

Keynote Address by

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on

**PROMOTING FINANCIAL AND HUMAN RESOURCES FOR
FAMILY PLANNING AND MATERNAL HEALTH**

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Your Excellencies,
Distinguished Guests,
Participants,
Ladies and Gentlemen

Introduction

This morning, the keynote address focused on MDG5-related progress, challenges and opportunities. Building on those deliberations, I would like to highlight the role of finance and human resources to achieve the MDG5-targets across the developing world. Although my address today will focus on the health system as a key pillar for progress, I would also like to stress that health system strengthening is not an end in itself but a means to achieve better health, linked to the social determinants (gender equality, culture, human rights) and reinforced by the critical role of other sectors such as education, infrastructure, agriculture, water and sanitation, etc.

Let me begin by emphasizing what we know but maybe do not always act upon: *The health MDGs are interlinked and mutually reinforcing*. A coordinated, and where possible integrated approach to health care is therefore more effective and efficient than addressing family planning, HIV, malaria, malnutrition, maternal and child health separately. At the service delivery level, it is clear that people's health needs are best served through the provision of an integrated package of essential health services - a one stop shop so to speak that responds to the individual's needs.

Guaranteeing universal and sustainable access to essential health services requires strong national capacity. More specifically, it requires robust health systems that are fair, accountable and adequately resourced. Governments, civil society organizations and development partners are scaling-up efforts to strengthen health systems in developing countries. UNFPA's mission is to support and strengthen national efforts aimed at making reproductive health services¹ universally and comprehensively available as part of an essential package of health services across the life cycle and the different levels of care. For UNFPA, engagement in health systems strengthening means better positioning reproductive health across all aspects of the 6 health system building blocks - Governance, Financing, Human Resources, Medical Supplies, Service Delivery and Health Information Systems. In fact, UNFPA believes that the ability to meet reproductive health needs is a signal indicator of the overall coverage, accessibility and quality of services in the health system.

So with those few introductory remarks let me focus on 2 critical Building Blocks, that is, Health Financing and Human Resources for Health in the context of Reproductive Health.

¹ i.e.; family planning services; pregnancy-related services, including skilled attendance at delivery, emergency obstetric care and post-abortion care; STI and HIV prevention and diagnosis and treatment of STIs; prevention and early diagnosis of breast and cervical cancers; prevention of gender-based violence and care of survivors; and reproductive health commodity security for each of these services.

Health Financing

Beginning with Health Financing, it is important to stress, particularly for Ministries of Finance, that funding for health is an investment, not a cost. Current investment levels in health, and in particular reproductive health, are in many countries neither sufficient nor equitable. What is needed is more money for health and more health for the money.

Late last year, UNFPA and the Guttmacher Institute launched a publication under the title: *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*. It estimated that in developing countries, a total of \$13 billion is currently spent on family planning and maternal and newborn health services. By doubling this investment, one would reduce deaths of women and newborns by almost 2 million a year. Considering that pregnancy-related death among women and newborns in developing countries results in an estimated \$15 billion loss in productivity each year, these investments pay for themselves. Likewise, investing in family planning is not only an investment in Human Rights, it is also smart economics as every dollar invested reduces the costs of pregnancy related care by \$1.50. If we truly want to ensure that every pregnancy is wanted, every birth is safe and every young person is free of HIV/AIDS these additional annual investments must be made!

Advocacy efforts aimed at securing additional resources would benefit from stronger coordination among stakeholders and a common set of evidence based data at country and at global levels. This is one of the reasons why UNFPA is leading an Inter-Agency Working Group on Costing (i.e.: a consortium of UN agencies, donors and other partners) to develop a unified costing and budgeting model for strategic planning at the country level.

Investments in health need to be further scaled up while at the same time more effective use of resources is required to maximize the impact of all investments in health. For many countries it is a challenge to raise sufficient funds to finance universal coverage. Tax bases are low and demands are great, resulting in insufficient fiscal space to fund the health sector. As a result people in developing countries often pay providers out of their own pockets for health care services. Such Out-of-Pocket-Payments to public and private providers account for 53% of total health expenditure in low income countries and in the context of Reproductive Health, they constitute the greatest source of financial resources. Such expenditures keep or force an estimated 150 million individuals into poverty each year. Many others refrain from seeking the needed health care all together- creating a vicious cycle of poverty and ill-health. As a result, health inequities are pervasive in many countries with the poor having limited access to health care and their health status consistently worse than those of their wealthier compatriots.

One way to address this imbalance has been the recent World Health Assembly resolution that urged member states to tackle health inequities and to offer social health protection to all. In this respect, countries such as Rwanda, Colombia, China, Mongolia, the Philippines, Sri Lanka and Thailand have achieved remarkable success in this area. After introducing a universal coverage law in 2002, Thailand for example was able to expand social health

protection from 70% of its population to 100% in only a few years. In Indonesia, the Health Insurance for the Poor (ASKESKIN) Programme exempts the poorest families from paying routine and emergency care. Other approaches include addressing the demand side through incentives such as vouchers which target families living below the poverty line as in Gujarat, India which provides free treatment during delivery and covers the mother's out-of-pocket travel costs to reach the health care facility, and offers financial support to cover loss of wages for the person who accompanies her².

Re-allocating funding for health in a more equitable way is one strategy to get more health for the money, but there are additional issues that must be tackled. Health systems are struggling to overcome challenges related to bureaucracy, fragmentation, transparency and accountability. Many of these can be categorized as governance issues while others relate more directly to donor practices, particularly in relation to predictability of resources and uncoordinated financing which prevents a comprehensive approach. In light of the Paris Declaration on Aid Effectiveness, good governance, alignment and harmonization of donor support are high on the political agenda. As partner countries and development partners embrace a more holistic approach to advancing health, there is an urgent need to strengthen mutual accountability and the management for results.

ODA for Health is critical for many countries and will remain so for the foreseeable future. This is widely recognized and since 1995, funding for health has more than doubled from about US\$8 billion to nearly US\$19 billion in 2006. Unfortunately, donor support for reproductive health (excluding HIV/AIDS) has in fact declined, especially for family planning. This has had a significant impact, not only because Reproductive Health services have been very dependent on donor resources in many countries but also because the demand for reproductive health services has grown over the years due to an increasing number of births, an increasing number of women of reproductive age, and an increasing desire to space births.

However, global concern that MDG5 has been lagging behind has galvanized action to scale-up efforts to improve reproductive and maternal health outcomes. This momentum has resulted in a partnership between UNFPA, UNAIDS, UNICEF, WHO and the World Bank (H4+) who have come together to harmonize efforts and to accelerate progress for the health of women, newborns and children in 25 high priority countries. More recently, complementary global initiatives were launched including the UN Secretary General's Global Strategy for Women's and Children's Health and the G8's Muskoka Initiative on Maternal, Newborn and Under-five Child Health. Both these recent initiatives have mobilized almost \$50 billion³ in commitments for the coming 5 years, and accountability mechanisms are being enhanced to track progress. UNFPA is an active partner in these initiatives, promoting a comprehensive and harmonized approach to reproductive health, including Family Planning.

² Investing in Maternal, Newborn and Child Health, the Case for Asia and the Pacific, Maternal, Newborn and Child Health Network for Asia and the Pacific, 2010.

³ \$5 billion through Muskoka, and \$45 billion through Global Strategy.

Pre-ICPD, family Planning was generally considered to be a tool to limit population growth and not as a matter of human rights in general and the right of individuals and couples to decide freely and responsibly on the number and spacing of their children. Tension between these two streams of thinking is re-emerging as part of the debate on climate change. We must continue to keep the family-planning debate anchored in a human rights approach. Some may claim that this is a false argument. It is not. Those concerned by rising population numbers as a precursor for further global climate change forget that environmental change depends not just of the number of people, but on their consumption and the energy needed to fuel it. The populations that are growing most quickly are those that consume the least, and therefore emit the least. The answer to global climate change must not begin and end with population size but with changing the model of production and consumption to reduce per capita carbon footprints.

Human Resources for Health

Let me now move to human resources for health which is also strategically linked to financing and an integral part of the health care system. Desirable reproductive health outcomes require the mobilization of health workers across the continuum of care to deliver quality reproductive health services as part of an essential package where and when required. Reproductive Health is dependent on having the right skills-mix available on demand (24 hours) at different levels of the health system that can facilitate normal deliveries; perform emergency obstetric care; and provide access to family planning services, etc. The health personnel required to deliver these services range from community outreach workers at one end of the spectrum to obstetricians, midwives, physicians and nurses at the other end. Many countries face serious shortages of health personnel and an estimated 2.4 million additional doctors, nurses and midwives are needed worldwide. In our globalizing and urbanizing world, developing countries are often struggling to finance the production of sufficient numbers of new cadre, ensure their appropriate distribution across the country and retain staff at country level given the global market for qualified medical professionals. At present, an estimated one-third of pregnant women in developing countries do not have contact with health personnel prior to giving birth while in the Asia and Pacific Region 61 per cent of women deliver their babies alone or with an unskilled attendant, without access to referral systems for emergency obstetric care⁴. This dramatically impacts health outcomes as there is a direct relationship between the ratio of health workers to population and survival of women around childbirth and children in early infancy.⁵

Over the past decades, considerable progress has been made in many countries to promote skilled attendance at birth. Egypt, Sri Lanka and Malaysia illustrate this progress having successfully reduced maternal mortality by substantially scaling-up the proportion of women

⁴ A Profile of Human Resources for Health in Maternal, Neonatal, and Reproductive Health in Community-settings in 10 countries in Asia and the Pacific Regions, Human Resources for Health Knowledge Hub, UNSW and Burnett Institute Medical Research Practical Action, 2010.

⁵ The global shortage of health workers and its impact, Fact Sheet Number 32, April 2006, WHO.

delivering in a health facility assisted by a skilled birth attendant (trained midwives, nurse midwives or doctors).⁶ Likewise, Indonesia has introduced a village midwife programme aimed at reducing maternal mortality by increasing the proportion of deliveries managed by trained professionals, particularly among poorer rural populations⁷.

An area that is gaining increasing momentum is task-shifting, that is, where identified tasks are moved to health workers with shorter training and fewer qualifications or it may also involve the creation of new cadres with clearly defined tasks to further expand the capacity of the health workforce to deliver services⁸. Programmes in both Honduras and Guatemala have demonstrated that it is possible to train nurse auxiliaries to provide quality Intrauterine Devices (IUDs) services⁹. Task-shifting involving community health workers can play an important role in strengthening access to and coverage of basic health services with the appropriate training and continuous support¹⁰. In the case of Ethiopia, more than 30,000 health extension workers have been deployed since 2007, a near doubling of the Ethiopian health workforce in only three years. The Health Extension Worker is trained for one year and then sent to a rural village, spending 75% of their time in the community and 25% at a health post, providing health care services such as maternal and child health, family planning, vaccination services, nutrition and adolescent reproductive health. However, task-shifting is not a solution in itself but rather it needs to be embedded in a range of other strategies to address the human resources challenge. Other short-term measures include more efficient use of the existing human resource base; financial and non-financial incentives; and the geographical distribution of the workforce.

It is clear that the human resources challenge must be addressed if progress is to be made on Reproductive Health specifically and on health outcomes more generally. Countries have to be ambitious and innovative in their delivery while at the same time the approaches put forward need to be appropriate to the actual context, the established health system and the mix of providers in a country. It is also important to recognise that no single solution can respond to the many different human resource issues, and that it also requires a multifaceted approach beyond the Health Sector, involving key Ministries such as Finance; Civil Service; Education and sub-sectoral authorities where appropriate. Critical stakeholders such as civil society organisations and the private sector (both for-profit and not-for-profit) are important partners in the process while the international community can play a key role in providing predictable, long-term recurrent financing and technical expertise in supporting country processes.

⁶ Investing in maternal health, learning from Malaysia and Sri Lanka. HDN, HNP Series, 2003, World Bank

⁷ Did the strategy of skilled attendance at birth reach the poor in Indonesia, Bulletin of WHO, Oct 2007, 85 (10)

⁸ Task shifting: rational redistribution of tasks among health workforce teams

⁹ Vernon, R. Nurse auxiliaries as providers of intrauterine devices for contraception in Guatemala and Honduras. Reproductive Health Matters 2009;17(33):51-60.,

¹⁰ U. Lehmann, D. Sanders. Community Health Workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. Evidence and Information for Policy, Department of Human Resources for Health, January 2007. WHO.

Strong political leadership and a sustained commitment will be critical over the longer term. This includes an endorsed comprehensive health workforce policy and plan that addresses training, recruitment, deployment, retention, equitable distribution, efficiency gains, motivation and a balanced skill-mix with both a short-term perspective and a longer-term vision¹¹. Important within this is strengthening the role and involvement of nurses and midwives. UNFPA has long given priority to increasing access to skilled care at birth as part of its strategy to reduce maternal mortality and ensure universal access to reproductive health. Within this area, midwives hold a very special and central position. Therefore, UNFPA has, in partnership with the International Confederation of Midwives and Government Partners, provided support for activities related to the education, regulation and association of midwives and other level providers.

Finally, I would like to conclude with the following:

- 1) To achieve better and more sustainable reproductive health outcomes, including family planning, we need to strengthen national processes and build on the current momentum around women's and children's health. This requires harmonizing and aligning behind country health plans and strategies while strengthening the management for results and mutual accountability at all levels.
- 2) We need to ensure that resources (financial, human, material) are scaled up for Reproductive Health and Health more generally while at the same time demonstrating more effective and efficient use of such resources.
- 3) We need to embrace an integrated approach to advancing health in general and reproductive health in particular.
- 4) We need to more concretely address the crucial role of gender equality, equity and equitable access to health services for the poor and marginalized (e.g., women, young people, ethnic minorities) in accessing health services, including Reproductive Health. This includes developing, strengthening and scaling-up efforts in support of social protection mechanisms, putting in place safety nets and strategies that protect a minimum level of access to essential services and income security for all.
- 5) We need to elevate the critical role that south-south collaboration and peer country learning can play in strengthening national efforts to advance reproductive health.
- 6) We need to strengthen the engagement of public private partnerships, looking at opportunities through innovation, technologies (e.g., mHealth) and the potential to further expand the resource-base (financial, human, material).

Thank you for your attention.

¹¹ Health Workers for All and All for Health Workers. The Kampala Declaration and Agenda for Global Action. First Global Forum on Human Resources for Health, March 2008.