

# High-Level Task Force for ICPD

RIGHTS, DIGNITY & HEALTH FOR ALL

## **Policy Considerations for Financing Sexual and Reproductive Health and Rights in the Post-2015 Era**

*February 2015*

This document was commissioned by the High-Level Task Force for the International Conference on Population and Development (ICPD)<sup>1</sup> to serve as reference and ‘food for thought’ for policymakers, donors, development partners, and civil society advocates working on sexual and reproductive health and rights issues. It may be especially relevant to stakeholders involved in national financial planning and budgeting and related advocacy, as well as the development of new global financing mechanisms related to implementing the Post-2015 Development Agenda.

### **Context**

The Post-2015 Development Agenda will influence policy priorities and resource flows for years to come. The success of the agenda depends not only on the substantive contents, or the “what”, but also the “how”, specifically financing and other means of implementation, such as knowledge and technology transfer, capacity building, improved policy coherence and an enabling environment, as well as the outcome of the Third Financing for Development Conference.

The commitments related to sexual and reproductive health and rights in the new global framework, as reflected in the Sustainable Development Goals,<sup>i</sup> will require increased and sustained funding to be achieved by the 2030 deadline. This paper puts forth policy considerations to this effect, to help lay the groundwork for implementation and improve resource mobilization at national and global levels. These policy considerations are based on good practices and lessons learned from a literature assessment and interviews with experts (see bibliography in Annex 2). Given the limited research available specific to financing sexual and reproductive health and rights, the paper draws largely from experiences from broader health and other sectors.

### **Smart Investment for Sustainable Development: Sexual and reproductive health and rights**

Sexual and reproductive health and rights (SRHR) are fundamental human rights, central to eradicating poverty and achieving sustainable development across its social, economic and environmental dimensions. SRHR – which encompass a range of issues, including universal access to SRH services and supplies, comprehensive sexuality education, and ending gender-based violence and harmful practices such as early, child and forced marriage – are fundamental to the ability of all people, especially women, adolescent girls and young people, to lead full, satisfying, healthy and productive lives. With a focus on prevention, investments in SRHR are not only critical to

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<sup>i</sup> Target 7 under the Sustainable Development Goal ‘Ensure healthy lives and promote well-being for all at all ages’ reads “By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes”. Target 6 under the SDG ‘Achieve gender equality and empower all women and girls’ reads “Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences”.

people's wellbeing and the prosperity and resilience of families, communities and nations, but are also proven to be cost-effective and cost-saving, freeing resources for investment in other development priorities.<sup>2</sup>

Despite the proven returns on investments, underfunding of SRHR persists. This is a contributing factor as to why the core goal of achieving universal access to sexual and reproductive services<sup>ii</sup> adopted by 179 governments at the International Conference on Population and Development (ICPD 1994) twenty years ago remains unfulfilled,<sup>3</sup> and why the Millennium Development Goal on improving maternal health (MDG 5) has been among the furthest behind.<sup>4</sup>

The compact adopted by Member States in 1994 stipulated that one third of funding for the ICPD Programme of Action in developing countries would come from overseas development assistance (ODA), and two thirds from domestic resources. Notably, as of 2011, the last year for which data is available, developing countries were covering three quarters of the ICPD package, a large share (62 percent) of which was financed out-of-pocket by private consumers<sup>5</sup> - with alarming implications for equitable access to these preventative and life-saving services. Furthermore, most of these domestic funds are from a few large countries, while many, especially Sub-Saharan African and Least Developed Countries, still face major challenges in mobilizing the required levels of financing.<sup>6</sup>

On the donor side, the bulk of ODA funding for health goes to HIV and AIDS,<sup>iii</sup> while support for reproductive health care and family planning fell by half between 2000 and 2010 as a proportion of total ODA for health.<sup>7</sup> In 2011, of the US\$11.4 billion in ODA that supported the ICPD package, 66 percent went to HIV with limited funding to other sexually transmitted infections, only eight percent went to family planning, 22 percent to basic reproductive health services, and 4 percent to research.<sup>8</sup> The solution, of course, is not to diminish support for prevention and treatment of HIV and AIDS, but to increase funding to support all, interrelated aspects of SRHR. For this, advocacy and political will are needed to secure adequate domestic public funding in all countries, and for donors to reach the yet-unfulfilled ODA target of 0.7% of gross national income and increase the proportion that goes to SRHR, with a focus on reaching those most in need.

Targets in the new agenda should not be misconstrued as the sum total of actions required to fully realize SRHR. The post-2015 era offers stakeholders an opportunity to apply lessons learned and avoid the overly distilled, reductionist and siloed approach to SRHR to which the Millennium Development Goals contributed. This approach engendered parallel, vertical funding streams and programmes for what are actually interrelated priorities -- maternal health, HIV/AIDS, family planning. This skewed funding trends away from *integrated* SRH service delivery, and excluded the broader agenda of action that transformative progress requires.

SRHR problems are entirely preventable. The costs of inaction – to health, lives, economic productivity and public budgets – far outweigh the costs of the investments required to fulfill SRHR. These investments have multiple high payoffs that will bolster poverty eradication and drive inclusive sustainable development in the post-2015 era and beyond.

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<sup>ii</sup> The costed ICPD package includes: family planning, basic reproductive health services, sexually transmitted diseases and HIV/AIDS prevention, basic research, data, and population and development policy analysis.

<sup>iii</sup> From 2009-2011, only 10% of reported ODA for health went to reproductive health and family planning (MDG 5); 58% went to MDG 6: AIDS, malaria, and other major diseases; 11% to health policy, administration and management; and 21% to other health purposes. (World Health Statistics, WHO 2013).

## **Scope and limitations**

While the aspiration is to secure sufficient, sustained, predictable financing for the full realization of sexual and reproductive health and rights for all, the focus of this document is primarily on funding universal access to sexual and reproductive health services provided by the health sector. This narrower scope is due to the more limited research available on the broader investments required for a holistic approach to SRHR as envisioned in the ICPD Programme of Action and Beijing Platform for Action, and the outcomes of their review processes.

SRH services are a critical aspect of SRHR, but a complete understanding of sexual and reproductive health and rights goes far beyond access to health facilities and services to include an array of social, legal, institutional and financial arrangements that enable individuals to exercise their rights in this area and address the underlying social determinants. Especially critical, for example, is investing in fulfilling the human rights of women and girls, as gender discrimination is one of the leading determinants of poor health and unwanted SRHR outcomes. It is also key to address inequities in access due to poverty and multiple forms of discrimination, stigma and social and economic exclusion affecting various population groups.

As such, SRHR requires a multi-sectoral approach that goes beyond the health sector. This includes, for example, financing by the education sector for comprehensive sexuality education, public education and awareness-raising; investments in infrastructure so that all health facilities have clean water supplies and are accessible by functional roads and affordable transportation; legal aid, legal reforms and support for national human rights commissions to guarantee equality and non-discrimination under the law, with bans and enforcement against coercive practices and sexual and reproductive rights violations; and budget appropriations for the health, education, justice, security, housing and other sectors to address gender-based violence and harmful practices against women and girls.

## **Policy Considerations & Recommendations**

### **1) Develop National Financial Action Plans for Sexual and Reproductive Health and Rights**

All countries should develop multi-year national action plans for financing SRHR, and ensure the integration of SRHR plans and budgets within broader national health strategies and budgets, as well as within other relevant sectoral plans (i.e. education, gender, youth, etc.). The plans should: a) reflect a holistic approach to sexual and reproductive health and rights and the actions required to achieve them, b) be developed through a participatory process that involves all relevant government ministries and civil society, especially women's and youth groups, and c) bring together all donors and development partners to coordinate efforts and avoid duplication. Financing plans should be measurable and transparent, and countries should provide for enhanced public, periodic and independent monitoring and evaluation mechanisms to track how commitments are being met. The Country Accountability Frameworks<sup>iv</sup> promoted by the Commission on Information and Accountability for Women and Children's Health provide a helpful reference for the development of such plans.

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<sup>iv</sup> Country Accountability Frameworks are platforms that bring together donors and country stakeholders to provide national follow-up to the recommendations of the [Commission on Information and Accountability for Women and Children's Health](#), (CoIA). COIA was created in 2010 by the WHO at the request of the United Nations Secretary-General to arbitrate the "most effective international institutional arrangements for global reporting, oversight and accountability on women's and children's health."

Plans should be driven by an equity perspective focused on reaching the poorest and most excluded sectors of the population and rural and remote areas of the country, with emphasis on achieving universal access to comprehensive SRH information, education and services, including all the core components (maternal-newborn health, contraception, HIV/AIDS and sexually transmitted infections, treatment for complications of unsafe abortion and safe abortion services), and tailored to the needs and perspectives of all age groups, with particular attention to adolescents and youth. Funding should cover at least an essential-level response to gender-based and sexual violence (with functioning multi-sectoral referrals in place). Financing for collection and analysis of disaggregated data should also be a priority in order to track equitable access and outcomes in relation to SRHR. A holistic approach would also imply budgeting support for national human rights mechanisms charged with protecting sexual and reproductive health and rights, and overall, ensuring other robust investments for enabling health system strengthening, gender equality and other key areas that particularly influence SRHR outcomes.

Where civil society and non-profit organizations are supplementing State responsibilities for the provision of services, funding in support of these activities should be included in financing plans. In addition, support for women's, youth, and other pro-SRHR advocacy organizations, including grassroots and community-based organizations, should be ensured, while respecting their autonomy and independence. They play an essential role in generating public demand and sustaining political will for required funding, and their participation in public budgeting processes can be critical to improving allocations for SRHR.<sup>9</sup> However, funding trends for SRHR and women's rights advocacy groups are not encouraging.<sup>10</sup>

Investments should also be made in increasing the financial and budgeting literacy and capacity of Ministries of Health and civil society to effectively engage in these processes and advocate with Ministries of Finance for sustained, predictable resources for SRHR. This includes advocacy to protect essential SRHR-related services from cutbacks under austerity and other macroeconomic measures, including reductions or caps on public sector wages, which can hamper hiring and retention of health providers.

## **2) Improve Tracking of Financial Resource Flows for Sexual and Reproductive Health and Rights**

States should improve systems for tracking and reporting domestic and international financial flows dedicated to sexual and reproductive health and rights, and regularly review allocations against expenditures. In the short term, all countries should report total health expenditure and total sexual and reproductive health expenditure by financing source, per capita. 'Compacts' between governments and all major development partners in a country should be in place that require reporting on externally funded commitments and expenditures, based on an agreed common format.

Building on this, States should work towards developing sexual and reproductive health sub-accounts based on a standardized framework for regular reporting, with distinction between funding supplied by 'government-as-source' (domestic public resources, i.e. taxes), and 'government-as-agent' (all financing disbursed by the government, including external revenue, such as ODA).<sup>v</sup> In addition, tracking of out-of-pocket expenditures by sex, socioeconomic status and other demographic or geographic variables should be improved in order to capture the financial burden and use of services among disadvantaged population groups and undertake appropriate policy responses to address inequities.<sup>11</sup>

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<sup>v</sup> These recommendations draw from those issued by the Commission Information and Accountability of Women and Children's Health.

Deficiencies in tracking financial flows to SRHR priorities present significant obstacles to understanding funding trends and conducting informed policymaking.<sup>12</sup> Only 11 countries have ever reported tracking SRHR spending through a reproductive health sub-account, and then only sporadically.<sup>13</sup>

In terms of international donor flows, the OECD-DAC database has been tracking a category called “population and reproductive health”, which is not synonymous with SRHR. For example, it may not include sexuality education, advocacy and community mobilization, and it may include expenditures such as census-taking, migration, trafficking and social protection, which while important in their own right and linked to SRHR issues, should be counted separately.<sup>14</sup> More recently, the OECD-DAC adopted a new scoring system to track aid for reproductive, maternal, newborn and child health (RMNCH), which was expected to be applied in 2014 for 2013 flows.<sup>15</sup> Another challenge is that the increasing use of sector-wide approaches (SWAps), which while providing a better basis for integration of services and policies, make it harder to track funding specifically for SRHR.<sup>16</sup>

### **3) Reduce Fragmentation of Donor Funding Streams**

Donors and recipient countries should take steps to improve coordination to reduce parallel programming and fragmentation of funding streams for sexual and reproductive health and rights.

The proliferation of new funding initiatives and donors, while very positive, can lead to inefficient resource use, duplication, excessive transaction costs and undue burden on scarce resources, especially human resources.<sup>17</sup> For example, as of 2009, even before several new large-scale initiatives were launched,<sup>vi</sup> there were more than 40 health-related bilateral development partners and 90 global initiatives.<sup>18</sup> One global estimate found that the average donor-funded health project left less than half of the available funds for project costs (e.g. infrastructure and equipment, drugs and materials),<sup>19</sup> and that the same health staff may be called to attend a high number of capacity building seminars funded by different donors covering similar topics.<sup>20</sup> A study in Rwanda found that government staff spent three days a year to service each aid mission, with 168 such missions per year, and an estimated 27% of all government and donor resources for health spent on administration.<sup>21</sup>

This concern with fragmentation comes at a time when there is increasing attention to investing in strengthening health systems as a whole, and thus to enhancing coordination among donors to fund country-owned health sector strategies. This is the objective, for example, of the International Health Partnership (IHP+), launched in 2007 and which has since grown to 63 partners, including over 50 developing country partners, bilateral donors and international development agencies.<sup>22</sup> However, without dedicated funding initiatives for SRHR, funding for it may become diluted or take a backseat to other health sector priorities. A dedicated financial action plan for SRHR (as described under Recommendation 1) can counter this risk, while the compacts among donors and national stakeholders (as described under Recommendation 2) can reduce overlap, fragmentation and funding gaps for particular issues at the national level.

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<sup>vi</sup> These include the Partnership for Maternal, Newborn and Child Health (2005), the Muskoka Initiative (2010), the Global Strategy and Every Woman Every Child, the Child Survival Call to Action (2012), Family Planning 2020 (2012), the United Nations Commission on Life-Saving Commodities for Women and Children (2012), the Global Vaccine Summit (April 2013), and the Every Newborn Action Plan (2014). The World Bank has announced a multi-stakeholder Global Financing Facility in support of Every Woman Every Child.

At the global level, as new partnerships and funding mechanisms materialize for implementation of the Post-2015 Development Agenda, such as the Global Financing Facility to Advance Women’s and Children’s Health under the auspices of the World Bank Group,<sup>vii</sup> the importance of seizing opportunities to promote strong coordination of funding streams – including to improve comprehensive programming and integrated service delivery from a rights-based approach – cannot be overstated.

#### **4) Improve Efficient Use of Available Resources**

To more effectively and efficiently employ financial resources allocated to SRHR, investments should be made to strengthen the financial planning and management capacities of relevant government authorities and health personnel.

Enhancing financial management skills through training and technology can improve government capacities to overcome the bottlenecks related to logistics, administration, procurement, infrastructure and human resources that impede the ability of a ministry to spend its allocations in a timely manner. The World Health Organization identified ten leading causes of inefficiency in spending for health, including hospital staffing not matched to hospital sizes; lack of motivation among staff that could be corrected through improved payment, hiring and promotion systems; and underuse of generics or overpayments for medicines that could be corrected with improved procurement practices.<sup>23</sup> Countries should also take full advantage of flexibilities in the TRIPS<sup>viii</sup> agreement to maximize access to less expensive generic medicines. Increasing absorptive capacity can not only help ensure better health outcomes for the same resources, but also make a credible case to the public and to donors that additional funding directed to the sector will be well-utilized.

#### **5) Increase Mobilization of Domestic Public Revenue for Health, including Sexual and Reproductive Health**

While a large proportion of SRHR spending comes from domestic sources, a significant portion of this is out-of-pocket expenditures by individuals, implying inequity in access to services based on ability to pay. There is thus a pressing need to maximize fiscal space for health spending, including for SRHR. Opportunities include improved tax collection, excise taxes (e.g. on tobacco or alcohol), earmarking tax revenues (hypothecation), financial transaction taxes, and exploring monetary and debt management policy scenarios that could free up resources for health, including SRHR.

Increasing government revenue through progressive *tax collection* should be priority. This can significantly enhance the predictability of funding, which is essential for setting and following through on longer-term priorities, such as overall health systems strengthening, which is critical to delivering quality SRH services. Many developing countries do not collect their total potential tax revenue, and have significant room to increase their tax-to-GDP ratios.<sup>24</sup> This is in part due to corporate tax incentives, which result in an estimated US\$138 billion in foregone revenue in developing countries.<sup>25</sup> In the absence of predictable, long-term financial commitments, hiring or retaining personnel, undertaking infrastructure expansions, or expanding access to treatments or life-saving commodities may be halted or reversed due to the vagaries of external funding. A review covering 43 Sub-

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<sup>vii</sup> For more information, see here:

<http://www.worldbank.org/content/dam/Worldbank/document/HDN/Health/ConceptNote-AGlobalFinancingFacilitySupportEveryWomanEveryChild.pdf>

<sup>viii</sup> Trade-Related Aspects of Intellectual Property Rights (See the World Trade Organization TRIPs Declaration, 2001)

Saharan African countries, for example, revealed one of the weaknesses in their health systems was the high reliance on donor support, which makes financing less predictable and sustainability less assured.<sup>26</sup>

Taxes on products that pose risks to health such as tobacco or alcohol - *excise taxes* - are another way to increase revenue, while incentivizing reduction in unhealthy behaviors that add to health costs. There are 22 low-income countries in which a 50 percent increase in excise taxes would generate a combined total of US\$1.42 billion per year.<sup>27</sup>

Another policy option is specific *earmarking of tax revenues*, known as *hypothecation*, an area in which there is substantial experience from which to draw. For example, Zambia introduced a levy on all gross interest earned in savings or deposit accounts, treasury bills, government bonds or similar financial instruments, raising US\$3.9 million for the health sector in 2009.<sup>28</sup> Belgium, Egypt, the United Kingdom, as well as several states in the United States of America, are reported to have some level of hypothecation for health of their tobacco taxes.<sup>ix</sup> However, the appropriateness of hypothecation should be evaluated on a case-by-case basis to assess potential risks: earmarking can be used as an excuse to direct less revenue to the sector from the general budget, and sector needs may increase or decrease in a way that puts them out of sync with the rate of earmarking.

*Financial sector taxes*—such as those on financial transactions—are fairly common in several countries, and other countries could build on this experience to collect additional revenue.<sup>x</sup> Countries can also increase *tax pressure on the mining and oil industries* as a way to capture extraordinary or windfall earnings generated in the extractive sector. Examples from countries as varied as Peru and Papua New Guinea show how governments can tax mining industries and channel those resources to health, education and other development priorities.<sup>29</sup>

Finally, *budget reallocations* could also be explored. For example, there are at least 15 developing countries whose defense budgets exceed the health budget, in some cases by a ratio of 2 to 1.<sup>30</sup> *Debt restructuring* is another policy option for generating resources for development priorities. Overall, greater transparency and public access to information about monetary and debt policies can enable dialogue among stakeholders and assessment of possible alternatives and their implications for particular population groups, bearing in mind States' human rights obligations.

## **6) Remove Financial Barriers to Accessing Sexual and Reproductive Health Services**

Countries should allocate sufficient funds to effectively remove financial barriers for people to access SRH services. Out-of-pocket expenditures for health care, including sexual and reproductive health, impoverishes individuals and families. For example, every year, about 150 million people suffer financial hardship from paying for health care, and 100 million are pushed below the poverty line.<sup>31</sup> Sub-Saharan Africans pay USD\$200 million out of their own pockets to obtain life-saving treatment for unsafe abortion complications.<sup>32</sup> In 2011, private consumers in developing countries paid over US\$34 billion out-of-pocket for family planning, reproductive health and HIV/AIDS-related expenses alone.<sup>33</sup>

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<sup>ix</sup> They include Alaska, Arizona, California, Maryland, Massachusetts, Michigan, Oregon and Utah (Doetinchem, 2010).

<sup>x</sup> The International Monetary Fund considers concerns that such taxes might drive away financial activity to be unfounded, pointing out that major financial centers – including the UK, Hong Kong, Switzerland, Singapore and South Africa – levy financial transaction taxes without limiting financial activity to an unacceptable extent (IMF, 2010).

Ideally, countries would provide *universal free access* to services and eliminate financial barriers at point-of-service delivery. This requires a commitment to a tax-funded budget allocation to ensure the provision of at least a minimum service package on a universal and free basis, of which sexual and reproductive health services must form a core part. Universal access to government-sponsored healthcare in Thailand, for example, where most of the sexual and reproductive health service components are included in the benefit package, has resulted in improved coverage of SRH services, including 99% skilled birth attendance in the period 2000-2008.<sup>34</sup>

Efforts to increase financing for health services, however, have led some countries to introduce user-fees at point-of-service delivery. While evidence on user fees' effects on the availability and quality of services is mixed, their clear unintended effect has been to create financial barriers to access.<sup>35</sup> Such barriers sometimes act jointly with social, racial, ethnic, gender-based and other forms of discrimination to make access particularly difficult for disadvantaged or marginalized groups.<sup>36</sup> In addition to user fees, the cost of transportation to a health facility, or the opportunity costs of missing work to visit a clinic, pose potential additional financial barriers that may keep people from accessing services they need.<sup>37</sup>

In the face of these barriers, countries have tried a variety of responses to ensure free access at point-of-service delivery for those who cannot afford to pay. These include user-fee waivers, reimbursement schemes for people who can demonstrate financial hardship, community insurance schemes with affordable premiums, vouchers, and conditional cash transfer programs—for example, cash payments to women conditional upon their use of maternal health services. It is difficult to make sweeping statements about the effectiveness of such mechanisms, as their degree of success in removing barriers is contingent upon highly contextual local and national factors. However, evidence suggests that they are generally uneven in their success in reaching the groups that most need them, fail to guarantee adequate quality of services, and tend to not be financially sustainable, often requiring donor-provided subsidies that are not reliable in the long term.<sup>38</sup> However, it is worth highlighting some evidence of success with the use of conditional cash transfers under certain conditions (e.g. existence of effective primary healthcare and mechanisms to disburse payments), as in the case of the PROGRESA/Oportunidades programme in Mexico.<sup>39</sup>

## **7) Mobilize New Innovative Sources of Financing and Scale up Existing Ones**

Various innovative sources of financing have been proposed and in some cases are already being implemented for a number of development priorities, including health.<sup>40</sup> These could be adapted to provide additional funding for sexual and reproductive health.

Examples include financial transaction taxes and debt swaps (as mentioned above), air ticket levies, carbon taxes, Advanced Market Commitments (whereby donors provide incentives for the development and low-cost sale of products, such as vaccines), or allocations of the IMF's Special Drawing Rights (which enable developing countries to access hard currency), among others (see Annex 1 for a list of examples, including countries involved in development and/or implementation, and amount of resources mobilized). The Monterrey Consensus on Financing for Development recognizes the importance of exploring innovative sources of finance "provided that those sources do not unduly burden developing countries."<sup>41</sup> They are no substitute for domestic resource mobilization efforts and overseas development assistance, but could leverage important additional resources.

This paper highlights only sources considered to be complementary to ODA, predictable, stable, and that address income redistribution.<sup>xi</sup>

## **8) Regulate Private Sector Financing for the Provision of Sexual and Reproductive Health Services**

The use of public-private partnerships (PPPs) as a means of financing SRH is on the rise, and in light of growing interest and prominent discussions on PPPs in the context of the Post-2015 Development Agenda, it will be especially important for countries and stakeholders engaging in such partnerships to expressly address the potential risks and shortfalls that can distort public health principles and objectives.

Public-private partnerships to finance sexual and reproductive health and rights, outsource service provision, or advance research and development should be carried out only under strong regulation and stewardship by governments and within an existing context of tax-funded public health care, to ensure equitable access, quality of care and compliance with human rights and ethical standards. This should involve *ex ante* screening to determine whether private sector partners have a demonstrated commitment to rights- and gender equality-based approaches, have any prior involvement in human rights abuses or corruption, respect tax and other financial obligations, comply with labour and environmental standards, and have no conflicts of interest, for which proper disclosure should be required. Such screening will also help guard against any reputational risks from partnering with for-profit entities with questionable records and that do not satisfy basic standards, particularly relevant for national governments and international and multilateral organizations such as the United Nations entering into global partnerships with the private sector. The decision to enter into PPPs should be taken in a transparent manner with the participation of affected communities, and with safeguards in place against undue influence by for-profit firms with conflicts of interest. The post-2015 era should serve as an opportunity to develop new guidelines and regulations for public-private partnerships, taking into account the principles and good practices under existing international guidelines.<sup>xii</sup>

PPPs are collaborations between the public sector and at least one for-profit entity, at national or global levels. One example of a global public-private partnership is the GAVI Alliance, which provides vaccines to children in the world's poorest countries, and includes the World Health Organization and other international entities, alongside the International Federation of Manufacturers & Associations, which represents the interests of several for-profit pharmaceuticals. Another global PPP is between USAID and Bayer Health Pharma, which collaborate to provide affordable contraceptives in the developing world.<sup>42</sup>

The rationale for such partnerships is that they can potentially increase impact by applying know-how and practices in which the private sector may have comparative advantages, leading to improved efficiency in the use of resources. PPPs can also be a way for the public sector to transfer risks inherent to some investments to private sector entities.

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<sup>xi</sup> Characteristics in line with Leading Group Discussion Paper (2007).

<sup>xii</sup> For example, see Human Rights Council (2008) *Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, including the Right to Development - Protect, Respect and Remedy: a Framework for Business and Human Rights*; United Nations Global Compact, *The Ten Principles*; UN Women (2010) *Women's Empowerment Principles, Equality Means Business*.

For-profit companies, however, are ultimately accountable to owners (e.g. shareholders) and driven by financial bottom lines, rather than the public interest and fulfilling SRHR. PPPs may also end up subsidizing for-profit actors -- including with public resources -- rather than transferring risk from the public to the private sector.

There is significant evidence that privatization of health services and the profit-driven behavior of firms involved in service delivery may negatively impact equitable access, especially by women and those least able to pay.<sup>43</sup> In addition, empirical evidence does not support the assertion that private sector involvement is necessarily associated with improvements in coverage, efficiency and quality of care.<sup>44</sup> Again, it is paramount to ensure private-sector service providers are subjected to the same rigorous human rights and ethical standards for quality of service as any other service provider.

### **9) Strengthen Monitoring and Accountability for Fulfillment of Financial Commitments to Sexual and Reproductive Health and Rights**

Despite many new initiatives and commitments related to various aspects of sexual and reproductive health and rights, political will and resources remain inadequate. If the Post-2015 Development Agenda and related human rights obligations are to be met, multi-layered monitoring and accountability systems linking national, regional and global levels must be put in place to track fulfilment of commitments, including financial commitments and resource flows, both from domestic resources and ODA. This should involve mechanisms for public, periodic, independent evaluation of how all actors progress towards meeting their commitments.

At national levels, country accountability platforms<sup>xiii</sup> should be established and strengthened to bring together governments, donors and country stakeholders to provide national coordination and follow-up to sexual and reproductive health financing commitments, based on an integrated SRHR policy framework and programming approach. Public, transparent, measurable national strategies and financial plans as outlined in earlier recommendations can serve as key accountability instruments at national levels.

At international level, particularly relevant in the context of the twenty-year review of the ICPD Programme of Action and the implementation of the Post-2015 Development Agenda, and as a complement to other monitoring and reporting mechanisms to be put in place, a *global independent expert review group* could be established, charged with periodic monitoring and strengthening accountability. This could build on the promising example of the Independent Expert Review Group on Information and Accountability for Women's and Children's Health (2011-2015), which, established under the rubric of the Secretary-General's *Every Women, Every Child* initiative, reports directly to the Secretary-General. It has brought together representatives from governments, international organizations, civil society, foundations, academia, and the private sector in a collaborative and constructive approach to 'learning-and-action' through its reviews of progress, and fostering cross-fertilization of new practices and mechanisms for strengthened accountability.<sup>xiv</sup>

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<sup>xiii</sup> As recommended by the Commission on Information and Accountability for Women's and Children's Health.

<sup>xiv</sup> The IERG, co-chaired by the Presidents of Canada and Tanzania, was established at the recommendations of the Commission on Information and Accountability. For more information and the IERG's reports, see [http://www.who.int/woman\\_child\\_accountability/ierg/reports/en/](http://www.who.int/woman_child_accountability/ierg/reports/en/).

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<sup>1</sup> The [High-Level Task Force for the International Conference on Population and Development](#), co-chaired by former Presidents Joaquim Chissano of Mozambique and Tarja Halonen of Finland, is an autonomous group of distinguished representatives from all regions of the world, with records of service in government, parliament, civil society, the private sector and philanthropy. Its mandate centres on the Post-2015 Development Agenda process.

<sup>2</sup> See, for example, High-Level Task Force for ICPD (2015) *Smart Investments for Financing the Post-2015 Development Agenda*, which presents the data demonstrating the financial and economic costs of inaction and benefits of investing in SRHR and interrelated priorities based on studies by leading global institutions, including the World Bank, the UN system, the Alan Guttmacher Institute, and among others.

<sup>3</sup> UN Secretary General, 2014

<sup>4</sup> United Nations 2012a; United Nations, 2012b

<sup>5</sup> UNFPA, 2013

<sup>6</sup> UN ECOSOC, 2013

<sup>7</sup> United Nations, 2012a

<sup>8</sup> UN Secretary General, 2014

<sup>9</sup> Guttmacher Institute, 2011

<sup>10</sup> Arutyunova and Clark, 2013; ARROW, 2011

<sup>11</sup> Commission on Information and Accountability for Women's and Children's Health, 2011

<sup>12</sup> Global Health Resource Tracking Working Group, 2005

<sup>13</sup> Hoehn 2014; Sidze et al, 2013

<sup>14</sup> Jones and Lander, 2012

<sup>15</sup> OECD, 2014

<sup>16</sup> UNFPA, 2013

<sup>17</sup> Task Force on Innovative International Financing for Health Systems, 2009a; WHO 2010; "Langkawi Report" 2009; WHO 2010.

<sup>18</sup> Task Force on Innovative International Financing for Health Systems, 2009

<sup>19</sup> Task Force on Innovative International Financing for Health, 2009a

<sup>20</sup> WHO, 2010

<sup>21</sup> Logie et al, 2008

<sup>22</sup> IHP+, 2014

<sup>23</sup> WHO, 2010

<sup>24</sup> IMF, 2011

<sup>25</sup> Action Aid, 2013

<sup>26</sup> African Union Commission, 2010

<sup>27</sup> Stenberg et al, 2010

<sup>28</sup> Stenberg et al, 2010

<sup>29</sup> Ortiz and Cummins, 2012; Stenberg et al, 2010

<sup>30</sup> Ortiz and Cummins, 2012

<sup>31</sup> WHO, 2010

<sup>32</sup> WHO, 2012

<sup>33</sup> United Nations, 2013

<sup>34</sup> Ravindran, 2012

<sup>35</sup> Palmer et al, 2004; Ravindran, 2012; Ankrah Odame, et al, 2014; Witter et al, 2007; Mishtal, 2010

<sup>36</sup> Killingsworth et al, 1999; Ravindran, 2012

<sup>37</sup> Ravindran, 2012; Borghi et al, 2006

<sup>38</sup> Ravindran, 2012; Ravindran and de Pinho, 2005; Ravindran, 2010

<sup>39</sup> Lagarde et al, 2007

<sup>40</sup> Le Gargasson and Salome, 2010

<sup>41</sup> Monterrey Consensus, 2002

<sup>42</sup> United States Government Global Health Initiative, 2013

<sup>43</sup> Ravindran and de Pinho, 2005; See also findings of a 12-country study in Thanentiram and Racherla.

<sup>44</sup> Ravindran and de Pinho, 2005; Dmytraczenko, Rao and Ashford, 2003

## Annex 1: Innovative Sources of Financing<sup>xv</sup>

Innovative source	Description	Existing?	Countries involved	Revenue mobilized (potential revenue, if initiative not implemented)
Air ticket levy	Small contributions deducted by governments from airplane ticket purchases. Funds mostly benefit UNITAID, a global health initiative providing funding to address inefficiencies in markets for the prevention and treatment of HIV and AIDS, malaria and tuberculosis.	Yes	Cameroon, Chile, France, Korea, Madagascar, Mali, Mauritius, Niger, DRC	USD 1.35 billion since 2006
Financial transaction tax	Small taxes (0.02 to 0.2%) applied to securities, high-frequency trading and credit default swaps, with a percentage of revenues allocated to development.	Yes	France	Euro 60 million allocated to development in one year
Financial transaction tax	Small tax applied primarily to transfers of shares and bonds, with a plan to gradually extend it to derivatives.	No	10 European countries are currently preparing to implement one (Austria, Belgium, Estonia, France, Germany, Greece, Italy, Portugal, Slovakia and Spain)	N/A
Market mechanism	A percentage of the revenues from the European Emissions Trading System are allocated to international development and climate-related initiatives.	Yes	Germany and Finland	Euro 3.2 billion expected by 2014 in Germany; Euro 80 million in Finland
Lottery	A small percentage of revenues from the national lottery are allocated to a special fund for agriculture and food security.	Yes	Belgium	Euro 88 million
Advanced Market Commitments	Donors commit funds to guarantee the price of specific products related to development (e.g. vaccines) once they have been developed.	Yes	Canada, Italy, Norway, Russia, UK (channeled through GAVI)	USD 1.45 billion

<sup>xv</sup> This list is based on mechanisms reviewed by the intergovernmental Leading Group on Innovative Sources of Finance, and the Task Force on Innovative International Financing for Health Systems, (Leading Group 2014 and Task Force Working Group 2, 2009).

	These commitments provide manufacturers with an incentive to invest and expand manufacturing capacity. In exchange, companies provide the products to developing countries at an agreed long-term price.			
Loan Conversion	Loans provided to developing countries to implement a development program. Credits are repaid by a third (private) party to the creditor on behalf of the debtor if the project is successfully implemented.	Yes	Japan, Pakistan, Gates Foundation	USD 65 million
Debt swaps	A creditor country cancels bilateral debt; in exchange, the debtor country reinvests in health projects.	Yes	Applied to health by Australia-Indonesia, Germany-Indonesia, Pakistan, Ivory Coast and Global Fund to Fight Aids, Tuberculosis and Malaria	Euro 81.8 million
Voluntary Solidarity Contributions	Solicitation of small voluntary contributions from large pools of consumers, for instance when purchasing airline tickets or paying monthly mobile phone bills.	No		N/A
Special Drawing Rights	Allocations of Special Drawing Rights – a reserve asset that can be issued by the International Monetary Fund and can free up hard currency reserves or allow countries to borrow hard currency at highly subsidized interest rates.	No		USD 20 to 390 billion per year (depending on different proposals)
Carbon taxes	A levy on use of fossil fuels.	No		USD 60 to 250 billion per year (depending on proposals)
Tobacco taxes	Internationally coordinated levy on tobacco consumption, building on existing national tobacco taxes.	No		N/A

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