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Women's Concerns Count

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* The views expressed in this paper are those of the author and do not necessarily represent those of the United Nations.

Women's Concerns Count!

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Based on findings by NGO partners

in Cambodia, China, India, Indonesia, Nepal, Malaysia, Pakistan, and Philippines.

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Women's Concerns Count!

This paper[Ψ] has been prepared by Indu Capoor[ΨΨ] and ARROW[ΨΨΨ] based on findings of the most recent monitoring of ICPD implementation by ARROW and NGO partners in Cambodia, China, India, Indonesia, Nepal, Malaysia, Pakistan, and Philippines. [*Asian Pacific Resource and Research Centre for Women: Monitoring Ten Years of ICPD Implementation; The Way Forward to 2015, Asian Country Reports.* 2005]. This includes an assessment of government reports on ICPD+10 submitted to UN ESCAP. It builds on ARROW's two previous regional ICPD and Beijing monitoring studies- [*Taking Up The Cairo Challenge: Country Studies in Asia-Pacific.1999* and *Women's Health Needs and Rights after Beijing. A Beijing Monitoring Study*. 2000] and also refers to the ARROW study *Access To Quality Gender –Sensitive Health Services; Women-Centred Action Research, 2003.* Policy recommendations are also drawn from the ARROW coordinated Women's Health and Rights Advocacy Partnership [WHRAP] initiative South Asian Policy Dialogue with Governments and UN agencies held in 2005.

Issue 1: The Beijing and Cairo goal of reduction in maternal mortality by at least 50% of the 1990 levels by 2000 has not been achieved in many countries despite the knowledge and technology being available to save women's lives.

ARROW's eight country study *Monitoring Ten Years of ICPD Implementation* brought forth the fact that two million women have died in these countries alone since 1994 from pregnancy and childbirth related causes. Of these, 259,530 died due to unsafe abortion, reasons for which include poverty. Annually, as many as 195,420 women continue to die from maternal mortality. To calculate these figures was difficult as country data is often not up to date or reliable and comparative baseline data is not easily available. China is

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the only country that achieved a 50% reduction in maternal mortality among the eight countries. In the six countries with high levels of maternal mortality, namely Cambodia [437], Indonesia [307], India [440], Nepal [905], Pakistan [500] and Philippines [172], the ICPD target of a rate of less than 125 by 2000, has also not been met.

The above data and analysis evaluating a Beijing goal achievement is not how the Government typically reports on progress in the UN review processes. This is of great concern as it means that progress is not being closely monitored and reported according to agreed objectives. A related concern is that governments are not acknowledging in their reports that unsafe abortion is one of the main causes of death accounting for 13% of pregnancy related deaths in South Asia and 15% in Southeast Asia. In the eight countries, only India and the Philippines mentioned unsafe abortion as a cause of death in their ICPD10 reports to ESCAP.

From our analysis, the main reasons for this poor progress are:

- Low policy priority to the health sector, especially reproductive health and women's health reflected in low health budgets which do not meet WHO guidelines.
- An inadequate and unaccountable primary health care system to deliver services which has become weaker and less affordable in all countries due to health sector reforms.
- Slow implementation of reproductive health policies and plans and weak monitoring, reporting and public accountability on progress in implementation and achievement of objectives.
- Poor implementation of liberal abortion laws [e.g. India, Malaysia and recently Nepal] due to low priority and very restrictive laws in other countries [e.g. Philippines, Pakistan] resulting in continued high levels of unsafe abortion. Many women and health providers of all levels were not aware of the provisions in the abortion law and women's legal rights.

Strategies: To address this issue, it is critical that the primary health care system is strengthened including increasing budgetary allocations; maternal mortality and unsafe

abortion are placed higher and more openly on the national policy agenda; in depth implementation progress is monitored more regularly and government accountability and transparency to the public acted upon.

Policy Recommendations to Government:

- Increase the per capita Government health expenditure [GHE] as recommended in the WHO Report of the Macroeconomic Commission on Health, to at least US $ 15 for developing countries [note: This is the current level in Sri Lanka]
- Increase the proportion of Public Health Investment to at least 3 % of the GDP and increase the allocation of this investment to reducing maternal mortality and unsafe abortion. [Note: The current figure in India is 0.9% and in Pakistan, 0.7%]
- Ensure that all related policies such as the National Health Policy, Reproductive Health Policy, Population Policy, HIV/AIDS policy, and Women's Empowerment Policies etc. have detailed target figures and time schedules to implement the actions known to reduce maternal mortality. These include, extending the number of functional emergency obstetric care facilities in all primary health care centres; increasing the availability and accessibility of fully functioning obstetric teams; making all existing clinic infrastructures fully functional with qualified and skilled staff, supplies and medication; increase the number of adequately trained and equipped skilled birth attendants, and increase the number of nurses; ensuring all clinics are also equipped for safe, legal abortion services including 24 hour availability of blood banks.
- Report annually on progress of implementation of plans to national and local stakeholders including NGO's and UN agencies using agreed upon indicators.
- Review urgently restrictive abortion laws and reform these laws to at least allow abortion to save the life of the mother, for mental health reasons, and for socio economic reasons, especially poverty.
- Urgently remove any user fees for reproductive health services [especially for childbirth, legal abortion, and contraception] introduced with health sector reforms.

ISSUE 2: Women's access to appropriate, affordable and quality health care [let alone gender- sensitive services] has not increased primarily due to the negative impact of health sector reforms.

Health sector reforms, promoted and financed by the World Bank, USAID and the Asian Development Bank, which were introduced in the late 1980's/1990's to address failing health systems, have not resulted in significant improvements in reproductive health outcomes in the last decade. The reform components have commonly included increase of user fees and expansion of social health insurance; decentralization of decisions on service delivery; the promotion of public-private interactions in health services, and the promotion of cost effective methods for priority setting. It was expected that reforms would improve the efficiency, affordability, coverage, quality and community participation of health services. However findings from the ARROW ICPD 10 regional study and the *Global Initiative for Sexual and Reproductive Rights in Health Reforms* coordinated by the Witwatersand University in Johannesburg reveal that the benefits and entitlements do not reach those intended and that health systems have, in fact weakened. Reforms have, in particular, affected the availability of controversial sexual and reproductive [SRH] services e.g. services for abortion, complications arising out of violence against women], low priority to SRH issues [e.g. infertility, which do not lead to DALYS-Disability Adjusted Life Years- saved] and services for marginalized groups such as adolescents and the elderly.

Some illustrative country findings from these two research sources are:

- In the Yunnan Province of China, where user fees now account for 50 % of maternal and child health [MCH] costs, utilization of SRH services has reduced.
- In Pakistan, the private sector has taken over the provision of family planning, drugs and preventive services. Basic health units and rural health centres are being contracted out and tertiary hospitals have begun to charge user fees.
- In Makasar [Indonesia], the cost of contraceptive pills and injectables increased after implementation of the health sector reforms [pills increased from Rp 1,000 to 2,500]

- The Philippines Government acknowledges that decentralization of health services to local government is a major concern. *"Many local governments do not have adequate institutional preparation to take on the responsibility of health care. They suffer from shortages of technical humanpower for health operations, lack of equipment, inadequate health facilities and inadequate referral systems among other health facilities"*. [Philippines Government Country Report UN ESCAP 2002].
- In countries like India, China and Bangladesh, the out-of-pocket expenditure as percentage of private expenditure on health continues to be abnormally high (above 90% approximately), which further puts pressure on impoverished households.

Strategies: Health Sector Reforms need to be de-mystified, understood, evaluated at all levels and the findings made public. They themselves need to be reformed to be based on principles of human rights [the right to health, women's rights and sexual and reproductive rights] not just on target oriented efficiency principles and economic justifications. Currently, only a few people understand them. Considering the huge impact they have on impoverished populations, the evaluations are few.

Policy Recommendations:

- Policy makers in Governments, UN agencies and multilateral agencies need to ensure that health sector reforms are **urgently evaluated** and later regularly monitored so that they can assess accurately the impact of the reforms on the marginalized and poor sections of our society and on the quality and affordability of health services.
- Governments should remove user fees for priority reproductive health services [like antenatal care, delivery, emergency obstetric care, abortion and family planning] for all women including young people and marginalized groups like migrant women. [The reduction of maternal mortality in Sri Lanka can be largely attributed to accessible and free services]

- In countries where social insurance has been introduced, the policy needs to cover reproductive health services and to be extended to the informal sector, and the poor and marginalised.
- **Health Sector Reform** introduction and review needs better assessment including; existing infrastructure and resources; targets committed during Cairo, Beijing and the MGD's; structured consultations/inputs from service providers, health clients [especially women,] and local communities; optimal utilization of resources available from federal and local budgets.

ISSUE 3: Rights based and gender-sensitive frameworks are not being extensively included in policies and services, [and in some cases where they have, progress has been later reversed] showing that commitment and political will to these paradigm shifts is still not strong along with a lack of technical capacity to implement them.

In the area of reproductive rights, progress has been made in the eight countries of the ICPD study as many new reproductive health policies shift away from a population control goal to comprehensive reproductive health. However, few have adopted a broader human rights and reproductive rights approach. For example, the four new national population policies [China, 2002, India, 2000, Pakistan, 2000 and Indonesia, 2004 still emphasise reducing population growth and encourage small families. Only China now provides contraceptive services for unmarried and young people within the primary health care system, thus recognizing young people's rights to decide on and access contraceptive services. It was found that NGOs were not involved in decision making on these new policies despite the Cairo agreement to do so and the need for their technical assistance on rights and gender approaches.

Also of great concern is the reversal of good reproductive health policy progress in India and the Philippines related to more conservative political parties leading the countries now. India's new population policy and some state population policies have clear demographic goals [unlike the national reproductive health policy]. In the Philippines,

not offering a full range of contraceptives ignores the quality of service delivery goal, as agreed to at Cairo.

On the contrary, natural family planning is being promoted as the preference by the government due to bowing to pressure from the Catholic Church. In some areas of Manila it is the only method available, which violates people's reproductive rights to making informed choices and access services.

There has been progress at the language level however, as all governments except the Philippines used the term reproductive rights in their presentations at the UN ESCAP's Asian and Pacific Population Conference in 2002. It was noted however, that UN ESCAP's Population Division did not include reproductive rights as a required heading for the country reports and thus none of the Governments reported on this. This is despite the ICPD Chapter VII being titled 'Reproductive Rights and Reproductive Health'. UN ESCAP also did not allow content on abortion in papers by experts for the conference nor the display of books which included a focus on reproductive rights. At that time, the US delegation was resisting the inclusion of the term reproductive rights in the conference outcome document.

There is no evidence on the ground that health services have become gender-sensitive, addressing gender equality and women's empowerment issues. In fact from case studies in the Philippines and Pakistan, there is evidence that poor women are further disempowered by the disrespect and lack of care and empathy on the part of health service providers in government services. The quality of NGO services was found to be much more acceptable to women.

The term gender-sensitive is frequently used but often in an unclear way by both policy makers and implementers. For example, the goal of gender equality as the final objective is usually forgotten or not understood and gender-sensitivity is not seen as a strategy towards achieving this but part of a de-politicized gender mainstreaming. ARROW did not find clear operational definitions of gender- sensitivity during the Women's Access study and resorted to constructing a new one.

Strategies: A two pronged strategy that includes greater and faster UN technical assistance to be provided to government [consultancies, training, resource materials, technical meetings] and stronger leadership and clarity on rights based and gender frameworks from UN agencies in active collaboration with civil society organizations, particularly women NGOs.

Policy Recommendations :

- Governments need to strengthen efforts and seek more technical assistance to ensure that a clear rights based agenda and gender equality framework is included in the development of all population, reproductive health, HIV/AIDS and women's empowerment policies and programmes and their implementation, monitoring and evaluation.
- UN agencies need to swiftly fund, develop, provide and promote more models, tools, best practices and clear conceptual and practical rights and gender-sensitive frameworks in collaboration with women NGOs.
- A policy requirement should be made that the Government must include sufficient women activists NGO's in decision-making on new and revised laws, policies and plans and ensure their representation and technical input on commissions and committees on population, reproductive health, women's health, HIV/AIDS etc.
- UN agencies [particularly UNFPA] should strengthen their role and be more active in clarifying, promoting and defending the ICPD human rights and reproductive rights framework in national laws, policies and programmes and in donor funding, beginning with a review of the content of these documents.
- UN agencies in collaboration with women NGOs need to facilitate and provide more national and regional technical meetings, training and general technical assistance beginning with top policy makers.
- National demographic surveys require to use a rights based and unmet needs framework and should thus interview both young and unmarried people and not only married women.

- Providing information and full reproductive health services to young people within the primary health care system should become a high policy objective on reproductive rights.

Issue 4: There is a lack of an effective national and regional system for government planning, monitoring, reporting and accountability on implementation of ICPD and Beijing agreements which also includes genuine participation of diverse NGO's.

For ICPD and the MGD's, national mechanisms for monitoring and evaluation were found to be varied including multi sectoral coordinating bodies, annual surveys and focal points. CEDAW reporting requirements are part of the system internationally as are the UN Commission on Population and Development and the Commission on the Status of Women. [*Investing in People. National Progress in Implementing the ICPD Programme of Action,1994-2004*.UNFPA. 2004]. For a comprehensive review of Beijing and Cairo implementation regionally, the UN ESCAP organised meetings are the main mechanism. Government reports to these bodies however, are not easily available to NGO's or the public either for input, discussion or critique unless they are presented in a UN meeting at which NGO's participate. Government does not yet see itself accountable to reporting also to civil society. The Minister of Women's Development in one of the eight countries firmly rejected the NGO request for an annual report on implementation of the National Action Plan on Women saying publicly in an NGO-GO dialogue, that she is accountable to the Cabinet only. The reports are also not comprehensive enough referring to only limited indicators and usually reporting on current status that does not include not measuring progress against a baseline.

Although the goal of gender equality is accepted in all international and national policies and dialogues, prevailing realities still indicate a poor presence of women in decision-making bodies influencing the planning and evaluation of women's development and women's health. There appears to be continued ad hoc government consultation of women NGO's and youth NGO's on the development of new laws and policies and the implementation and evaluation of current policies. [Details were given in issue 3].

Health NGO's like the Family Planning Associations (FPAs), which have been government partners in service provision for 50 years, are usually the only NGO to be represented on the Population Commissions and Reproductive Health Committees but represent only themselves and not all NGO stakeholders.

Women NGO's are in various states of organisation, some having national networks and forum or councils, although often the more activist NGO's do not belong to the service oriented forums but have their own networks. Participation of diverse women NGO's in monitoring and evaluation is thus complex and requires a deep understanding and conscientious mapping of groups. If this is not done, then women NGO participation becomes mere tokenism and not genuine participation.

The ARROW monitoring studies have found that advocacy oriented NGO's which are more critical and demanding of government, are often not included in consultations, let alone in decision-making processes. A more influential role in decision-making for NGO's was an agreement of the ICPD, however this has not happened nor is this area reported by governments reflecting the low priority of strengthening NGO-GO relationships for both the government and UN ESCAP's Population Division.

There is an acute dearth of documented evidence and appropriate data, especially on sexual and reproductive health and gender based indicators essential for realistic planning and evaluation. The relaxed approach of Governments is reflected in the lack of reliable monitoring data even on vital indicators like maternal mortality. A reason for this could be attributed primarily in South Asia, to State attention being deflected towards armed conflict and militarisation of the region, rather than on core health issues.

Some illustrative findings on data unavailability and reliability at country level from the regional ICPD 10 study were:

- Poverty data was not disaggregated by sex

- Accurate data on maternal mortality is a serious problem with various agencies and the governments coming up with different rates. Only China and Malaysia provided critical data on the provision of emergency obstetric care.
- Unmarried women and young women were not included in any reproductive health data including unmet need for contraception and abortion prevalence. [i.e. data is not disaggregated by age]
- Lack of benchmark data on critical indicators of 1990/94 [prior ICPD and Beijing] for comparison in calculation of achievements.
- Unsafe abortion incidence data was not available, nor was abortion incidence. Also unavailable was data on STD's, RTI's, and reproductive cancers including the actual number of women dying of such cancers.
- Accurate and up to date data on HIV/AIDS prevalence was not available in the eight countries nor the data on the actual number of women infected
- No quality of care data available on family planning services and health services including the abuse and discrimination of women by health service providers
- Affordability data on costs of seeking health services was not available.

Strategies: To effectively implement policies, and enhance NGO and women's influence of policies and the allocation of resources for meeting ICPD, Beijing and MGD agreements, a unified centralised system of monitoring and evaluation of progress that percolates down to the state and village levels and has agreed on indicators, needs to be established with clear NGO roles.

Policy Recommendations

- Create a common regional and national monitoring system of the Beijing, Cairo and MGD objectives with indicators agreed to by all stakeholders- government, NGO's, UN agencies, researchers and parliamentarians.
- Annual monitoring and public reporting of budgets and expenditure by local government bodies and the auditor general's office is required to ensure efficiency in resource use and progress in achievement of Beijing, Cairo and MDG goals.

- Designation of national focal points from within the government (Ministries of Health and Women's Empowerment) who will host regular annual forums in which presentation of government reports and dialogue with civil society on progress achieved, will be an on going agenda.
- Increased resources and technical assistance to the capacity building of politicians and government officials including those in the remotest areas, in order to develop skills and commitment for working effectively as monitors of health services and women's rights.
- Ministries of Health should initiate a coordination mechanism for women's health and reproductive health and rights for information sharing and project coordination, with a senior cabinet minister convening the initiative and including all relevant line ministries.
- Introduce new dynamism by creating Task Forces composed of governmental organizations, parliamentarians, researchers and civil society organization representatives to plan and monitor specific components in the National Plan on Women and the Reproductive Health and Rights Plan.
- A national system for implementation of ICPD and Beijing agreements needs to include information and education dissemination up to the end user level and establishment of an effective feedback loop involving the NGOs.

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