

Turning the financial crisis into opportunity for SRHR

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Europe always has been one of the most important supporters of the SRHR agenda, since before Cairo, at Cairo and after. Although it is clear that Europe now has its own challenges, particularly in recent times. This is not just due to the financial crisis, but also because of the entry of states like Malta into the European Union, whose views on SRHR are somewhat different from most other Member States. Those challenges and Europe's ability to handle and face them are problems not just for Europe, but for the whole world. Europe needs to speak with one voice, the same one it used in Cairo, if this agenda is to move forward.

With that in mind, however, I'm going to focus on the potential impact of the financial crisis on the global SRHR agenda, because the links between it and its implications for SRHR have still not been strongly laid out. Hypothetical arguments exist at this point, and we can see which way the 'wind is blowing', but we also want to talk about the nature of programming and whether there is the possibility for turning the crisis into an opportunity. So this presentation will look both at finance and at programming.

Health financing: Trends and needs

In Cairo, advocates from the global North and South pointed out that well-functioning health systems are essential for fulfilling the SRHR agenda, and SRHR needs to be seen in this context. However, it has taken a very long time for this recognition to get on the agenda after Cairo – a lot of time was wasted.

After adjusting for cost of living differences, high-income countries spend 30 times more per-capita on health than low- and middle-income countries. More than half of health spending in poor countries is out of pocket, which means that catastrophic illness, accidents, poor primary care and referral and inequitable private and public health insurance all hit poor people the hardest. You have enormous levels of untreated illness – far greater than in the US, where it has become worse in recent years.

By the middle of this century, changes in population size and composition will raise health care spending needs by between 37% (in East Asia/Pacific) to as high as 62% (in the Middle East and North Africa region). This represents an enormous health burden, especially in light of the irony that public share of health expenditures is poorest in low-income countries. For those of you in this region who are annoyed with cutbacks in public spending on health, the following table may be salutary.

| | Public share of health spending | Social health insurance | Out of pocket health spending |
|-------------------------------|---------------------------------|-------------------------|-------------------------------|
| Low income countries | 29% | 2% | 93% |
| Lower middle income countries | 42 | 15 | 85 |
| Upper middle income countries | 56 | 30 | 85 |
| High income countries | 65 | 30 | 56 |

Changes in external sources of health funding

External sources of health expenditure, in the form of official development assistance (ODA), represent 8% of health spending in low-income countries on population-weighted basis; and 20% on country-weighted basis. There are 12 sub-Saharan African countries where external sources account for more than 30% of health spending. Clearly, changes in ODA will have a substantial impact on countries which have greater dependence on external sources.

Development aid for health was \$ 10 billion in 2003 (i.e. one-seventh of total ODA, which was 0.25% of gross national income (GNI) in 2003 against Monterrey goal of 0.7% and Millennium Project goal of at least 0.54%)

World Bank econometrics suggest that health spending has a strong impact on maternal mortality and child mortality; that parallel investments in infrastructure and education also help; and that economic growth impacts are direct and lead to higher health spending generally.

External sources of health financing represent 55% of all external flows to Africa and only 9% to other developing countries. Specific disease-focused global programmes account for 15–20% of health aid. A very high proportion of this is off-balance-of-payments (BOP) and even off-budget. A study of 14 poverty reduction strategy papers (PRSPs) showed that 30% was off-BOP and 20% was off-budget, but in the BOP, which totally contradicts donors' talk about country ownership.

There is no question of accountability or civil society participation under these circumstances; because no one knows it exists since these expenditures are not in published budget documents. In short, the approach of the World Bank and International Monetary Fund (IMF) thru PRSPs makes it very difficult to document expenditure figures, therefore there is no roadmap to integrate sectoral strategies into macroeconomic policies, no micro-macro links or medium-to long-term links, and no real improvement in predictability.

Potential impacts of the financial crisis on health financing: Three pathways

Pathway 1: Via lower growth of gross national product

The strength of the Asian 'tiger' phenomenon is also its weakness in terms of the extent to which exports have dropped off in Asia. Trade protectionism (e.g. agricultural subsidies, 'buy American' pressures) has led to a decline in exports. When the money dried up, it dried up faster for trade than for production, so countries dependent on exports have been hit very hard.

Countries that export goods and human beings, as well as those involved with outsourcing (for example, Bangalore) have seen huge job losses because of a drop in earnings from outsourcing. There has also been a fall in migrants' remittances sent back to their home countries.

Also, in developing countries with significant financial sectors, financial sector losses have spilled over into the real economy. This phenomenon is most important for 12 countries in the G20, for example. When governments start tightening their belts in reaction to this, there are direct impacts on out-of-pocket spending by households, and gender effects soon surface in terms of who gets services, who has to wait longer periods of time before being taken to doctor. These impacts affect girls and women much more than boys and men.

Pathway 2: Growing dependence on IMF borrowing

There has been a loss of fiscal policy space in many countries (e.g., Hungary, Iceland, Latvia, Honduras, Pakistan, Ukraine etc.) due to typical structural adjustment conditionalities. The US is pushing governments to raise stimulus spending to 2% of GDP, but the IMF requires low-income borrowers to stay below 1%. This double standard of fiscal stimulus for the rich and fiscal discipline for everyone else has remained virtually unchanged despite the crisis. Domestic companies have been replaced by foreign ownership, and large financial consultancy services, such as BCS, Deloitte and MCK, have declared losses in India! This 'born-again' structural adjustment phenomenon urgently needs tracking from Europe.

Pathway 3: External assistance for health

As mentioned previously, this is especially important for countries whose health systems are heavily dependent on external funding, including ODA the Global Fund, private funding sources etc. This needs tracking and advocacy to better understand what is taking place and the impact it is having.

Programming challenges for SRHR

SRH has been "utterly marginalised from the global discourse about health and well-being ..."
– *Lancet 2006*

The ICPD agenda has been fragmented by a number of phenomena. For example, it has been fragmented by the separation of sexual and reproductive health from health systems strengthening (which is the basis for sustainability); by the continuing separation of family planning, including reproductive health supplies, from STIs/reproductive tract infections (RTIs)/maternal mortality – essentially separating MDG 5 from the reproductive health target. It has also been fragmented by the separation of young people's health/rights from adults (including in sex education); by the separation

of HIV from the rest of SRHR; and by the separation of health from rights/responsibilities, which has left safe abortion hanging and has slowed the transformation of gender relations.

Turning crisis into opportunity: example of HIV and SRHR

“From the very beginning of the global response to the AIDS pandemic, prevention has been marginalised. Treatment has dominated. This systematic imbalance in clinical and public-health programmes is largely responsible for the fact that around 2.5 million people become newly infected with HIV each year.” – Richard Horton and Pam Das, Editors, The Lancet¹

In terms of programming and finance, how can we bring HIV and SRHR back together? Before and after ICPD they ran as parallel streams. This was made clear, for example, by the UNAIDS’s Global Strategy Framework on HIV/AIDS (UNAIDS 2001), which took an epidemiological approach with a focus on ‘high-risk’ groups such as sex workers, injecting drug users and men who have sex with men. It included nothing about strengthening primary health systems and incorporating HIV prevention, counselling, testing and treatment into the full array of community-based sexual and reproductive health services as agreed at ICPD. In fact, in a 290-page history of the first ten years of UNAIDS, ICPD is mentioned only once (in connection with the missed ICPD+5 targets relating to young people’s knowledge of HIV prevention methods), and the words ‘reproductive health’ do not appear in the index at all! (Knight 2007)

Within the MDGs, HIV is positioned under MDG 6 with malaria and other infectious diseases, as if it is a vector-borne disease, while the rest of sexual and reproductive health has been placed under maternal mortality, as part of MDG 5. Funding through the Global Fund (from 2002) has gone largely to treatment rather than prevention, even in the face of rapid feminization of HIV infection.

UNAIDS and WHO are working in parallel, and as useful as the Three Ones principles² are, they offer very little to enable integration into national SRHR or MDG strategies.

Can Humpty Dumpty be put back together again?

“Condom use is a critical element in a comprehensive, effective and sustainable approach to HIV prevention and treatment. Prevention is the mainstay of the response to AIDS.”
– UNAIDS, March 2009³

¹ www.lancet.com 6 August 2008

² Principles for the coordination of national AIDS responses, calling for: One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority, with a broad-based multisectoral mandate; and one agreed country-level Monitoring and Evaluation System.

³ ‘Condoms and HIV prevention: Position statement by UNAIDS, UNFPA and WHO’, http://www.unaids.org/en/knowledgecentre/resources/featurestories/archive/2009/20090319_preventionposition.asp

The many interrelated issues – including violence, stigma etc. – must not sit separately, because they are all closely linked both with SRHR and HIV.

To this end, I have five suggestions.

1. Although every organization has its own mandate, leadership can assign key actions relating to SRHR, including HIV/AIDS, a higher priority. An example of this is the recent statement about prevention by the Executive Director of UNAIDS⁴. This was a valuable move, although it is only a statement at this point and must be followed up with action.
2. Invest in health systems with priority on SRHR. An example is the recent move by the Global Fund in this direction, and the move by the International Health Partnership (IHP) on SRHR outcome indicators.
3. Prioritize prevention programmes in schools, communities, and health systems, including information and counselling on the positive aspects of sexual and reproductive health as well as on how to avoid STIs/HIV, unwanted pregnancies, sexual coercion and gender-based violence. There are examples of forward movement in this regard from Nigeria, Cameroon, Brazil, Peru, and Pakistan.
4. Assist countries to incorporate SRHR fully into their national, district and local-level HIV/AIDS control programmes, and, conversely, to incorporate HIV prevention and treatment into all aspects of sexual and reproductive health information and services. Harmonize this with planning for MDG goals.
5. Bilateral and multilateral donors need to amend their HIV/AIDS policies and budgets to invest more systematically in SRHR. The challenge remains in implementation, namely fostering close working relationships and collaboration between what have been separate staffs and lines of work and achieving a better balance between budgets for HIV/AIDS and the other components of SRHR. This is where EuroNGOs and its members' positioning in donor countries becomes extremely important – going beyond generalized calls for integration to look at specifics of budgets, staffing, lines of work etc.

⁴ **ibid.**