POST-2015 WOMEN'S COALITION

A coalition of feminist, women's rights, women's development, grassroots and social justice organizations working to challenge and reframe the global development agenda.

An Advocacy Brief: Post 2015 Development Agenda

FINANCE AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Introduction

Resource mobilization is a critical issue in the current discussions on the Sustainable Development Goals and the post-2015 development framework. Proposed goals should be adequately resourced in order to be achieved across all developing countries. The outcome document of the 47th session on Commission on Population Development (CPD) states "Program of Action requires for its implementation adequate mobilization of resources at the national and international levels." Similarly, the outcome document of the 13th Open Working Group explicitly highlights 'finance' as one of the key targets of the proposed goal of **means of implementations and revitalization of the global partnership for sustainable development.** One of the four targets under this goal is to mobilize additional financial resources for developing countries from multiple sources.

Women's health, with specific reference to sexual and reproductive health and rights (SRHR), has to be analyzed in the context of current global economic landscape. Key over-arching trends that will impact financing for SRHR are:

- A significant reduction in public spending specially for health sector by many states in the face of global recession.
- A growing trend of privatization of health, national governments are drifting away from their responsibilities to provide universal health care.[1]
- Restrictive conditions of international trade agreements.
- An increased diverting of development cooperation towards concerns of security.

These combine to increase 'Out-of-pocket-expenditures' for health, making the ability to pay the major determinant of access to health care when s/he needs it most.[2] This has adverse impact especially on the poor and on poor women in particular as women are most-often the last recipients of household financial resources.

Context Analysis

In the current context the following are key issues with regards to resource mobilization for SRHR – reduced public funding for the health sector, vertical funding, and increased privatization of the health sector. There is also lack of funding for women's and human rights organizations which uphold sexual and reproductive health and rights agenda in countries and also demand accountability from duty bearers.

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Reduced Public Funding and Support:

Austerity measures taken by many states to battle the global recession has reduced public funding specially in health sector which has hit the poor, especially women, the hardest. According to a study carried out in 181 countries, "overall, 68 developing countries are projected to cut public spending by 3.7% of GDP, on average"[3] Some of the major adjustments that have been made by many governments in the health system are "increased user fees or charges for health services, reductions in medical personnel, discontinuation of allowances and increased copayments for pharmaceuticals."[4] These have resulted in uneven and insufficient spending on health care by the governments of many countries.[5] Furthermore, health spending cuts can present significant dangers to populations in developing countries, in particular.[6]

Official Development Assistance (ODA) on the other hand fell from US$ 122.4 billion in 2008 to US$ 120 billion in 2009. While this has gone up again to US $ 128.7 billion in 2010, Organization for Economic Co-operation for Development (OECD) preliminary findings suggest slower aid growth in the future. The UNFPA estimates that US$ 68-70 billion yearly is needed to achieve the Program of Action of the International conference on Population and Development (ICPD). Of this the amount, 1/3 (about US$21.7 billion) should come from donor funding, yet in 2008, donor funding stood at US$10.4 billion.[7]

Increased Privatization of Health Sector

There is an increasing privatization of the health sector. Privatization could happen in different areas of the health sector including financing, service delivery, capacity-building, management and investment. Privatization of health is, "the marketization of health for profit; the shifting of responsibility of service provision to the private, commercial sector; and the shifting of financing of health to out-of-pocket payments by households."[8]. It refers "not to the existence of a private sector in health, which is a universal phenomenon. It refers to deliberate interventions through policies and funding support to expand private sector provision of health care services; to introduce or expand private financing of health care (e.g. out-of-pocket expenditure, private insurance) and other market mechanisms within public sector health services; and to the gradual withdrawal of the state from taking responsibility for universal access to health care services."[9]

Unfortunately, the trends have shown that privatization is, "about the governments handing over responsibility for the health of the people of their country to a whole range of different organizations and agencies, who may or may not work together, and who may or may not agree to and then implement a common plan to achieve a set of coherent, comprehensive public health goals and universal coverage. Rather, by definition, as private entities, these organizations and agencies are more interested to develop their own "market segment" and serve "their clients."[10]

Lack of private sector regulation by the government has widened the gap between poor people and health facilities. "The increasing trend of privatization of healthcare coupled with higher rates of out-of-pocket expenditures poses a significant barrier towards achieving universal access to health in general and women's SRH services in particular.[11]

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Restrictive International Trade Agreements

Restrictive conditions of existing international trade agreements such as the Trade Related Intellectual Property Rights (TRIPS) Agreement and Free Trade Agreements (FTAs) have further eroded access to health services, in particular, for the poor. Among 20 WTO agreements only five are critical to public health including GATT, the General Agreement on Trade in Services (GATS), and TRIPS[12] all of which exclude sexual and reproductive health, with the exception of HIV, from their health issues.

Costs of medicines have increased due to international patent system codified by TRIPS.[13] The innovation in the patent system is, "meaningless if the majority of the people in need do not have access to it. It is unacceptable that innovation is reserved for the rich."[14] In addition, the governments of the South are required to adopt TRIPS-plus with greater intellectual property standards than those required by TRIPs which has led to further increase in the price of medicines. [15]

Furthermore, limited public health expertise among the trade negotiators coupled with limited or no space for public health professionals inside trade negotiations have caused absence of holistic public health including SRHR approaches in the trade debates.

Vertical Funding and absence of SRHR

The Millennium Development Goals (MDG) era has seen a vertical approach in policy-making and budgeting on health which has reflected also in ODA supports. This approach has been complemented by emergence of several funding initiatives[16] with no SRHR as their core funding policies. There also has been a, "siloed approach to development, which has been fortified by single-issues international funding mechanisms employing vertical health interventions such as the Global Health Initiatives. These have further weakened health systems in many low income countries."[17]

Lack of Governance and Accountability of Health System

Poor reproductive health outcomes can also be a result of weak governance and lack of accountability in the health system. Health system governance has not received the adequate attention it deserves. It is imperative that there is a dire need to address the gap between health policy development and implementation. Weak monitoring and evaluation systems also aggravate the ability to monitor implementation and outcomes of policies and programs just as much as inequitable health financing.[18]

Women's and Human Rights Organizations are Underfunded

Despite the fact that there is significant interest in 'investing' in women and girls[19], the large majority of the organizations remain quite small – not by choice, but due to challenges to mobilize the resources they need to fulfill their programmes and visions"[20]. AWID's 2011 survey has shown that a large majority of women's groups are still operating on small budgets.[21] This is threatened in the climate of funders choosing to make larger grants as these organizations are unable to handle large amounts of money, and such funding changes the key nature of their work. However these small activist organizations are those who are working on the frontlines to push the human rights agendas especially sexual and reproductive rights. They also uphold sexual and reproductive health and rights agenda in countries and demand accountability from the duty bearers.

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CASE STUDIES

Pakistan

The issue of sexual and reproductive health and rights (SRHR) in Pakistan is very important, and can be assessed from three interrelated perspectives: women's social status, state priorities and donors' agenda.

As a traditional patriarchal, as well as feudal and tribal society[1] Pakistan harbors strong values on issues regarding family, sexuality, SRHR and gender relations. The state of SRHR in Pakistan cannot be understood without Islamic, social and cultural norms shaping society's collective attitude towards SRHR in general and women's issues in particular. This situation is generating dismal facts, such as low literacy rates, gender-based violence, lack of discussion and education on sexuality issues, whether formal or in public discourse, and women's lack of autonomy to make decisions regarding their bodies. These in turn translate to poor sexual and reproductive health. Consequently, poor women's health in Pakistan is as much a social as a medical problem. Since its inception through 1980s, the National Family Planning Programme—the main reproductive health service provider in Pakistan—has been poor in terms of density, service provision and quality. There are number of socio-economic, religious and cultural reasons behind this poor performance but a main factor is the lack of priority given to this issue by state. The security-obsessed state of Pakistan, which allocates its maximum resources to fight the US-led war on terrorism, has very low priority for social sector spending and women's development. Even its other South Asian neighbors, like Bhutan and Nepal, are spending 10 times more on the health sector. The sexual and reproductive health-related initiatives in Pakistan have been mainly donor-dependent. Donors' funding is mainly related to mother and child care however, and though it brought the MMR down to marginal extent (from 346 to 276/100,000 in one decade), much more is needed to provide comprehensive sexual and reproductive health services, provide comprehensive sexuality education, and address sexual and reproductive rights. Another issue is the question of enhancement and effectiveness of donors' aid. Donor's national security interests as conditionality for aid is a bottleneck to the improvement of SRHR. For instance, USAID's financial aid for Pakistan in the field of reproductive health[2] has waxed over the decades according to the political interests of the US in the region. Such aid should always be free of strings.

Source: Bushra Khaliq, Executive Director, Women in Struggle for Empowerment (WISE), Lahore, Pakistan. Email: bushra.khaliq@yahoo.com. The case study was published in ARROW's* For Change*, Repoliticising Financing: Re-energising Political Support Form Women's Health and Sexual and Reproductive Health and Rights in 2011.

Latin America and the Caribbean

Health financing in Latin America has long been dominated by social insurance schemes, represented by Social Security Institutes (SSI), that cover the formal employed sector. These represent some of the "world's oldest, most powerful, most complex and most deeply institutionalized social security systems."[22]. Social security funds constitute at least 50% of public spending on health in most countries of the region, and some rise above 75% (e.g. Costa Rica 85% and Chile 89%)[23].

Health sector reform in Latin America has generally been in response to the segmentation of the health system into the social security sector, funded with multi-party financing, the public sector with government funding, and the private sector financed by private out-of-pocket expenses and private insurance. Access to health services was also segmented according to each social group's ability to pay. Thus, reforms were aimed at achieving integrated health systems with better co-ordination across financing mechanisms, thereby improving access to care and improving health system efficiency.

[1] There are added challenges to women in tribal and feudal settings of Muslim society. For instance, in the tribal belt of Pakistan, mullahs of the Muttahida Majlis-e-Amal (MMA) government have prohibited women from visiting male doctors. Tribal societies have higher incidences of customary practices like early marriages, exchange marriages, bartering women to settle disputes and stoning to death. Government campaigns on contraception are also more difficult to implement in tribal areas.

[2] US interests in Pakistan revolves around the war on terrorism. Pakistan is among the top recipients of military aid after Iraq and Israel. In 2010, the US approved for the first time US$7.5 billion for five years for non-military aid, meant for the social sector in Pakistan. However, the conditions to this aid were so stringent that many Pakistanis considered it tantamount to selling their sovereignty.

In some countries, financing reforms introduced the participation of the private sector into insurance schemes (e.g. Chile, Colombia and Peru). In others, the main focus was on rationalising social insurance schemes and unifying the system fragmented across numerous contributing funds (Argentina and Uruguay)[24] The widespread existence of social and private insurance schemes meant that those who were uninsured would incur out-of-pocket expenses to pay for health services. To address this issue, a few countries (e.g. Bolivia and Colombia) have introduced financing reforms aimed at universal coverage with a basic package of essential services.

Brazil is an exception to reform experiences in other Latin American countries. Here, health financing reforms were spearheaded by a social movement which radically transformed the fragmented health system. A proposal to create a single unified public health system financed by tax revenue and aimed at universal coverage was incorporated in the1988 constitution. This was within the context of decentralisation and democratisation of the health sector[25]. However, despite these efforts, Brazil continues to have significant (59.7%) private spending on health, as is the case in other countries of this region, with private insurance accounting for nearly half (48.1%) of this spending[26]. English speaking countries of the Caribbean are financed principally through tax revenue, supplemented by out-of-pocket payments and donor funding. Reforms tend towards creating national health insurance schemes and encouraging hospitals to be financially autonomous[27].

Source: The Health Rights Reforms? Health Sector Reforms and Sexual and Reproductive Health. Editors: TK Sundari Ravindran and Helen de Pinho. The Initiative for Sexual and Reproductive Rights in Health Reforms. Women's Health Project, School of Public Health, University of the Witwatersrand, South Africa

Key Policy Directions and Priority Actions

- Governments and donors should support to meet agreed funding requirements to ensure universal access to sexual and reproductive health services by 2015 and beyond.[28]
- Government of all countries especially with poor health indicators should increase their budget allocation for health and include SRHR as one of the major components.
- In order to achieve universal access to health, all barriers to access health facilities must be removed. The countries have to move away from, "'out of pocket' expenditure' towards a greater share of government expenditure of health through tax revenue and through social insurance paid for jointly by users, employers and/or government reduce."[29]
- Governments must not disengage from its regulatory role. Instead reforms in social services must be part of a political agenda that balances economic growth with equity and ensure the meaningful participation of civil society and other stakeholders in the public health system.[30]
- Governments should regulate public sectors and ensure that they address public health care, including SRHR. In addition, the benefit of public private partnerships (PPPs) in health must be reassessed to support claims that they benefit public. Public and private resources must be channeled to achieve health equity within a cohesive policy framework.[31]
- Private sector actors should be held accountable for the results of their programme for women and girls in order to reinforce that economic growth and profit are not the end of development goals. [32]

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- A budgetary analysis of health allocations must be included in a monitoring system that should be developed for all public health systems. This should have clear indications on resources spent on each program in compliance with the recommendations of WHO.[33]
- The state budget should be redirected to ensure gender equality and "to redress inequalities and discrimination in the household, in asset ownership, and in labor and credit markets. This can be achieved through various measures including spending on education and training that close gender gaps, investments in access to health care, and expenditures that reduce women's care burden."[34] This can be achieved through gender-responsive budgeting (GRB) which is a tool to promote gender equality by assessing the effect of government revenue and expenditure policies on both women and men.[35]
- Countries must, "develop and implement policies that balance access to essential medicines and intellectual property rights protection, thereby facilitating the affordability of medicines and creating efficient market disincentives against the spread of substandard drugs."[36]
- Participation of health professional in trade negotiations is important to "ensure that health is protected in trade policy and agreements. Similarly, trade professionals need to engage on health issues to understand better the epidemiologic, medical, economic and social implications of limitations on health services, products and innovations."[37]
- A Sexual and Reproductive Health Sub accounts is a crucial tool for setting priorities, allocating budgets, and advocacy as well as for increasing transparency and drawing accountability from governments tasked with providing RH services.[38]
- Donors should review vertical funding mechanisms for components of SRH services, and put them under the same umbrella.[39] It is a moral call for all donors to support funding for issues such as gender equality women's rights, sexual and reproductive health and rights (SRHR) human rights even if it is not sexy.
- Donors should ensure multi-year and core funding to the women's right organizations as they are key to facilitate strong results. Core funding allows flexibility to respond to changing circumstances and context.[40]

Key Definitions

Aid: 'Aid' refers to official development assistance (ODA) reported to the Development Assistance Committee (DAC) of the Organization for Economic Co-operation and Development (OECD).

Bilateral vs. Multilateral Aid: Bilateral aid is given by one country directly to another; multilateral aid is given through the intermediacy of an international organization, such as the World Bank, which pools donations from several countries' governments and then distributes them to the recipients.

Official Development Assistance (ODA): ODA is a grant or loan from an 'official' (government) source to a developing country or multilateral agency for the promotion of economic development and welfare. It is reported by members of the OECD Development Assistant Committee (DAC) according to strict criteria

each year and by a small number of donors outside of the OECD DAC group, who typically report a less comprehensive dataset. It includes sustainable and poverty-reducing development assistance (for sectors such as governance, growth, social services, education, health, and water and sanitation) as well as funding for humanitarian crises. "There is a possibility that the development ministers of the Organization for Economic Co-operation for Development (OECD) will agree on a new definition of ODA at the end of 2014."[41]

This issue brief was prepared by the Asian-Pacific Research & Resource Centre for Women (ARROW) for the Post 2015 Women's Coalition.

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