

# Benign Neglect: How Sexual and Reproductive Health (SRH) Services are Being Sidelined by Current Global and National Financing Practices

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## Overview

- No global initiatives
- Weakness of recent macro financing instruments
- Faulty health planning and allocation
- Ill-understood household care-seeking and financing
- Overall impact: SRH interventions are failing the poor

# Objectives

- Poverty reduction strategies and other and recent donor instruments
- National budgeting and resource allocation
- Sector planning tools and approaches
- Programmatic thrusts
- Household behavior and financing

## PRSPs and reproductive health

(World Bank, 2005)

- 33% have minimal discussion on poverty and reproductive health
- Only 52% provide discussion of reproductive health policies and programs
- Reproductive health indicators not well-defined or standardized

# PRSPs & maternal mortality reduction

(Danguilan, 2005)

- Statements of questionable evidence
- Scant analysis of most important factors contributing to high maternal mortality
- Mix of strategies not prioritized
- Strategies to strengthen health systems not linked specifically to SRH
- Indicators rarely mention UN Process Indicators

## IDA buy-down program

- “Buy-down” refers to a third-party paying off all or part of a specific IDA credit on behalf of government
- Infectious and communicable disease control projects have clear advantage over SRH
- Countries presenting immunization, TB control, HIV/AIDS, and sexually transmitted disease interventions “defeated” those presenting SRH

## Budget support/PRSCs: pros

- Provide the broader framework for improved resource allocation to SRH
- Provide the venue (via the “policy matrix”) for system-wide discussions of SRH instead of project discussions under vertical interventions
- Good if SRH interventions are the “hard” targets in the policy matrix

## Budget support/PRSCs: cons

- Health and population specialists could be sidelined
- Health team may disappear, reducing sector technical discussions
- Resources under PRSCs/budget support are outside MOH control
- Short time-horizon (3 years) not suitable for SRH

## Sectoral strategies: problems of using DALYs

- Fails to capture the scope of reproductive and maternal health problems
- Reinforces the medical model and vertical approach
- Relies on limited data on the incidence & prevalence of ill health
- Unable to account for pre-existing conditions aggravated by pregnancy
- Unable to account for still-births and abortion

## Sectoral strategies: unintended consequences of SWAps

- Critical SRH interventions are under-emphasized
- Focus on cheaper interventions rather than comprehensive and emergency obstetric care (EmOC)
- Basket funding often neglects financing for HRH and referral care
- SRH requires more investments in social mobilization and community responses

## Sectoral strategies: unintended consequences of SWAps

- Infrastructure freeze harms maternal mortality reduction
- SWAps tend to focus on “process” issues over technical & programmatic discussions
- Preference for generalist staff over technical specialists

## National budgeting and investments

- Public-finance principles on “externality” ignores individual nature of pregnancy and non-infectious child illness
- “Incremental” budgeting: historical SRH underfunding is carried over into the present & future
- SRH tends to be underfunded in debt relief
- Medium term expenditure frameworks tend to focus on budget efficiency (use of resources) and often ignore budget effectiveness (service coverage rates & outcomes)

## National budgeting and investments

- Gender budget analysis is yet to lead to dramatic increase in resources for SRH
- Since there is no global SRH initiative, in a “zero-sum” budget process, counterpart funds required by existing global disease initiatives take away domestic funds that could otherwise be used for SRH

## Programmatic issues

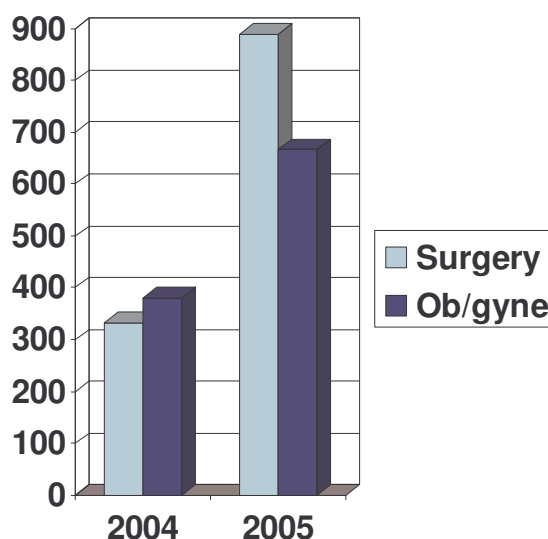
- Focus on maternal deaths. Move away from costly comprehensive approaches towards specific interventions that can effectively avert maternal mortality
- Move away from “TBA mindset” to EmOC, and the well-entrenched mentality that EmOC is expensive
- Recognize that EmOC’s and IMCI’s sunk costs benefit the health system as a whole

# Programmatic issues

- Do not conflate family planning and maternal mortality reduction
- In child health, re-focus on cost-effective “child survival” interventions
- Program planning plagued by data problems

# Programmatic issues

- HR shortage - a real obstacle in expanding SRH service and improving quality
- Pemba, Mozambique: addition of just 1 doctor led to dramatic increase in surgery and ob/gyne cases



# Public/private mix of services

% relative contributions of financing (Rannan-Eliya, et al., 2000)

Services	Egy pt		Sri Lanka	
	Public	Private	Public	Private
Family planning	71	29	80	20
Maternal and child health	94	6	93	7
Infant care	69	31	69	31
Child birth	62	38	65	35
Other OB/Gyne outpatient	25	75	36	64
Other OB/Gyne inpatient	81	19	70	30
Total	60	40	65	35

## Household care-seeking behavior and public/private mix

- Family planning and MCH tend to be a domain of the public sector while child birth and infant care tend to be mixed public and private
- Ob/gyne outpatient care tends to be the domain of private providers, in contrast with ob/gyne inpatient care
- Private providers tend to attract clients for services that are more intimate and require more privacy
- SRH supply does not necessarily create SRH demand

# New demand-driven instruments

- Vouchers under social marketing programs
- Prepayments and health insurance
- Conditional cash grants
- Long-term investments in girls' education