

The Pledge to End Poverty

The image and the reality of
international aid for health and
population

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November 29, 2007

The end of poverty ...

- Destination to be reached preferably by 2025

- **Role of rich countries**

“provide increased development assistance and improved global rules of the game”

- **Role of poor countries**

“stay on track to reach universally agreed Millennium Development Goals”

- Renewed high profile international attention: enhanced national policy focus on poverty reduction, visibilized budget allocations and allowed civil society involvement in public policy process

Partial understanding of poverty ...

- Social/gender relationships and structures that govern access to resources/services to come out of poverty rarely addressed by econ/social policy
- In addition to hunger and lack of human capital, denial of fundamental freedoms and human rights as central to poverty process and experience is not recognized (powerlessness, lack of freedoms, discrimination, social marginalization)
- Silence in the arenas of political empowerment and social transformation

International obligation to end poverty

Not a new agenda, but new attention, greater urgency and public discourse

WHY?

- rich countries have the means and the know how
- poverty breeds large populations that puts pressure on limited natural resources on this fragile planet
- increased vulnerability to new health risks from greater global integration and population movements
- societies destabilized by extreme poverty and seen to breed violence and global terrorism

International obligation to end poverty ...

How?

- by giving poor countries financial aid that are actually loans to be repaid
- by providing technical assistance (expatriate consultants) to transfer technology
- but, often in a context neutral way and in defiance of local knowledge
- processed through huge and expensive bureaucracies (eg. World Bank, bilateral aid offices)

International aid for health and population

- Ill health, high fertility and poverty linked in causal ways
- Health and population control obvious candidates for international aid in fight against global poverty
- **Several grand views dominated**
 - Population control as route to poverty reduction
 - RH approach and health sector reforms
 - Universal goals to end poverty
- This paper reviews experience of Bangladesh to utilize aid for health and population to reduce poverty

Population control as route ...

- Fear of consequences of population explosion in poor countries: cannot wait for economic development and modernization
- Transfer modern birth control technology through nationwide FP programmes: assumption that supply will create demand
- Promotion of FP will reduce poverty
- Effectiveness maximized by segregating health and family planning services
- Rapid scaling up during 1970s and 80s
- Decline in birth rates in most of LA and Asia from 1990s

RH approach and sector wide programmes

- “Success” of FP programmes led to shift of donor attention to health generally
- Concerns over poor utilization of aid, wastage, duplication, poor implementation
- Concern over long term financial sustainability: need reforms in health sector
- RH approach: explicit policy shift away from “demographic concerns” to well being of individuals as centre of sustainable development

Universal goals for poverty reduction

- Reaching end of extreme poverty by 2025 through MDGs
- Crucial role of health in journey to end poverty: three health related MDGs
- Interdependent goals and targets, emphasizes integrated econ and social policy, reduction of both income and human poverty high on international agenda
- Assumption that ODA can break poverty trap through targeted investments that raise level of capital per poor person
- Each poor country needs a PRS
- PRS process positively strengthened donor image

The reality...

Bangladesh Family Planning Programme (1975)

- “no civilized measure too drastic to keep population of Bangladesh on the smaller side of 15 million” FFYP 1973
- Successive CPR targets and single minded contraceptive delivery service, neglect of contraception related health
- Very small effective demand for birth control, limited to well off educated women, did not deter donor funding

The effect:

- Huge investment in physical and human infrastructure despite weak demand: wastage of loan money
- Targets: ideal situation for abuse of women’s personal freedoms and the human rights of the poor
- Inequitable distribution of “demographic dividends”

The reality...

Health and Population Sector Programme (1998-2003)

- Since mid 1970s progressive resource shift in favour of primary health in rural areas
- Government adopted RH approach following ICPD, coincided with World Bank SWAp in health sector
- Essential package including RH to be delivered through integrated health and family planning services
- Community based one-stop service, owned and managed by community

Effects:

- Good on paper but unworkable: over designed and over budgeted
- Disregard for institutional and social context, local knowledge
- Scrapped by the new government in 2001

The reality...

Poverty reduction strategy (PRS) and the MDGs (2000)

- Strong donor emphasis on country ownership
- Assumption that ownership contributes to democracy
- Process of preparing PRSP taken very seriously

Effects:

- Ownership superficial at best since PRS is the eligibility criterion to access Bank-Fund concessional loans
- Ownership of implementation more crucial: needed information, transparency and accountability of both government and donors
- Progress on health MDGs but systematic disparities in outcomes

The Reality ...

- Targets are useful but carry risks of increased marginalization
- Attention on targets diverts attention away from poorest and most deprived groups
- Become obstacles for much needed prioritization of limited resources and neglect of effective local know how
- Creation of effective demand for services not emphasized enough: 'free' or subsidized services do not reach all
- Social protection schemes may be useful to create demand
- Silence on important aspects of women's health related to poverty reduction: universal access to safe RH care, women's lesser ability to pay, increased exposure to violence

What has citizenship and rights got to do with it?

- The ways in which democracy (or its absence) affects poverty are not straightforward or even “pretty”
- Bangladesh: ‘non institutional forms of accountability’ operate at macro level: puts pressure on government to provide for those with ‘greatest capability deficits’
- Absence of accountability at grassroots and severely governance challenged policy environment: puts government on defense, gives upper hand to donors
- Donors behave irresponsibly: impose over designed programmes, disregards local knowledge, ignores local institutional context, promotes unequal relationships with government partners
- But who will monitor donors??

What has citizenship and rights got to do with it?

- Repeated disregard for rights of poor in order to protect interests of powerful creates tension between ‘procedural’ and ‘participatory’ forms of citizenship
- Increasing instances of mobilizations and struggles by ordinary people, workers, farmers, health service users, clients, teachers, students
- Spilled over into political arena: greater participation in elected bodies and local committees
- Contestation of ‘culture of patronage’ and norms of exclusion, re configuration of state citizen relation and new meanings of citizenship

In conclusion ...

- Building citizenship from the grassroots and enhancing collective capacity of poor people is the most promising basis for holding policy makers and actors to account to keep commitments to ‘end poverty’
- Strengthening voice and participation of the poor in policy processes means ‘changing the way these processes are done’
- Is the international community and national governments prepared to enter into a global social contract to ‘end exclusion and ensure justice’
- Is it time to think of a rights based poverty line?