by UNAIDS. Range estimates given in square brackets.
Reproductive health problems such as early and unwanted childbearing, HIV/AIDS and other STIs, pregnancy related complications and death account for a significant part of disease burden among women and adolescent girls in East Africa.

In East Africa, 13% of all DALYS are caused by reproductive health problems. The burden of disease is disproportionately distributed across socio-economic groups with poor women carrying the greatest burden due to poor economic status, weak health system, unsupportive policy environment, socio-cultural factors, and access to health services.

The high burden of disease for poor women is reflected in maternal mortality rate and the long term illnesses and disabilities including obstructive fistulae. This data reflects the high level of unmet needs for obstetric care and other reproductive health services among women in East Africa. A vast majority of births still take place at home (58% in Kenya, 62% Uganda and 64% in Tanzania). Even those who make it to health facilities after overcoming several barriers receive poor quality of care in some facilities. This may be related to limited infrastructure capacity, human resource shortage, shortage of supplies etc.

Abortion is the second most important cause of maternal mortality in the region despite being one of the preventable causes of maternal mortality. Most public health facilities have limited capacity to offer comprehensive post abortion care services significantly affecting availability of these services. Reproductive tract infections have far-reaching consequences including infertility and HIV/AIDS transmission. There are marked gender disparities in HIV prevalence rates in the region. For example, in Kenya, HIV rates among women of 15-49 years are nearly double the rates in men within the same age bracket. HIV infection among girls aged 15-19 years old is six times higher than boys of the same age group.

Preventable factors underpin the high burden of reproductive health related ill health. In East Africa, inequity in access to health care plays a significant role to the observed high maternal mortality rate. Other poorly understood but systemic factors negate the advantages accruing from the use of antenatal services, and so actual delivery falls to the hands of unskilled caregivers at home.

Private-not-for profit health providers could be an important source to improve reproductive health care for poor women, they are an important component of health service delivery in Kenya accounting for up to 50% of care in the rural areas. Among the mission sector are protestant groups, catholic groups and Muslim run health facilities. Mission services are located mostly in rural areas while mosque affiliated services tend to be in urban areas. In the hard to reach areas, religious organizations in particular may be the only reliable health providers available for the majority of the communities. In Uganda the private sector owns about 48% of the health facilities. In Tanzania, Voluntary agencies own 44% of the National Hospitals and contribute significantly to health sector through the provision of curative services and limited preventive and promotional health services. Previous reviews in the region indicate that although the not-for-profit sector had direct access to a wide range of donor agencies the support was variable and not always assured. Some institutions were significantly more successful in obtaining external donor funds than others. While in Kenya, government funding to the sector stopped in 1997, in Tanzania the NFP had been successfully integrated into the public sector.

Are PPPs facilitating the collapse of the public health sector? Because, the first assault on public health systems came in form of the SAPS and whatever little is left is now being farmed out into private hands.’
Rosemarie Muganda-Onyando (Kenya)


Examples of functional PPPs in Southern Africa

<table>
<thead>
<tr>
<th>Name</th>
<th>Common objectives</th>
<th>Partners</th>
<th>Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa Comprehensive HIV/AIDS Partnership (ACHAP)</td>
<td>HIV/AIDS Reduce spread and transmission; Improve access to care – continuum of hospital to home Outputs: Institutional development and decentralised capacities</td>
<td>Government of Botswana: Ministries</td>
<td>Private sector: Merck</td>
</tr>
</tbody>
</table>
How do we create meaningful partnerships?

Advocates for reproductive health need to ensure that parameters set for non-for-profit PPPs for reproductive health operate within the ICPD and rights framework and are accountable to poor women and men. It is critical to provide regulatory frameworks and yardsticks to measure PPPs that strengthen government abilities to meet reproductive needs of poor women as agreed to at the ICPD.

There is a potentially positive role for public-private interactions in the provision of sexual and reproductive health services. Harnessing private sector resources would be one of the most pragmatic routes to expanding sexual and reproductive health services. This is because much of the reproductive health services beyond pregnancy-related care and family planning have been available only in the private formal, informal and traditional sectors in South Asia and East Africa. We need to have publicly funded sexual and reproductive health services for low-income groups; complemented by services financed by effective pre-payment schemes for those with ability to pay. Services would be provided by a combination of public and private sector providers, with the government being the major purchaser of private sector services.

For such a strategy to work, a necessary condition is willingness and ability of governments to play a regulatory and stewardship role. Regulation by and stewardship of the government of public-private interactions in health, including in sexual and reproductive health services is needed to maintain a minimum acceptable standard of care and to contain prices and input costs.

The following are some points to consider when designing advocacy strategies for PPPs for reproductive health.

- promote equity - the bottom line must be that equity to ensure poor women and men's reproductive health is promoted.
- strengthen the role of government through PPPs as it remains the primary responsibility of governments to live up to their commitments to provide for the poor.
- engage and inform Local grassroots communities in order to ensure the efficiency and accountability of the PPPs.
- train both public and private sectors in order to maintain standards and achieve objectives for quality reproductive health.
- regulate and ensure transparency - publicly tendered (depending on the framework of the interaction), and the objectives, participants, intended outputs made public. In cases of franchising, the franchisee for example would have to meet certain basic requirements.

Areas to build not-for-profit PPPs for reproductive health:
- Advocacy for sexual and reproductive health and rights,
- Reproductive health services, training and capacity building, regulation,
- Monitoring and Evaluation
- Research,
- Resource mobilization (technical, financial),
- Information systems (HMIS),
- Community mobilization,
- Gender-responsive budgeting,
- Centres to prevent gender based violence.

In terms of PPPs need to differentiate between the for-profit and not-for-profit. It is with the for-profit sector that partnerships for reproductive health should be strengthened. The parameters of partnerships need therefore to be clearly marked out.

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Policy Framework

A workable and just policy framework for PPPs must operate specifically within a rights agenda that is gender sensitive—guided by ICPD-PoA and within a framework of strengthening public health system to reach and service the poor. When advocating for such a policy framework we need to recall that:

- Reproductive health is not the same as ‘basic’ health needs- a PPP should reiterate the commitment to provide reproductive health and to conduct the activities with gender sensitivity.
- When setting the parameters for PPPs for reproductive health we also need to look at broader governance issues- global partnerships, which determine how national PPPs are made. We need to look at who is setting the agenda for PPPs-to look at the political nuances of it— who are the players and what is their agenda? What is the political context? It is difficult for governments in countries in East Africa and South Asia to determine these agendas, where half their budgets are being provided externally- private companies, international NGOs or other donor governments.
- It is important to consider the sustainability of PPPs – how and when to institutionalise them to ensure quality and long term effect. We also need to recall that PPPs are not the answer for everything missing in reproductive health services.

Regulatory frameworks

A regulatory framework will enable both government and private parties to be held accountable. Part of the accountability must include engagement with local communities, community participation and involvement is necessary in order to ensure that PPPs take up their specific needs. It is important to prevent a ‘verticalization’ of reproductive health PPPs. In addition reproductive health has to be part of a comprehensive agenda because reproductive health outcomes are impacted by such other issues as malaria and anemia etc. The public sector must also grow through PPPs. In addition it is important to monitor how the public sector national health and RH policies and strategies has learnt, changed, and been strengthened by PPPs.

It is therefore important to:

- Work with existing national regulatory frameworks as a point of reference and ensure that these frameworks actually promote partnerships for quality reproductive health care, equity and access for the poor.
- Ensure the regulatory bodies are composed of independent different parties that are competent in assessing the different requirements of such PPPs.
- Work with professional bodies that are normally independent and can set standards and regulate and supervise and we can employ them appropriately to set or enforce standards.
- Take stock of what is on-going in our countries and see what is also available out there in other regions, in order to see what works best and how.

Advocacy strategies

Reproductive health advocacy must be formulated at the global, regional, national, and grass-roots level. At the global level- inter-regional exchanges, sharing and comparable investigations are very useful. Reproductive health advocates can assess what is working in the different regions, who the players are and who are the players and what are the funding mechanisms, the governance structures- and based on this they can PPPs for promoting health and what can work for us.

Reproductive health advocates need to:

- foster a broad dialogue among different stakeholders for not for profit PPPs for reproductive health.
- create awareness of what PPPs mean for family planning other reproductive health services, maternal health in communities, what the responsibilities of PPPs are and what they need to achieve in reaching out to the poor.
- involve local leaders- religious and non-religious. Reproductive health advocates
- lobby for an evaluation of existing PPPs supported and assess what equitable outcomes are emergin.
- use PPPs to push governments to continue to support reproductive health within the ICPD agenda.
- identify clear target groups and opportunities (such as working at regional levels SAARC, East Africa regional institutions)
- support PPPs promote the ICPD agenda.
Research

Although public-private interactions have been promoted for about 15 years now, there are very few studies mapping the full range of such arrangements or those evaluating how effective they have been in ensuring better access to a wider range of sexual and reproductive health services. We need to research into which types of partnerships are working specifically in reproductive health and at what levels (national, regional, grassroots) What role has the government taken, what roles have the private sector taken, what roles have the beneficiaries played. We also need to ask what role PPPs are playing in impacting national policies. We need to look at global PPPs and how they are functioning in the countries (at national level). Indeed, there is an urgent need for research in virtually every aspect of public-private interactions in health and their implications for sexual and reproductive health services. Among areas that need further research are:

- Conduct a study of specific types of public-private interactions for reproductive health: contracting of different types, privatization of insurance, social marketing, social franchising with specific reference to their implications for expanded coverage and equitable access to sexual and reproductive health services.
- Prepare case studies of ‘successful’ public-private interactions which have enhanced access to sexual and reproductive health services. What needs to be done to get the for-profit and not-for-profit private sectors to enter into partnerships that promote population well-being?
- Analyze the actors, context and processes underlying the promotion of privatization and public-private interactions specifically in sexual and reproductive health services at the global level and in specific country contexts.
- Undertake case studies of global public-private partnerships, their impact on national health systems and their consequences for sexual and reproductive health services in particular.
- Investigate women’s experiences with different types of public/private providers and perspectives on what is important in terms of the range and quality of sexual and reproductive health services.
- Analyze of regulation and incentive mechanisms in different settings to understand better what works in which context with what effect.
- Look at the socio-cultural factors that impact RH and even the outcomes of PPPs.

Launch of Development 48.4 on Sexual and Reproductive Health and Rights and SID Sri Lanka Chapter Public Seminar held 2nd March 2006

The SID Sri Lanka Chapter hosted a major launch of Public Seminar and Launch of Development Volume 48 no 4 on ‘Sexual and Reproductive Health and Rights’ with much ceremony, press coverage and a large audience from the development policy community. Following the welcome by Upananda Vidanapathirana, President, SID Sri Lanka Chapter the Hon. Nimal Siripala De Silva Minister of Healthcare & Nutrition gave the key note address and launched the journal issue with a most informative discussion on development and reproductive health. SID Vice President Khawar Mumtaz gave the vote of thanks underlining the importance of reproductive health in the region and the important voice SID provided on this occasion.
The Seminar chaired by Wendy Harcourt, Editor of Development was addressed by Dulitha Fernando from Sri Lanka, Ravi Duggal from India, Nicolas Muraguri from Kenya, Bina Pradhan from Nepal and Sundari Ravindran from India. They presented different perspectives on sexual and reproductive health and rights from their national experiences within the human rights framework and specifically in relation to the ICPD agreements. They brought out some of the harsh realities faced by poor women in South Asia and East Africa mindful of the constraints for resources due to current macro-economic policies that fail to place health or gender high on the priority list. They concluded that it is important for the public to keep the pressure on governments to deliver the many promises of the 1990s, particularly the agreements reached at the ICPD as well as consolidating the promises of the Millennium Development Goals on eradicating and in particular to end maternal mortality still endemic in the two regions.
I would like to express appreciation on behalf of UNFPA for a very fruitful workshop and public seminar. The launch of the journal dedicated to reproductive health was indeed timely and would greatly facilitate the reviving of the ICPD agenda.

Malathi Weerasooriya, Assistant Representative UNFPA/Sri Lanka

Prime Minister The Hon. Ratnasiri Wickremanayake meets international guests to discuss the journal issue.

Participants of the SID Workshop Colombo, Sri Lanka March 1, 2006

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Malathi Weerasooriya, Assistant Representative UNFPA/Sri Lanka
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