The impact of health sector financing reforms on sexual and reproductive health services in Africa

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Introduction

Background
This review is part of a global initiative committed to understanding the inter-linkages between sexual and reproductive health (SRH) and health sector reforms (HSR) and the manner in which these ultimately contribute towards promoting or obstructing improved life opportunities for all Africans, particularly women. This paper focuses on health sector financing reforms and explores their impact on SRH services in Africa. The key financing reforms it considers include user fees, sector-wide approaches to health financing by donors and community financing schemes.

These financing reforms are contextualised within the broader health sector reform agenda on the continent and the associated ideological paradigm driving this agenda. The stated intention of these reforms is to improve the performance of health services and systems and to increase access and equity. In reality, however, particularly in Africa, their practical application is not necessarily focused on responding to the needs of populations but instead they are an integral part of a broader agenda of international financial institutions (IFIs) to achieve macroeconomic restructuring, particularly in relation to reducing the role of government and its expenditure levels.

Another key contextual factor is the lack of progress in the realisation of the agenda of the International Conference on Population Development (ICPD). ICPD represented a critical step forward ideologically in relocating the debate around population development in the broader context of rights. However, the translation of the international policy commitment into national practice has been slow, stagnant or backward moving. This is related to a lack of commitment by some national governments to engendering approaches to policy and practice with a specific emphasis on empowering women. However, problems of moving the ICPD agenda forward are also directly linked to the broader process of health sector reform and its impact on prioritisation and service financing and delivery. It is the latter issue that is of particular concern in this paper.

Methodology
The approach taken to writing this paper consisted of the following four phases: (i) conceptualisation; (ii) information gathering; (iii) writing up the first draft; and (iv) incorporating feedback from reviewers and editing the document.

The conceptualisation phase was necessary as it was clear that the focus of a paper such as this was inherently ideological. It was therefore necessary to be explicit about the conceptual framework that guided the gathering of information and, more importantly, the interrogation of this information.

The information gathering phase consisted of doing internet searches and document collection with a specific focus on gender and SRH services, gender and health sector
reform, health sector financing reforms in Africa and broader political-economy issues within Africa. The approach taken to writing the report was to: (i) propose a conceptual framework around which research and advocacy initiatives within HSR and SRH can dialogue; (ii) describe the complexities of the African context, which has shaped the environment within which health sector reforms have been conceptualised and implemented; (iii) engage with the impact which health care financing reforms have had on health broadly in Africa and SRH in particular; and (iv) point out lessons, opportunities and information gaps. The paper is structured in line with this approach.

Conceptual framework

Health as a right

Health is conceptualised within this paper as a public good and a right to which all human beings are entitled. Cook et al (2003) argue that the right to health is an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health. The authors assert that the right to health contains both freedoms and entitlements: freedoms would include the right to control one’s health and body, including sexual and reproductive freedom, and entitlements would include the right to a system of health protection that provides equality of opportunity for people to enjoy the highest levels of health.

The notion of health as an entitlement is echoed by various multinational institutions and is recognised in the Universal Declaration of Human Rights. The Declaration affirms that everyone has the right to a standard of living adequate for the health of himself (sic) and of his family, including food, clothing, housing and medical care and necessary social services (Article 25.1). According to the international Covenant on Economic, Social and Cultural Rights (CESCR), state parties recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Article 12.1). The CESCR provides guidance to countries on what they are required to do to comply with this right. It asserts that in order to ensure its realisation, the following elements are critical for health service provision and financing: availability, accessibility, acceptability and quality (Cook et al 2003).

In relation to availability and accessibility within a rights-based approach, there is a clear expectation that the responsibility lies with society as a whole and government in particular. Government must ensure that there are functioning health care facilities and a sufficient quantity of services and essential drugs in order to promote health care availability. The emphasis placed on equitable access to health services underscores the notion that quality health care should not be the preserve of those who can afford it, or access it through other forms of ascribed elitism, such as being part of the political elite or being an urban citizen. In essence, access to health care is seen as a right for all citizens, rich and poor, male and female, and importantly within the African context rural and urban citizens. Whilst citizens is used as a term to emphasise the universality of the right, within the African context many people can be excluded on the basis of their status as non-citizen, having fled from armed conflict in their own country or other such situations. It is therefore useful to conceptually it as a human right to which all people are entitled, irrespective of their background.

Gender is a significant factor in determining the extent to which women and girls, in particular, are able to exercise their right to health, including their right to sexual and
reproductive health. Their financial dependence on their male partners, their socio-cultural marginalisation as a result of patriarchal values and belief systems, and male domination of policy decision-making all serve to create an environment which is disabling for optimal SRH outcomes. This underscores the need for women and girls, who form the bulk of the poor and vulnerable within African societies, to receive special attention in health policies to ensure that they are not marginalised.

**Sexual and reproductive health service issues**
The users of SRH services are overwhelmingly women. This has been significant in framing the societal and state response to the financing and provision of SRH services. Within the context of patriarchal societies, the fact that SRH services have largely targeted and serviced women has served to undermine the value of the service.

Traditionally located within a population control paradigm, the emphasis has been on controlling women’s fertility rather than on encouraging women to take control of their reproduction and sexuality. In order to meet the rights-based requirements described above, services have to be rendered in ways that enable women to make healthy choices. In addition, the actual services to be provided are considerably broader than under the historical reproductive health paradigm of family planning, limited prenatal care and essential obstetric care. The elements of the SRH service package envisaged by ICPD include a wider range of services for: family planning based on choice; safe pregnancy and childbirth; prevention, diagnosis and treatment of reproductive tract infections, sexually transmitted infections (STIs) and human immunodeficiency virus (HIV); as well as elimination of harmful practices such as female genital mutilation and domestic violence. This expanded package also includes services such as treatment of HIV-positive pregnant women to prevent transmission to the foetus and newborn, infertility management and detection and treatment of reproductive cancers.

Health systems have a long way to go in providing comprehensive, integrated SRH services that are rights-based and meet the myriad of challenges facing African populations. In addition to the increased scope of service provision required, there are growing demands placed on the health system relating to the HIV/AIDS pandemic, as the client-base is expanding to include men, adolescents and HIV-positive women, men and infants. These factors translate into increased resource requirements to ensure that the paradigm shift for SRH services can be realised.

**Health sector reform Issues**
HSR has been defined as sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector (Berman 1995). At a country level, reform typically involves a number of initiatives to address these goals, including:

- implementation of new public management systems;
- reorganisation of the health ministry, linked to overall reform of the public sector’s budgeting, accounting and planning systems;
- decentralisation of sector activities, including local ownership and accountability for the planning and/or management of service delivery and decentralisation of financial management;
- improving stakeholder participation and accountability to primary stakeholders;
- promoting the growth of private health service provision, including through contracting out of services to the private for-profit or NGO sectors;
- introducing alternative financing mechanisms such as user fees, and social and private insurance schemes.
HSR has to be understood against the political-economic backdrop of globalisation and the increasing power of the international financial institutions in determining national government policy responses. HSR is not just a technical, management process. Rather it is inherently political as it involves changing the distribution of resources between different stakeholders. The implementation of HSR is ideological as decisions about resource distribution are linked to perspectives on the relative roles of the state and the market and how these relate to each other in facilitating individuals and populations meeting their needs. Indeed, most HSR is directed at promoting greater reliance on the market to provide and finance social services, with a decreasing role for the state in meeting the needs of its citizens. In addition, while equity and effectiveness are stated objectives of HSR, most reform initiatives have been primarily efficiency motivated and oriented (Gilson 1998).

**Promoting dialogue between SRH and HSR using a rights-based approach**

Two issues stand out as important in assessing health care financing reforms in relation to SRH from a rights-based perspective. Firstly, as indicated previously, the expanding package of SRH services and client base require additional financial resources, with a specific responsibility on the state to support these requirements. This is contrary to the general approach of current financing reforms in terms of reducing the state’s role. Secondly, the move towards increasingly placing the burden for health care financing on individuals is likely to create difficulties in accessing SRH services in particular. Many women are in relationships in which they are financially dependent on their male partners and/or in which financial control within the household is exercised by their male partner. Thus if accessing SRH services has financial implications indirectly through travel related expenses or directly through user fees, they need to negotiate this with their male partner. This can serve to compromise a woman’s access to services as, for example, he may not agree with her usage of contraception or she may not want to disclose her contracting an STI for fear of violence.

This points to the different ideological approaches underlying HSR and SRH; HSR rests on the promotion of market approaches to social service provision and financing as an integral part of macroeconomic restructuring packages imposed by IFIs, while the ICPD plan for SRH services is based on promotion of women’s rights and human rights more generally.

Despite these differences, there is some common ground in relation to the agenda of HSR and SRH and rights, in that they both (i) share the goals of equity and equality; (ii) advocate for decentralisation as an important tool through which to ensure access to services; (iii) argue for community participation in setting health priorities; (iv) need to be contextually adapted in respective country settings; (v) require capacity building in relation to technical skills for optimal implementation at a local level and (vi) require leadership and commitment from national government, particularly at the level of policy.

Some authors have argued that whilst a number of elements of health financing reform may be detrimental to SRH, some could be beneficial. The rights-based approach taken to SRH over the past decade, which emphasises equity, empowerment and rights, could play a critical role in positioning health financing reforms in ways that improve health status overall.
Arising from this analysis, it is useful to locate it within a socio-economic justice paradigm as a conceptual framework through which to engage with the inter-relationship between HSR and SRH status. *Justice* is a useful conceptual bridge through which to bring the respective disciplines concerned with health status together as it denotes that fairness and addressing inequality are fundamental areas of collective concern. The model presented in Figure 1 captures this inter-relationship.

![Figure 1: The common foundation of the ICPD and HSR agendas](image)

This paper evaluates health care financing reforms in relation to this conceptual framework to identify their impact on SRH services and the extent to which they promote health rights and the common foundation of equity, access and empowerment.

**The African context**

The legacy of colonialism is a critical variable to be taken into account in understanding the context within which health care financing reforms have been initiated and implemented in Africa. Colonialism continues to be a defining feature of the way/s in which legal, political and economic systems have unfolded on the continent. Colonialism, defined as an economic system in which European countries expanded their market using the colonised nations as a base for raw materials and cheap labour, played a key role in shaping the structure and form of post-colonial economies. Bond et al (2002) note that this has given rise to a socio-economic context that is inherently unequal and contributes towards shaping an environment that is bad for the health of Africans.

In the period of neo-colonialism, debt has been used as a central instrument of the elites in the North to ensure the continued subjugation of countries of the South. The extent
of this is highlighted by the fact that repayment of debt averaged 16% of state spending during the 1980s, compared to 12% on education, 10% on defence and 4% on health. In the 1980s the IFIs were used as vehicles through which to ensure that African countries repaid Northern commercial bank loans, in exchange for these institutions gaining power over the countries to impose austere macroeconomic policies. This occurred through what have been termed structural adjustment programmes, which emphasised liberalisation, export orientation and an end to social subsidies.

Most of the macroeconomic reforms that the IFIs have insisted African countries adopt under what has become known as the Washington Consensus have been characterised by the following components: (i) government budget cuts; (ii) increases in user fees for public services; (iii) privatisation of state enterprises; (iv) the lifting of price controls, subsidies and any other distortions of market forces; (v) liberalisation of currency controls and currency devaluation; (vi) higher interest rates and deregulation of local finance; (vii) removal of import barriers (trade tariffs and quotas); and (viii) an emphasis on promotion of exports, above all other economic priorities.

The colonial inheritance and heavy indebtedness have contributed to poverty being a critical theme in defining the social and economic landscape within Africa. Sub-Saharan Africa (SSA) accounts for one-quarter of the world's 1.2 billion people living on less than $1 per day and, of the twenty countries classified by the United Nations Development Program (UNDP), as possessing the lowest human development index, nineteen are in Africa (UNDP, 2002). Poverty in the region is characterised by a lack of access to income, employment opportunities, shelter and the means to satisfy the basic needs of life. The majority of people have insufficient or no access to basic social services, such as education, health, food and clean water.

Within this context of socio-economic deprivation and inequality, it is unsurprising that Africa's 784 million people continue to suffer from a huge burden of potentially preventable and treatable disease. It is estimated that 2.4 million people die from HIV/AIDS each year, 600,000 from tuberculosis and more than one million from malaria (Department of Health 2001). The HIV/AIDS pandemic is of particular concern. By 2003, more than 17 million Africans had died of AIDS and it was estimated that more than 28 million of the 40 million living with disease globally were in SSA (UNAIDS 2003). Respective United Nations reports have highlighted the fact that HIV/AIDS has had a particularly harsh impact on women in Africa, as compared to other regions in the world. In the 30 SSA countries that have registered the highest HIV/AIDS prevalence levels, the average life expectancy has declined, standing at approximately 47 years in 2002, roughly seven years lower than what would have been the case in the absence of the pandemic (UNDP 2002). It is estimated that US$10 billion could turn the tide of the HIV/AIDS crisis in Africa, yet African governments are paying over $15 billion each year on debt repayments (Africa Action, 2003).

In relation to SRH, the World Health Organisation (WHO) estimated in 2001 that SRH problems account for 18% of the total global burden of disease and 32% of the burden among women of reproductive age worldwide. By comparison, respiratory illnesses account for 11% of all disability-adjusted life years (DALYs) lost, cardiovascular diseases for 10% and neuropsychiatric conditions for 13% (www3.who.int/wgoisis/menu.cfm?path=evidence, burden_estimates,burden_estimates_2001_subregion&language=english).
It is the reality of this disease burden that African health systems have to respond to. The residue from colonialism is evident in the persistent bias in orientation of health system and distribution of health resources in the following ways (Bond et al 2002):

- specialist versus primary health care services;
- curative versus preventative services;
- provision of a network of hospitals for colonisers versus clinics for indigenous people;
- accessible services for the urban elite and not for the rural poor;
- health systems for the majority of people are generally fragmented with uncoordinated providers, limited insurance systems and are inaccessible and oppressive.

Based on the above, there is clearly a need for HSR, particularly to address the skewed allocation of resources which impacts on access to health services for those in need. In some countries 60% or more of government health spending is devoted to urban hospitals, serving just 10% of the population. In Ghana for example the more affluent population account for three times more public health spending than the poor (Bond et al 2002). According to the WHO, in ten developing countries between 1992 and 1997, only 41% of poor people suffering from acute respiratory disorders including tuberculosis were treated in a health facility compared with nearly 60% of the affluent. The impact on reproductive health mirrors this trend as over the same period only 22% of births amongst the poorest 20% of people were attended by medically trained staff compared to 76% amongst the richest (Bond et al, 2002).

From the perspective of the primary focus of this paper, the need to increase allocations to, and improve provision of, SRH are of particular concern. There is considerable evidence globally to show that investment into SRH services is cost-effective in the medium to long term and contributes significantly towards decreasing the disease burden through reduced morbidity and mortality. The World Bank's Disease Control Priorities Report 1993 showed that a hypothetical increase in contraceptive use from zero to 20% as the result of providing family planning services in a high mortality, high fertility setting such as SSA was highly cost effective in preventing a range of adverse effects such as maternal deaths, perinatal deaths, maternal morbidity and low birth weight infants. Another study that measured the benefits of an increase in family planning estimated that a US$169 million increase in family planning funding in 2001 would save the lives of 15,000 women (8,000 who would have died as a result of unsafe abortion, and 7,000 from other pregnancy-related causes) as well as the lives of 92,000 infants (www.guttmacher.org/pubs/fund_impact.html).

The cost of providing modern contraceptive services to current users in the developing world is US$7.1 billion per year, including the cost of labour, overhead and capital as well as contraceptive supplies. This spending could prevent 187 million unintended pregnancies, 60 million unplanned births, 105 million induced abortions, 22 million spontaneous abortions, 2.7 million infant deaths and 215,000 pregnancy-related deaths 79,000 from unsafe abortions and 685,000 children from losing their mother as a result of pregnancy-related deaths, as well as the loss of 60 million DALYs 16 million among women and 44 million among infants and children (Allan Guttmacher Institute 2003)

In summary, Africa's political roots, embedded in the rough soil of colonialism and underdevelopment, and maintained through the stranglehold of debt and IFI conditionalities, continue to have a significant impact on the economies of post-colonial
Africa. The burden of disease, directly linked to socio-economic hardship and most evident through the prevalence rates of HIV/AIDS on the continent, has further exacerbated the context within which we explore SRH service provision and health status. Indeed, if one were to measure SRH services and status through HIV/AIDS prevalence levels, clearly the continent is in crisis. The need to transform African health systems is undeniable. The critical challenge is identifying an appropriate basis on which to do this to ensure that it contributes to improving access to services and health status overall.

**Health sector financing reforms in Africa**

**Introduction**

WHO (2000a) has identified four main types of financing for health services: (i) government-raised (through general and specific taxes); (ii) social insurance contributions (often levied through payroll and other taxes as well as other contributions); (iii) private insurance contributions; and (iv) out-of-pocket payments. Ravindran (2002) identifies a fifth category of donor funding or external aid and highlights that health sector financing reforms essentially relate to changing the relative shares of these alternative financing mechanisms. As indicated previously, the emphasis in recent reforms has been to promote private funding sources. However, health care financing reforms have not focused only on shifting between financing sources and generating additional resources for the health sector but also on ways of improving the use of financial resources and changing resource allocations.

Most high-income countries rely heavily on either general taxation or mandated social health insurance contributions whereas most low- and middle-income countries depend far more on out-of-pocket financing (WHO, 2002a). The irony in this is that in low-income countries in which populations are generally poor and consequently tend to have greater health risks, individuals have to bear the greatest burden of paying for health care.

Within the African context, health care expenditure funded from private sources often exceeds that from public sources. For example, private sources of funding accounted for more than 50% of total health care resources in 18 of the 44 African countries included in a WHO review (www.who.int/nha/en). Out-of-pocket payments, in particular, are in many African countries the single largest source of health care funding. For example, these payments accounted for 81% of total health care expenditure in Sudan in 2001, 77% in Nigeria and 75% in Côte d’Ivoire. There also tends to be a heavy reliance on donor funding. In countries such as Zambia and Mozambique (see Figure 2) donor funding accounts for nearly half of all health sector funding. In contrast, tax funding is universally low in SSA, with almost all countries (40 of the 44 African countries in the WHO database) falling far short of the Abuja Declaration goal of 15% of government expenditure being devoted to health care.
It is within this context, that we evaluate the individual financing mechanisms. Issues around tax funding are considered first, followed by those relating to donor funding, which is most frequently channelled via government ministries. Thereafter, the key private financing mechanisms that have dominated reforms in Africa over the past few decades are considered, particularly user fees, the so-called Bamako Initiative and the more recent innovation of community based pre-payment schemes. The final section focuses on private voluntary and social health insurance mechanisms.

**Tax funding, government budgets and resource allocation**

The macro-economic context of underdevelopment, a heavy and growing debt burden and the dictates of structural adjustment programmes outlined earlier have had considerable implications for tax funding of health systems in Africa. Governments have been able to allocate extremely limited resources to the health sector, resulting in an average per capita government expenditure of less than UW$50 (using purchasing power parity rates) in the vast majority of African countries. The WHO National Health Accounts database indicates that 42% of countries had per capita government expenditure of less than or equal to $20 in 2001. A further 32% spent between $21 and $50 per capita on health from government funds, 12% spent between $51 and $100 and only 15% spent more than $100 per capita (www.who.int/nha/en). The countries with the lowest levels of government funding for health services in 2001 were the Democratic Republic of Congo ($5), Ethiopia ($6), and Sudan and Nigeria ($7).

Thus, in the African context within which resources are at a premium and health systems are burdened by high levels of disease and related health challenges, the efficient and equitable use of resources is critical to sustainable health care financing. Key ways in which resources can be optimised are: (i) reprioritising public health resources for primary health care (PHC); (ii) improving the efficiency of public hospitals; and (iii) reallocating resources between geographic areas and user groups.

As highlighted previously, the colonial inheritance translated into health systems where the vast majority of resources are consumed by hospitals. However, the burden of disease is primarily attributable to illness that is preventable and/or treatable through
basic primary health care interventions. Thus a relative redistribution of limited
government resources towards primary health care services could improve the health
status of African populations dramatically. Attention should also be paid to the types of
services provided at the primary care level and priority given to the most cost-effective
services, which include many SRH services (see earlier discussion).

Improving hospital efficiency is another important way to ensure optimal utilisation of
the existing resource base within the public sector. Two critical ways in which to do this
are (i) to ensure that patients receive care at the appropriate levels of care and do not
utilise hospitals, which have a higher unit cost, unnecessarily and (ii) to ensure technical
efficiency within hospitals. According to the Economic Development Institute of the
World Bank, (1998) many public hospitals in southern African countries are over-
crowded and inappropriately used, particularly where they fill the gap created by poor, or
non-existent PHC services. However, the urban, hospital-centred and curative bias of
most health systems in Africa has proved hard to redefine, while restructuring or closing
down a hospital is financially and politically difficult.

Redistribution of limited government resources to promote equity and ensure that those
with the greatest need for health care and the least ability to pay receive the benefit of
government funded services has recently received attention in a growing number of
African countries. For example, both Zambia and South Africa (in the period
immediately after the first democratic elections) adopted needs-based resource allocation
formulae to guide the allocation of public health sector resources between geographic
areas (Gilson et al 2000).

Many SRH services would be considered public goods (e.g. provision of condoms in
preventing the spread of HIV and other STIs) and thus require adequate government
funding. There need to be explicit efforts to ensure that SRH services receive the priority
they deserve in the competition for limited government resources. Given that SRH has
primarily been conceptualised within a family planning paradigm in many African
countries and consequently is seen as a women’s issue and not a broader societal issue, it
is unlikely that it will receive priority in budget decision making without vociferous
advocacy for financing of these services. Gender mainstreaming, including gender
budgeting is an important technical skill that is necessary to ensure that the ICDP agenda
is achieved, supported by adequate government financing of SRH services.

**Donor funding – the sector wide approach**

Donor contributions are a significant source of revenue for health services in many
African countries. Data from the World Health Report (2000) indicates that Chad has
the greatest dependence on donor funds (63%), followed by Eritrea (52%) and Zambia
(49%) (www.who.int/nha/en).

While donor funding is essential for the maintenance of basic health services in many
African countries, this funding mechanism is not without its problems. This is
highlighted in the example of Angola which, having emerged from decades of war and
having a highly centralised economic system, is heavily dependent on international aid
for health care financing. Donors are the main source of funding for rehabilitating
infrastructure, purchasing medical equipment, and supporting various health
programmes such as essential drugs, the Expanded Programme of Immunisation, health
education, family planning and AIDS prevention (Guimaraes & Chipesse 1998). A
critique of donor involvement in the country has been that donors fund areas that they
are most interested in, which may not necessarily be the most pressing health problems. For example, despite malaria being the greatest killer in Angola, only two agencies support malaria prevention and control activities whilst HIV/AIDS attracts many more donors. In addition, donors have tended to concentrate their efforts in accessible and convenient areas within Angola, which are not always the areas with the greatest need. Experience in other countries has indicated that donor funding may also result in duplication of services and hence wastage of resources.

In an effort to reduce fragmentation of donor efforts and to maximise the benefit of donor funding, the Sector Wide Approach (SWAp) has been introduced, particularly in Africa, as a vehicle through which to co-ordinate and prioritise the use of funds from external agencies. SWAps evolved from the Sector Investment Programmes promoted by the World Bank in the 1980s. These initiatives have received support and buy-in from several bilateral and multilateral donors who were attracted by the opportunity to engage in closer policy and institutional dialogue with recipient countries.

The SWAp supports a single health sector policy and expenditure programme under government leadership and in partnership with donors. The aim is to adopt common approaches across the sector and progress towards a situation in which all funds are disbursed by government. It has been argued that the core advantages of such an approach are that it ensures greater efficiency and equity, decreases transaction costs and contributes towards the sustainability of health policy and health systems development (Seco & Martinez 2001). SWAps have been implemented in the health sector in Ghana, Zambia (see box), Uganda, Mozambique, Sierra Leone, Tanzania, Senegal, Mali and Burkina Faso as well as in a few Asian countries.

**The experience of Zambia with SWAp**

Effective co-ordination of donor funding in Zambia has been a process of building a common vision, and establishing buy-in and support with the relevant stakeholders. A number of critical obstacles have been overcome, notably (i) arriving at a shared vision of the health sector; (ii) improving dialogue, accountability and transparency; (iii) reducing mistrust; (iv) agreeing on a uniform reporting, disbursement and auditing system; and (v) improving the Ministry of Health's assertiveness with donors. A number of obstacles continue to face Zambia including the culture of some donors who support vertical programmes and projects, the supervisory missions from individual donors, the political situation within the country and the lack of use of the logical planning framework, which most donor agencies use to develop project documents.

(Source: Kalumba & Musowe 1998)

The advantage of the SWAp for donors is that they have been able to focus on outcomes and policy issues, including reforms, rather than inputs. The advantage for governments is that they have been able to play a stronger role in setting the sectoral priorities and are therefore less driven by a range of donor special interests.

Nevertheless, Cassels and Janovsky (1998) have identified emerging challenges and concerns in relation to SWAps. From the perspective of donors, it means that they will be funding recurrent expenditure and in certain instances risk being associated with corrupt or unproductive spending. For governments, the increased transparency inherent in a SWAp can decrease their ability to accommodate political pressures to spend outside an agreed programme. They also highlight that separate donor funding has traditionally been seen as the best way of protecting spending on programmes that address major
causes of ill health such as malaria, HIV/AIDS and tuberculosis. A SWAp could serve to compromise the priority given to these activities or the technical quality of the programmes. This concern is obviously pertinent for the funding of SRH service provisioning.

A critical question in this regard, is the extent to which SRH stakeholders feed into defining sector wide priorities. Jeppsson (2002) recognises that understanding and exploring power dynamics within the SWAps process is critical to influencing the decisions that are made and the sectoral priorities that are established. The importance of who is included in the SWAps process and who is not is thus fundamental and SRH advocates have to position themselves to take this reality into account.

On the one hand, there is evidence that SWAps have had a detrimental impact on SRH services, as highlighted by Gulaid (2002) in relation to Ghana. Certain respondents in Gulaid’s study highlighted that contributors to the pooled donor fund wield considerable influence on priority setting, whereas others including many of the stakeholders in reproductive health do not have a voice. As major SRH role players were side-lined in the SWAP process, SRH service provision arguably was not given the priority it deserved. The possible relationship between a SWAP and inattention to a critical programme area such as SRH service provision cannot be dismissed as this message is consistent with anecdotal information on SWAps in East Africa.

On the other hand, the fact that many donors have been focusing heavily on funding HIV/AIDS presents an opportunity for financing in the area of SRH. The priority placed on HIV/AIDS can be utilised to package a comprehensive SRH package in relation to addressing the pandemic. Such a package should include prevention strategies (e.g. promotion of dual and barrier methods, and highlighting the importance of sexual negotiation for safe sex), as well as treatment and care strategies. It provides an important opportunity for the health care system to position itself strategically to improve financing of SRH overall and to position HIV/AIDS within this paradigm (Blanchet 1991; Ramachandran 2000).

**Donor funding more generally**

Both multilateral and bilateral donor agencies have funded SRH programmes. The multilateral agencies include United Nations Population Fund (UNFPA), United Nations Childrens Fund (UNICEF), UNDP, WHO, Food and Agriculture Organisation, International Labour Organisation, the World Bank and the European Union. Bilateral agencies include those of the United States, United Kingdom, Norway, Germany, Sweden, Canada, Japan, Ireland, Switzerland and Netherlands. Further support is rendered through international non-governmental agencies (NGOs) such as the International Planned Parenthood Federation, Ipas and CARE International.

The policy approaches taken by donors to key SRH issues impact significantly on SRH status in Africa. A case in point has been the impact of US foreign policy on the funding of two key SRH resources in Africa viz. UNFPA and IPPF. The United States Mexico Policy, also known as the Gag Ruling, prohibits funding by the United States government of any work relating to abortion. This has had a significant effect on IPPF funding with negative ripple effects felt in countries like Ethiopia, Zambia and other parts of the continent. In 2002-03 three clinics providing critical SRH services at a community level in Ethiopia were forced to close. In Zambia the core funding of the IPPF affiliate was reduced by 23%. At a service delivery level this translated in an
estimated 20,000 people being unable to obtain condoms and an estimated 12,000 women being unable to access family planning and RH services (Braam & Dangor 2002).

In relation to UNFPA, Figure 3 shows that relative to the size of the country and economic position globally, the funding of the US is small than that of other top donors. Nevertheless, the decision by the US to withhold funds from UNFPA has had far-reaching implications for many countries, particularly in Africa (Briefing for the group of 77, 2002). This is important because UNFPA is the largest international public sector supplier of contraceptives, condoms and other reproductive health supplies.

In summary, the reliance on external donor support whilst being critical for SRH service delivery in Africa has made countries on the continent a victim of foreign policies, notably the Bush Gag Ruling, which contradict the investment requirements and needs of marginalised and vulnerable groupings.
**User fees and other forms of out-of-pocket payments**

Out-of-pocket payments are made at the point of service delivery by the individual consumer. The quantity and quality of services that can be purchased are thus by and large related to the level of income of an individual and/or household. Through this process health is shifted from being defined as a public good and right to becoming a commodity. In most African countries, other financing options are restricted to the rich and out-of-pocket payments are the only option for the poor. As indicated previously, out-of-pocket payments are frequently the single largest source of finance for health services in African countries. Figure 4 illustrates the example of Morocco, where households clearly bear the brunt of health care financing in that 54% is attributable to household direct payments. The burden is even greater in some other African countries. In Sudan, for example, out-of-pocket payments account for 81% of total health care expenditure. In Nigeria and Côte d’Ivoire, 77% and 75% respectively of funds come from this source (www.who.int/nha/en).
Out-of-pocket payments frequently take the form of fees to a private provider. These would usually be set at levels sufficient to cover the entire cost of the health service or medicine, including a profit component for private providers other than NGOs. Out-of-pocket payments also occur when a patient is charged a user fee at a public health facility. User fees at public health facilities are frequently set below cost-recovery levels. For this reason, the term “cost sharing” is often used for this form of financing.

Advocates of user fees argue that they will generate revenue for the health sector which will tax the rich and, through a system of fee exemptions, can protect the poor. This additional revenue can then be used to increase the quantity and improve the quality of health services for all. It is also argued that user fees can improve health system efficiency as they can encourage patients to follow the correct referral route if lower fees are charged at primary care facilities than at hospital level.

However, a review of the theoretical arguments and empirical evidence regarding user fees as a means of financing basic social services draws very negative conclusions. Evers & Juarez argue that:

- User fees do not guarantee greater efficiency and effectiveness;
- The market does not necessarily work for health sector services;
- User fees collect very modest amounts of money compared to the budgetary resources allocated to basic services;
- Protecting the poor is difficult because exemption schemes seldom perform well and are costly to administer; and

Inability to protect the most vulnerable is a particular concern. A comprehensive UNICEF study showed that schemes to exempt the poor from user fees are both rare and ineffective (Reddy & Vandemoortele 1996). Poor people are generally unaware of exemptions and there are often complex administrative barriers to accessing them. Exemptions that are based on means testing are most difficult to implement effectively. Many countries instead target exemptions at specific categories of patients, diseases or services. For example, in Tanzania certain illnesses such as HIV/AIDS, tuberculosis and...
other communicable diseases are treated free of charge, irrespective of people's ability to pay, due to public health considerations. A system of exemptions has also been established in the country for maternal, child health and family planning services as well as for children under the age of five years. Other areas of women's reproductive health are not exempt and certain contraceptive services such as voluntary sterilisation and Norplant are not available in public health facilities in some regions (Centre for Health and Gender Equity, 2002). However, even categorical exemptions may not be effective as there is no formal procedure for informing clients about them. Where fee revenue is retained at facility level, health providers have little incentive to publicise the exemption system because to do so would exacerbate the paucity of funds at health centres.

Fees are not the only cost incurred by individuals and households when they seek care. Transport costs to a health care facility can be particularly burdensome for those living in a rural area. A study by Christie and Ferrara (1999) showed that financial factors represented the most significant reason for people not using health facilities when they need to.

Experience in Africa has shown that user fees have impacted negatively on the poor by reducing access to much needed health services. For example, in Ghana, Swaziland and the former Zaire the introduction of user fees led to reduced utilisation of health services (Arhin-Tenkorang 2000). Similar findings across Africa are reported in the box.

<table>
<thead>
<tr>
<th>Evidence on the impact of user fees in African countries</th>
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<tbody>
<tr>
<td>• In Kenya, the introduction of a 33 cent fee for a visit to outpatient health centres led to a 52% reduction in outpatient visits. After the fee was suspended, visits rose by 41%.</td>
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<tr>
<td>• In Dar es Salaam, Tanzania, three public district hospitals saw attendance drop by 53.4% between the second and third quarters of 1994 after user fees were introduced.</td>
</tr>
<tr>
<td>• In Niger, cost recovery measures implemented as part of a structural adjustment programme between 1986 and 1988 resulted in a drop in utilisation of preventive care services and increased exclusion of the most impoverished from care at Niamey Hospital.</td>
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Reduced access inevitably impacts on health status. Standing (1999) reports that evidence from Nigeria associates the introduction of user fees with a 56% rise in maternal deaths and a 46% decline in hospital deliveries in the Zaria Region and a decline in the use of maternal and child health services in Zimbabwe in the early 1990s.

The charging of user fees at public sector facilities in African countries clearly has a significant impact on SRH services, many of which are largely preventive. In the context of limited resources in poor households, expenditure will be directed largely at curative services. Women, and particularly mothers, will direct their health spending towards taking care of their children and prioritising the health needs of husbands and extended family members for whom they may be caring.

Evidence supports the claim that access to financial resources within the household, and hence the use of health facilities charging a user fee, are very gendered. Thus the Living
Standards Measurement Survey of 1999 in Mozambique showed that although women were 30% more likely to report illness, they had the same utilisation patterns as men. This means that despite requiring health care services more often, they did not seek it out more often (Christie & Ferrara 1999). Certain SRH services are particularly susceptible to under-use. For example, if contraceptives are not readily available free of charge from government and/or NGO facilities, sustained usage of contraceptives will be virtually impossible for many. In addition, the costs of STI treatment are prohibitively expensive. This has implications for vulnerability to HIV infection given the relationship between STDs and HIV/AIDS.

Over the past five years, as the effect of user fees in low- and middle-income countries has became more apparent, support for user fees by the IFIs has waned. In a policy statement at the end of 2000, the World Bank announced that it was stepping back from the promotion of user fees for basic social services in the developing world and that it supported the provision of basic health care for free. Whilst there is no clarity of the extent to which user fees have been withdrawn from loan conditionalities since this statement, clearly there is recognition by the IFIs - who have been the key architects of health care financing reforms in Africa - that commercialising access to health services ultimately contributes to underdevelopment.

Bamako Initiative community financing schemes

The Bamako Initiative (BI) arose in the late 1980s from research commissioned by UNICEF into the challenges of health system delivery. The initiative sought to develop a locally self-supporting primary health care system for all of Africa by 2000 (UNICEF 1994). The research recognised that debt, falling export prices and military spending forced many government to slash health budgets and that this resulted in health workers going unpaid, drugs becoming scarce for long periods and a maintenance backlog of equipment and vehicles. Most national health budgets, according to the research, continued to favour high-cost curative care for a small urban elite at the expense of low cost preventative measures desperately needed by the poor rural majority.

African Ministers of Health thus met in Bamako, Mali in September 1987 and developed and adopted a new strategy for providing accessible, affordable and sustainable health services in SSA. The aim was to transform 40,000 government health facilities into a new kind of health service controlled by and responsible to the communities they are intended to serve. The quote describes both the overall goal and the means by which this was to be achieved:

The goal of the Bamako Initiative is universal accessibility to PHC. The attainment of this goal would be enhanced through a substantial decentralization of health decision making to the district level, community level management of PHC, user-financing under community control and a realistic national drug policy and provision of basic essential drugs, leading to a self-sustaining PHC with emphasis on promoting the health of women and children (WHO 1998).

As part of the new strategy, Ministers of Health agreed to provide sufficient resources to improve PHC in their countries, to use their budgets for the benefit of the largest and neediest section of the population and to explore creative approaches to community financing methods. The BI particularly promoted a focus on ensuring that there were adequate supplies of essential medicines in rural PHC facilities, through what is termed a
revolving drug fund. Donors provided an initial supply of medicines to PHC facilities and patients were charged above cost-recovery fees for medicines dispensed to provide sufficient funds to replenish these supplies. Any revenue generated above the amount required to maintain a constant supply of medicines was to be used to improve PHC services in general. As UNICEF was the key proponent of this initiative, particular emphasis was given to improving maternal and child health services.

The Bamako Initiative in Benin

Benin is seen as a good example of successful implementation of the BI, particularly in relation to the outcomes of increased resourcing for mother and child health services. Community involvement in PHC in Benin helped reduce child death rates, boost immunisation coverage and increase access to antenatal care. Before becoming involved in the BI, Benin had one of the highest under-five death rates in the world (203 for every 1,000 live births) and only one-third of women had access to antenatal care. Less than 30% of the population had access to functioning PHC and the government spent only about US$1.50 per capita a year on health care. By 1990 the BI had helped to revitalise the entire existing health care network in Benin and the country achieved the objective of reaching 75% of children through the national immunisation programme. By 1998 death rates among infants and children under five were down by nearly 20%, immunisation coverage was being sustained at around 80% and 65% of women were using antenatal services.

Source: WHO 2000b

Although there have been some successes with this form of community financing, there are concerns that the burden of paying for health care is being placed on the rural poor. Studies in countries such as Burundi, Guinea, Kenya and Nigeria has shown that whilst the BI has provided a service that was cheaper for households than was available before, even basic charges are prohibitive for many (McPake et al 1993). McPake et al (1993) highlight the need for countries to consider the access of marginalised groups when setting price structures and to protect against possible excess costs due to over-prescription in a context where revenue is generated from the sale of medicines. Whilst the evidence shows that most people do find amounts of money to pay for health services which are large in relation to their income, this is more attributable to extensive community support mechanisms than a reflection of ability to pay. HIV/AIDS has heightened the challenges as households struggle to find resources for their additional health care requirements, whilst having a diminishing human resource base within the household to generate income.

Another study exploring equity impacts of BI type community financing in three African countries emphasised the importance of establishing equity goals to drive implementation (Gilson et al 2001). The study focused on Benin, Kenya and Zambia. It showed that the dominance of concern about financial sustainability contributed to equity failures. In all three countries there was a failure to protect and benefit preferentially the poorest within communities. Even in Zambia, where the Ministry of Health provided guidance on who to exempt and where revenue generation was not an explicit goal of the fee system, providers interviewed in the study complained that if the exemption policy were applied fully it would prevent revenue generation.
A potentially positive aspect of the BI financing mechanism is that community participation is a central component. However, gender dynamics at a community level mean that men have greater decision-making power relative to women and enjoy more status and opportunity to participate in political and social structures than their female counterparts. This has implications for their participation within community financing initiatives, particularly in relation to managing community resources and determining the services prioritised for improvement with such resources. This is borne out by studies that focus on community participation within the BI. These studies identify the existence of local hierarchies and geographical constraints that might prevent committees from adequately representing the interests of the entire community, especially vulnerable groups such as women (Hissock 1990; WHO/UNICEF 1999).

From a SRH perspective, the challenges of BI financing schemes are similar to those outlined previously for the more traditional user fee mechanisms. However, this is somewhat tempered by the particular focus on maternal and child health services in the BI approach. This explicit focus has ensured that at least some of the additional resources generated through this financing mechanism are used for extending and improving SRH-related services.

**Community-based pre-payment schemes**

Another form of community financing that is becoming increasingly popular in the African context is that of community pre-payment or insurance schemes. Instead of paying at the time of use of a health service, individuals and/or households make payments in advance and are then able to use services free of charge when needed (Economic Development Institute, World Bank 1998). These contributions may be made directly to a local facility or to a community-based insurance scheme that reimburses the provider for services used by a scheme member. Most rural pre-paid community schemes receive contributions either once or twice a year. As these payments are timed to coincide with harvests, there is greater ability to pay scheme contributions.

An example of such a scheme is the Community Health funds set up in Tanzania. These aim to broaden the pool of resources available for delivering primary-level care and to share risks and benefits among large pools of households (50,000 individuals in each pool). Services that are covered at the health dispensary or clinic level have been clearly defined. They include maternal and child health, basic curative and chronic care and preventative health services. Payments may be in cash or kind, and in some instances members work in exchange for payment, such as building health facilities (World Bank 1998).

Lessons from the Tanzanian experience in relation to meeting the needs of the poorest point to the following issues:

- Maintaining government and donor support within an overall financial plan for the health sector, so that the full burden of financing is not left to communities;
- The creation of local decision-making structures which try to take into consideration the needs of the poorest by specifically seeking representation from civil society groups such as churches, NGOs, women and others, and by putting procedures in place that allow the voices of the marginalised to be heard;
- Developing benefit packages broader than curative care to ensure the wide dispersion of benefits within the community; and
- A package of training and supervision which strengthens local management practices and emphasises the importance of addressing the needs of the poorest.
The impact which pre-payment schemes may have on equity and efficiency is related to utilisation, both of the scheme and of health care facilities by scheme members. The positive effects on equity include the following: (i) richer people cross-subsidise care for the poor; (ii) more people have access to good quality care; (iii) pre-payment is well-suited to self-employed farmers who tend to be poorer on a seasonal basis; and (iv) prepayment and decentralised control over resources by communities often helps to redress geographical inequities in public expenditures for health. The negative aspect of pre-payment schemes is that those who are unable to pay remain vulnerable to exclusion. The negative effect is often compounded by the distance of a particular household from its closest facility.

From a gender perspective and in relation to access to SRH services, a pre-payment scheme has considerable advantages over user fees, revolving drug funds and other BI type schemes. In particular, most community pre-payment schemes encourage, or require, entire families or households to become members. The main reason for this insistence is to ensure that members have a range of risk profiles rather than those with the greatest risk of ill-health being the only members. The household membership approach means that women do not have to rely on accessing financial resources from male partners when they need to use a health service. This should improve access to SRH and other services for women. It would also apply to other users of SRH, such as adolescents wishing to access contraceptives, who may not be able to access household resources for user fees for these services, but who would be covered under a household membership of a pre-payment scheme. A potential obstacle to such access advantages would be if SRH services are not included in the insurance scheme benefit package, which is frequently determined by a community committee. As highlighted for BI schemes, these committees may be dominated by men and may not give appropriate priority to SRH services and other services that particularly benefit women.

Other forms of health insurance
Two other forms of health insurance are found in Africa, but are far less widespread than community-based insurance schemes. The first category is private voluntary insurance. The second category of insurance is that of mandated insurance, whereby there is a legal requirement for certain groups to contribute to a health insurance scheme.

Private voluntary insurance is found in countries such as South Africa and Zimbabwe, where high- and possibly middle-income groups belong to what are termed medical schemes. Membership is voluntary, and monthly contributions are made in order to access a reasonably comprehensive benefit package.

Against a backdrop in which there are high levels of unemployment, most Africans are not in a position to participate in private health insurance schemes. Evidence suggests that private insurance puts women at a disadvantage as it is structured in a way that women and not society as a whole bear the costs of reproduction. Under many private insurance schemes, childbirth is either not covered or women pay a higher premium than men (Evers & Juarez, 2003). If providers are paid on a fee-for-service basis by an insurance scheme rather than directly by a patient, there is an incentive to provide more services, and more expensive services, than may be required. For example, Ramachandran (2000) points to evidence from India that the use of private health insurance has resulted in higher rates of caesarean section and hysterectomy without valid medical indications. Certain payment schemes only cover the member and not his/
her family members. Within a social context within which men are more likely to be within formal employment, they are more likely to be direct beneficiaries and women are more likely to be excluded.

Mandated insurance schemes which only cover specific groups, such as those in formal sector employment, is termed social health insurance (SHI). A mandated scheme that covers the entire population, irrespective of whether a person has made monthly contributions or not, is termed national health insurance (NHI). Very few African countries (for example, Kenya, Burundi and Tanzania) have attempted to initiate SHI. This is largely due to the fact that less than 10% of the African labour force is within the formal economy (World Bank 1995). However, SHI is receiving serious consideration in a growing number of countries, including Ghana and South Africa.

A key concern in moving towards SHI is that it would create a two-tier health system. Kutzin (1996) argues that given the small size and relative privilege of those in the formal sector in African countries compared to the majority of the population, SHI would implicitly serve to entrench inequalities. He points out that in Burundi a compulsory social insurance scheme for civil servants, members of the armed forces, employees of parastatals and universities and their dependents was the cause of great inequities in the use of government subsidies for health. Mandated health insurance schemes tend not to be self-financing and usually involve a substantial element of subsidy. This subsidy could be better used for other purposes in the African context given the numbers of those who benefit relative to the health needs of the overall population.

From a gender perspective, SHI more frequently than private voluntary health insurance includes dependants of a primary member who, in the African context, is overwhelmingly a man. This will serve to promote access to health services of women and children. Given that both private and social health insurance schemes tend to have relatively comprehensive benefit packages compared to community pre-payment schemes, a wider range of SRH services is likely to be accessible under such schemes. However, as pointed out previously, certain reproductive services may be excluded from the package, and these types of insurance schemes tend to only benefit a high income minority.

Conclusions and recommendations: Key issues in relation to health care financing reform and SRH services

In the context of extremely limited government resources and a mounting debt burden, expanding the package of SRH services and reaching a wider range of beneficiaries in line with the ICPD vision is a major challenge for African countries. There is undoubtedly potential for improving efficiency and equity in the use of limited government resources, particularly in relation to reducing the urban, hospital bias. Nevertheless, additional resources are required to address the ever-growing health care needs, particularly given the HIV/AIDS pandemic. Donor funding plays an important role in meeting these needs. However, increased domestic resourcing for health services is required to achieve sustainable health service financing. The key issue is to identify financing mechanisms to generate additional revenue for health services that will have the least adverse effects on the vulnerable and ensure access for those with the greatest need.

There is overwhelming evidence that user fees are not an appropriate mechanism to achieve this goal. Direct financial costs are a critical impediment to women in Africa
accessing health services that could save their lives. There are numerous examples of financial obstacles to SRH and other health services. There is evidence to suggest that this particular form of privatisation of health care financing, that has been particularly favoured by IFIs, has resulted in women dying unnecessarily (Women's Global Network for Reproductive Rights 2001).

Some form of health insurance is likely to be the most appropriate mechanism to supplement government and donor funds. SHI protects users, particularly women, from the difficult task of having to find ready cash at the time of need to use health services. Private insurance and SHI tend to cover a very small proportion of the population, while community-based pre-payment schemes are seen as holding out good prospects as a sustainable mechanism for generating additional resources for the health sector. A key issue is to promote improved representation in decision-making in community insurance structures. The fact that in many instances men hold decision-making power in community financing schemes, and that SRH issues impact on women and men differently, currently translates into a situation in which SRH services frequently do not receive adequate priority.

Key lessons emerging from the review are:

- The SRH status of women, men and adolescents in Africa has been impacted negatively by macroeconomic factors, which have in part manifested through health sector financing reforms.
- An agenda for changing the form (reform/transform) of health systems is critical to address a number of historical challenges inherited from colonialism, most notably inequitable access to services.
- There is growing acknowledgement by key drivers of health sector financing reforms such as the World Bank of the detrimental effect of user fees on health status.
- Health as a basic human right should be used as an overarching framework through which governments, donors and other stakeholders engage in discussions on how to improve accessibility and efficiency of health services and ultimately health outcomes.

Merrick (2000) proposes a useful matrix which examines specific reforms, how these are expected to improve the health system, what their impact has been on sexual and reproductive health, identifies risks and opportunities and consider how these risks can be mitigated. A gender analysis could be integrated into this framework so that the needs and experiences of women and girls versus men and boys are taken into account. The framework should engage with the desired outcomes of both SRH and HSR. This could assist in exploring the negative and positive impacts of the two on each other.

A number of recommendations arise from this review: (1) There is a need for more in-depth research to understand the specific impact of different health sector financing reforms on SRH in African countries; (2) There is a need to develop a continent-wide strategy with key role players focusing on promoting the idea of health as a human right. There is a need to promote saving the life of the continent, saving the lives of women, saving the lives of children through making health care accessible and equitable. This strategy should involve government ministers, women's health advocates, debt cancellation advocates, HIV/AIDS activists and sympathetic donors. At the same time, stakeholder-specific strategies should be developed. (3) Partnerships should be encouraged between the public and private sectors within a framework of a right to
health strategy; (4) Investment in building capacity at a local level should take place to ensure that decentralised financing mechanisms improve SRH status; (5) There is a need to embark on a strategy that sensitises donor agencies to the multi-dimensional nature of investing in SRH services as a priority area, and to conceptualise support for HIV/AIDS interventions within an integrated SRH model; (6) The capacity of governments should be built at a central and local level to integrate gender mainstreaming tools in planning and conceptualising budgets and (7) It is important that institutional mechanisms that exist in African countries, such as Gender Ministries, are brought on board to build consciousness around the importance of engendering approaches to decision-making at all levels, including the community level.

There is clearly a need to widen and deepen the information base covered in this report. The focus of research in the area should specifically be to initiate strategic advocacy and policy responses to facilitate a rights-based approach to SRH service provision and health status overall on the continent. Key questions to be addressed in such research include:

- What are the financial and human development benefits of investing in SRH services in Africa?
- What does equity mean in practice in relation to SRH and other health service delivery? What are the specific implications in relation to health financing?
- What are the barriers to equity in relation to SRH and other health service delivery? How is this different for key target groups, namely women, men and male and female adolescents?
- What financial barriers do women experience in accessing health services and SRH services in particular? How can these be addressed?
- What are the specific financing-related challenges experienced by countries in Africa in expanding SRH services in line with the Cairo specifications? How can these be addressed?
- How have health care financing reforms contributed towards addressing or exacerbating the HIV/AIDS pandemic? What are the lessons?
- Are there good models of community participation and engagement on SRH in Africa that can be replicated? Similarly are there models of community financing schemes which are gender-sensitive and can be replicated?
- Who are the key role players that need to be targeted to develop an understanding of the importance of integrating SRH service provision with financing reforms in ways that have positive health outcomes? What are their perspectives?
- What messages do we need to convey? What research needs to be done to develop these messages? How should these messages be packaged?

Health sector financing reforms arise directly from the political economy of Africa - a historical landscape shaped by colonialism and a macroeconomic landscape dominated by globalisation and the forces of finance capital. Undoubtedly change has to take place in Africa in order to address the myriad of SRH challenges compounding mortality and morbidity on the continent. The ICPD agenda remains relevant to addressing many of these challenges, most notably the centrality of sexual and reproductive rights and of integrating gender as a tool of analysis at the level of policy, programming, budgets and management. It is critical that SRH advocates are integrally involved in debate and research around health care financing reform, to find ways in which to ensure that core elements such as sector wide approaches and community financing schemes are engendered and that SRH priorities are integrated into these processes.
Access, equity and empowerment are core approaches around which HSR and SRH advocates can develop common frameworks. These broad concepts can be thoroughly interrogated and utilised to push the reform agenda towards the transform agenda. There is no option in Africa but for advocates to fight for the basic right to health as the key to the right to life of women and all people on our continent. This basic right to life cannot be determined by the forces of the market and/or the ideology of patriarchy, but should instead be there by virtue of a common humanity we wish to protect and advance.
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**Abbreviations**

AIDS  Acquired Immuno Deficiency Syndrome  
BI  Bamako Initiative  
CESCR  Covenant on Economic, Social and Cultural Rights  
DALY  Disability-adjusted life years  
HIV  Human Immunodeficiency Virus  
HSR  Health sector reform  
ICPD  International Conference on Population Development  
IFI  International financial institutions  
IPPF  International Planned Parenthood Federation  
NGO  Non-governmental organisation  
NHI  National health insurance  
PHC  Primary health care  
RTI  Reproductive Tract Infection  
SHI  Social health insurance  
SRH  Sexual and reproductive health  
SSA  Sub-Saharan Africa  
STI  Sexually transmitted infection  
SWAp  Sector wide approach  
UNDP  United Nations Development Programme  
UNFPA  United Nations Population Fund  
UNICEF  United Nations Children’s Fund  
WHO  World Health Organisation
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