

GENDER RESPONSIVE BUDGETING AND WOMEN'S REPRODUCTIVE RIGHTS: A RESOURCE PACK





UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.

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UNIFEM is the women's fund at the United Nations. It provides financial and technical assistance to innovative programmes and strategies that promote women's human rights, political participation and economic security. UNIFEM works in partnership with UN organisations, governments and nongovernmental organisations (NGOs) and networks to promote gender equality. It links women's issues and concerns to national, regional and global agendas by fostering collaboration and providing technical expertise on gender mainstreaming and women's empowerment strategies.

UNIFEM has supported initiatives on gender responsive budgeting in over 20 countries. This support facilitated a growing momentum among governments, civil society and parliamentarians to engage in budget policy-making at national and local levels from a gender perspective.

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We are very pleased to introduce the UNFPA/UNIFEM resource pack, “Gender Responsive Budgeting and Women’s Reproductive Rights,” and the training manual, “Gender Responsive Budgeting in Practice.” We feel certain that these two publications will add value to the available wealth of training resources and help you to build expert teams to meet the growing demand at country level. The goal is to encourage a gender perspective in the national planning and budgeting processes.

Gender responsive budgeting helps to track the way that budgets respond to women’s priorities and the way that governments use funds to reduce poverty, promote gender equality, reverse the spread of HIV and lower the rates of maternal and child mortality. It helps ensure government accountability to the commitments made to women in the Cairo Programme of Action on Population and Development and the Beijing Platform for Action for Gender Equality and Women’s Empowerment and to achieving the Millennium Development Goals.

Today, more than ten years after the Cairo Programme of Action and the Beijing Platform for Action, we can see significant progress in the areas of women’s empowerment, gender equality and women’s reproductive rights and health. Yet much more remains to be done. We trust that, in your hands, you shall find the tools to help take us further along the road towards even greater progress.



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Debbie Budlender, Gender Budget Expert and Specialist Researcher at the Community Agency for Social Enquiry (CASE), November 2006.

ARV	Anti-retroviral
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSCQBE	Civil Society Coalition for Quality Basic Education
CST	Country Support Team
CSVR	Centre for the Study of Violence and Reconciliation
CTST	Country Technical Services Team
DFID	Department for International Development
DHS	Demographic and health survey
DVA	Domestic Violence Act
EmOC	Emergency obstetric care
FOWODE	Forum for Women in Democracy
GAP	Gender Advocacy Program
GBV	Gender-based violence
GDP	Gross domestic product
GFATM	Global Fund for HIV/AIDS, TB and Malaria
GR	General recommendation
GRB	Gender-responsive budget(ing)
HBC	Home-based care
HIPC	Highly Indebted Poor Country
HSR	Health sector reform
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population Development
IDRC	International Development Research Centre
IEC	Information, education and communication
IFI	International financial institution
IMF	International Monetary Fund

ACRONYMS

IPPF	International Planned Parenthood Federation
MAP	Multi-Country HIV/AIDS Program for Africa
MCH	Maternal and child health
MDG	Millennium Development Goal
MKSS	Mazdoor Kisan Shakti Sangathan
MTCT	Mother-to-child transmission
MTEF	Medium-term expenditure framework
MYFF	Multi-year Funding Framework
NAC	National HIV/AIDS Council
NGO	Non-governmental organisation
PAF	Poverty Action Fund
PAFMC	Poverty Action Fund Monitoring Committee
PHC	Primary health care
PoA	Program of Action
PRSP	Poverty reduction strategy paper
RH	Reproductive health
SNA	System of National Accounts
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UDN	Uganda Debt Network
UN	United Nations
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
USA	United States of America
VAT	Value-added tax
VAW	Violence against women
WBI	Women's Budget Initiative
WDM	World Development Movement
WHO	World Health Organisation

BACKGROUND

The Budgeting for Reproductive Rights resource pack was produced under a UNFPA/UNIFEM Strategic Partnership aimed at developing a Coordinated Approach for Effective Technical Assistance to Gender Responsive Budgeting (GRB). This partnership is intended to build the capacity of UNFPA's country support teams (CSTs) to provide support in using the GRB approach to in-country partners. The partnership draws largely on UNIFEM's experience in supporting GRB initiatives in over twenty countries since 2000.

Gender Responsive Budgeting encompasses a broad range of possible activities. The types of activities for which country partners request support are also very diverse. Thus, it is not possible to provide simple recipes for either the country partners or for UNFPA CSTs. The purpose of this resource pack is to provide relevant knowledge that may facilitate mainstreaming gender-responsive approaches into reproductive health on one hand and the inclusion of specific aspects of gender inequality and disadvantage into national policy frameworks, on the other hand.

Overall, the UNFPA/UNIFEM initiative aims to:

- expose CSTs to the range of GRB tools and activities available and how these relate to different development situations;
- provide CSTs with basic materials (in the form of this resource pack) on different aspects of relevance to GRB as well as references to further reading on each aspect;
- provide a smaller group of CST members with practical experience in a workshop setting on how to respond to the different requests of countries.

Two pilot workshops were conducted in early 2006 to validate the content of the resource pack and develop the training manual on GRB. These workshops were intended to assist participants in using the resource pack, gaining the skills to use GRB in different circumstances and supporting others in applying GRB tools.

PURPOSE AND FORMAT OF THE RESOURCE PACK

The resource pack takes the form of brief “sheets” on a range of issues. The sheets are relatively independent of each other, but are organised into different sub-topics (as outlined in the Structure section on page 10). A user does not need to read through all the sheets at one sitting, but rather can use them as needed.

Each topic contains references to further reading. In some cases, these are the main source for what is written in the resource pack; in other cases, they refer to related writing. The sheets also describe a range of experiences of using GRB in different countries to illustrate different aspects and tools. These examples include some in which gender was not incorporated, despite opportunities to do so.

The resource pack builds on, rather than repeats, the existing general materials on GRB. In particular, it should be seen as a complement to the BRIDGE resource pack and to the Commonwealth Secretariat's publication, *Engendering Budgets: A practitioner's guide to understanding and implementing gender-responsive budgets* (D. Budlender and G. Hewitt, 2003).

Unlike these general materials, the UNFPA/UNIFEM resource pack focuses on issues which are most likely to be part of country requests to UNFPA CSTs. It focuses primarily on health, particularly reproductive health; on HIV/AIDS; and on violence against women as it relates to health services. These foci were suggested in an E-discussion facilitated by UNIFEM when the project commenced, and are informed by UNFPA's most recent Multi-year Funding Framework (MYFF). The materials in the Pack are intended for use in developing countries and look at how GRB can be used to direct attention to those who are most in need and those who are disadvantaged by their gender, economic status, location and/or other characteristics.

STRUCTURE OF THE RESOURCE PACK

The resource pack is organised into nine sections.

- “What is GRB?” provides a brief discussion of what GRB is and what it can and cannot achieve. It discusses, in particular, how GRB can assist in mainstreaming gender and in dealing with general issues of disadvantage and poverty. It explains how the GRB approach could assist in addressing key concerns of UNFPA's MYFF.
- “Some key linkages” explores how the GRB approach can be used in rights-related work. It also draws links between reproductive health and a range of other issues of concern to UNFPA, including sexual and reproductive health and rights, gender-based violence, HIV/AIDS and poverty. In addition, it discusses the links between reproductive health and more general health-related issues such as primary health care and health sector reforms which are happening in many of the developing countries where UNFPA operates.
- “Economic considerations” discusses the economic arguments that can be used to address UNFPA's concerns and allocate adequate budgets to address such concerns effectively. It also sheds light upon the concept of unpaid work. This issue is usually overlooked in traditional economic and budget discussions but needs to be addressed in order to generate gender-equitable outcomes.
- “Using the budget angle to advance other work” illustrates a key theme of these materials, namely that the GRB approach can be used to good effect in different programs, campaigns and activities. Possible arenas for using the GRB approach include the poverty reduction strategy papers (PRSPs), the Millennium Development Goals (MDGs), and work on particular issues such as maternal mortality and gender-based violence. The last part of the section describes how GRB work can foster increased public participation in policy making.
- “What do budgets look like?” introduces different ways of presenting and formulating budgets and discusses the challenges and opportunities provided by different budget formats. In fact, the format and presentation of budget documents differ significantly between countries and can be intimidating.

- “Frameworks and tools” presents the most well-known analytical approaches to GRB work including illustrations of the various ways in which they have been used in relation to reproductive health or other issues of interest to UNFPA. The section emphasizes the need to use existing frameworks as a starting point and generator of ideas rather than as a blueprint.
- “Actors, activities and focus” firstly discusses the different actors who could be involved in GRB-related activities then it presents some of the options in terms of the focus of budget work. While other sections talk about focus in terms of the issue, this section discusses focus in terms of scope (sectors, level of government, etc) as well as in terms of activities (research, advocacy, etc). Finally, the section points to the typical stages of the budget cycle and suggests possible interventions for different stages.
- “The Revenue side” discusses some of the possibilities on the revenue side of the budget although most of the GRB work in developing countries has focused on the expenditure side of the budget. The section includes a brief presentation of the major donor initiatives on HIV/AIDS.
- “Statistics in GRB work” suggests creative ways of both working with what is available and encouraging the enhancement of statistics over time. A common complaint among those who undertake GRB work is the inadequacy of sex-disaggregated data and gender-relevant statistics more generally.

WHAT IS GENDER RESPONSIVE BUDGETING?

This section provides a brief discussion of what GRB is, what it can and cannot achieve. In particular, it explains how GRB can assist in gender mainstreaming as well as in dealing with issues of disadvantage and poverty. It discusses how the GRB approach could assist in addressing key concerns of UNFPA's MYFF. Later sections elaborate on many of the points raised briefly here.

DEFINING GRB

Analyzing the impact of government expenditure and revenue on women and girls, as compared to men and boys, is fast becoming a global movement to build accountability for national policy commitments to women.

Source: UNIFEM 2001 Annual Report: 17

Through development and application of various tools and techniques, women's budgets can make a number of crucial contributions. These include efforts to:

- recognize, reclaim and revalue the contributions and leadership that women make in the market economy, and in the reproductive or domestic (invisible and undervalued) spheres of the care economy, the latter absorbing the impact of macroeconomic choices leading to cuts in health, welfare and education expenditures;
- promote women's leadership in the public and productive spheres of politics, economy, and society, in parliament, business, media, culture, religious institutions, trade unions and civil society institutions;
- engage in a process of transformation to take into account the needs of the poorest and the powerless; and
- build advocacy capacity among women's organizations on macroeconomic issues.

Source: Blackden, C.M. & Bhanu, C. 1999. Gender, Growth and Poverty Reduction. World Bank Technical Paper 428: 64–65.

Gender-responsive budget (GRB) work is about ensuring that government budgets and the policies and programs that underlie them address the needs and interests of individuals that belong to different social groups. Thus GRB work looks at biases that can arise because a person is male or female, but at the same time considers disadvantage suffered as a result of ethnicity, caste, class or poverty status, location and age.

We focus on the budget because it is the most important policy tool of government. This is so because without money the government cannot implement any other policy successfully. Thus a government can have a very good policy on reproductive health, gender-based violence (GBV), or HIV/AIDS, but if it does not allocate the necessary money to implement it, the policy is not worth any more than the paper it is written on.

Many terms are used for GRB work. Some people refer to “gender budgets,” some to “women's budgets,” some to “gender-sensitive or responsive budgets.” For the most part, these terms all refer to the same thing—efforts to ensure that government budgets promote gender equality and equity.

Some terms can, however, be misleading. The term “women’s budget,” for example, can make people think that GRB is about separate budgets for women or men. This can easily happen even when names using the term “gender” are included. GRB is not about separate budgets for women or men, girls or boys. Neither is it about seeing how much money is allocated for women and girls or for gender projects. It is not about seeing how many women and men are employed in government and at what levels and salaries, nor is it concerned with how many women-owned businesses get procurement contracts from government. Instead, GRB is about mainstreaming – ensuring that ultimately there is gender awareness in all the policies and budgets of all government agencies (although, for practical and strategic reasons, the focus will initially be on selected agencies). This is in line with the UNFPA multi-year funding framework (MYFF) focus on mainstreaming gender equality and equity, as well as HIV/AIDS prevention in all UNFPA activities.

The fact that GRB is intended to promote mainstreaming means that usually Ministries of Finance must play a lead role. Gender equality machineries should play a support role. Other line ministries have responsibilities in relation to their own planning and budgeting processes. The Ministry of Finance is especially necessary if the initiative is attempted across a number of different line ministries. However, smaller initiatives which focus on only one sector can sometimes advance without initial involvement of the Ministry of Finance.

GRB is not about 50% male: 50% female, because 50: 50 is “equal” but is sometimes not equitable. GRB is about determining where the needs of men and women are the same and where they differ. Where needs are different, allocations should be different. Health is an area in which male and female needs often differ. Both males and females suffer from influenza, malaria, and tuberculosis, although the economic and social implications of these diseases may differ according to gender. In addition, women tend to have greater reproductive health needs than men. Women also tend to use health services more often than men—both for themselves, and in their roles as carers for other members of the household. This means that 50:50 in terms of health funds reaching men and women probably implies a bias against women. The role of women as carers also means that we need to think beyond the direct beneficiaries to the impact on the other people with whom they live and interact.

GRB work involves looking at the impact of government budgets on different social groups. GRB work is thus not only about looking at male and female, but also about looking at the different needs of young and old, rural and urban, rich and poor etc. In addition, it is looking at how these different characteristics intersect and interact with each other. Crudely stated, GRB work is mainly concerned with how budgets affect those who are most disadvantaged, who are simultaneously female, poor, rural, etc.

This understanding means that in GRB work we do not simply advocate for something because it is “good for women.” Sometimes something that at first sight appears “good for women” is only good for a small group of relatively privileged women. For example, lifting of import tax on sanitary napkins in a poor country is not a great achievement in terms of equity, as most poor women will be unlikely to spend even a few dollars or shillings on a sanitary napkin given all their other more urgent needs.

GRB must consider the ability of individuals to satisfy their needs themselves. No government has sufficient resources to satisfy all the needs of all people living in a country. Thus, the government must focus on (“prioritise”) those who are least able to satisfy their own needs.

BOX 1: ADVOCATING FOR AFRO-DESCENDANT WOMEN IN PORTO ALEGRE BRAZIL

Associação Cultural de Mulheres Negras (ACMUN) is an organisation of women of African descent in Porto Alegre in Brazil. The organisation has put a lot of energy into mobilising around improved and non-discriminatory access to health services. As part of these activities, ACMUN conducted a survey to find out more about the links between access to health services, HIV/AIDS and violence against women.

The survey confirmed that Afro-descendant women had poor access to health services. There were two health systems available to people living in the community. The better service was very expensive, and thus unaffordable for most of the Afro-descendant women. Many health professionals also lacked sensitivity and respect in their treatment of Afro-descendant women. More generally, the professionals often tended to humiliate poor people. Finally, despite previous attempts to educate the health professionals about SRH, including HIV/AIDS, gender equality and women's rights, they were not sufficiently sensitive to the needs of black women.

After completing the survey, ACMUN formed a health network which brings together women's groups, groups of HIV-positive people, and others. The network plans to use the survey results and recommendations in advocating for better local and national policies on health services, HIV/AIDS prevention and violence against women.

Reference: UNIFEM. 2005. 2005 Progress Report on Enhancing Human Security Through Gender Equality in the Context of HIV/AIDS. UNIFEM.

GRB work can involve a range of different activities, including research, advocacy, monitoring, training, awareness-raising, policy analysis and policy design. A range of different actors such as government, the legislature, civil society, academia, donors and the international financial institutions (IFIs) may also be involved. The nature of the activities is to some extent determined by the nature of the actors.

GRB has a lot of potential and can be used in many different ways. The quotes at the beginning of this sheet illustrate some of the expectations that UNIFEM and the World Bank have of GRB. While it is good to see the potential, one should also not expect too much of GRB. A paper by the UN Research Institute for Social Development (UNRISD) (Budlender, 2006) discusses some of the many expectations as well as limitations of GRB. Whether GRB succeeds or not depends on the actors, their goals, their understanding, and the activities they undertake. Most importantly, it depends on the political and social context of the country in which the GRB happens.

Over-ambitious claims about GRB are likely to result in disappointment. GRB should be seen as an approach to be used at multiple stages in the policy making process, by different players in different ways to advance different causes. It should be seen as part of the wider effort towards gender mainstreaming. This resource pack also focuses on how GRB can be used to advance sexual and reproductive health and rights and other areas of interest of UNFPA. GRB alone will not bring about significant changes. However, if combined with other initiatives, it can contribute to change.

Reference: Budlender, Debbie. "Expectations versus Realities in Gender-responsive Budget Initiatives." UNRISD. [http://www.unrisd.org/80256B3C005BB128/\(httpProjectsForResearchHome-en\)/E177294B96D2F07CC1256CC300399CB8?OpenDocument&panel=unpublished](http://www.unrisd.org/80256B3C005BB128/(httpProjectsForResearchHome-en)/E177294B96D2F07CC1256CC300399CB8?OpenDocument&panel=unpublished)

GRB AND UNFPA

UNFPA's current multi-year funding framework (MYFF) covers the period 2004–2007. The MYFF is the organisation's medium-term strategic plan. Several elements of the MYFF suggest strongly that GRB could play a useful role.

In terms of focus, the MYFF is clear from the start that the overall aim is to contribute to the implementation of the Program of Action (PoA) of the International Conference on Population Development (ICPD) within the context of poverty reduction. It is also clear that the overall direction of the organisation must build on what is happening in country programs and be relevant in “diverse programming contexts and in a changing external environment.”

Thus, the MYFF focuses on “results” rather than on “deliverables.” This approach is in line with the performance budgeting approach discussed elsewhere in this pack. The MYFF results are framed in terms of three goals (one each for reproductive health, population and development, and gender equality and women's empowerment) and six outcomes.

The MYFF notes that “priority issues” such as HIV/AIDS prevention, adolescent reproductive health, and gender equity and equality, have been “mainstreamed throughout the framework.” These areas have been used to guide the focus of this pack. The MYFF also notes that preliminary findings from 151 countries suggest that HIV/AIDS, adolescents' reproductive health, gender equality and women's empowerment are top ICPD priorities. With respect to population and development, population ageing, poverty, migration and data quality are regarded as key. This pack refers to all of these issues.

The MYFF emphasises the need to build a strong evidence base of models, replicable experiences, good practices and lessons learned, as well as to build the technical knowledge and expertise of staff. The UNFPA/UNIFEM Strategic Partnership Program for a Coordinated Approach for Effective Technical Assistance to Gender-Responsive Budgeting, under which this resource pack is being produced, will contribute to this.

The paragraphs dealing with advocacy and policy dialogue note the need to strengthen the capacity of country-level stakeholders to advocate for ICPD goals within a rights-based approach to development. Here again there is emphasis on the need for a strong evidence base (i.e. facts and figures) if advocacy is to be effective. The emphasis on policy dialogue reflects UNFPA's interest in engaging in country-led development frameworks such as sector-wide approaches (SWAs), PRSPs and health sector reforms.

One of the MYFF's proposed indicators relates directly to budgets, in that the document proposes that national commitment to reproductive commodity security be measured by the proportion of the health budget allocated to contraceptives. Another indicator relates to the existence of national and sub-national mechanisms that advance civil society participation in planning and monitoring quality reproductive health services. This indicator can be given a budget angle if it includes civil society participation in the budget process.

Reference: United Nations Population Fund. 2004. The Multi-Year Funding Framework, 2004–2007, Report of the Executive Director. DP/FPA/2004/4. Paper presented at UNFPA's Executive Board First Regular Session, January 23–30, 2004, in New York, New York.

SOME KEY LINKAGES

The first part of this section discusses how the GRB approach can be used in rights-related work and in promoting gender equality and equity. The second portion looks at links between reproductive health and a range of other issues of concern to UNFPA, including sexual and reproductive health and rights, gender-based violence, HIV/AIDS and poverty. It also discusses the links between reproductive health and more general health-related issues such as primary health care and the health sector reforms which are happening in many of the developing countries in which UNFPA operates. The reforms are especially important from a budget viewpoint as they influence both the revenue and expenditure sides of the budget.

BUDGET WORK AND GENDER EQUALITY AND EQUITY

A budget is the most comprehensive statement of a government's social and economic plans and priorities. In tracking where the money comes from and where it goes, we can see who benefits from public resources, and how. Although budgets are usually perceived as gender-neutral, as a set of numbers that impartially affect women and men, closer inspection reveals that this is often not the case. Generally, budgets are gender-blind rather than gender-neutral.

GRB analysis looks beyond the balance sheets to probe whether men and women fare differently under existing revenue and expenditure patterns. This process does not involve creating separate budgets for women, or aim solely to boost spending on women's programs. Instead, it helps governments understand how they may need to adjust their priorities and reallocate resources to live up to their commitments to achieving gender equality and advancing women's human rights—including those stipulated in CEDAW, the Beijing Platform for Action and the MDGs. Engendered budgets can be critical to transforming rhetoric about women's empowerment into concrete reality.

Assessing budgets through a gender lens requires thinking about government finances in a new way. It calls for including equity in budget performance indicators, and examining the impact of budget policies on gender equality outcomes. It also focuses on the relation between government spending and women's time spent in unpaid care work such as water and fuel collection, caring for the sick, childcare and many others. Conducting a gender-responsive budget analysis can be seen as a step not only towards accountability to women's human rights, but also towards greater public transparency and economic efficiency. With compelling evidence that gender inequality extracts enormous economic and human development costs, shifting fiscal policy to close the gaps yields gains across societies.

BOX 2: HIGHLIGHTS OF UNIFEM'S WORK IN GRB

Working in close partnership with women's organisations and scholars, UNIFEM has helped pioneer cutting-edge work on GRB that is being picked up by both local and national governments. Advocacy and training for government officials, parliamentarians and women's groups, the development of budget analysis tools and wide sharing of knowledge on what works have helped the concept catch on, resulting in changes in a number of countries.

In Ecuador: After initial training sessions for local officials and women's organisations, GRB work has taken off in a number of municipalities. In Cuenca, local authorities issued a decree that makes it a priority to hire women for infrastructure projects. The city's budget for the past three years has included specific funds to foster women's equality, as spelled out in an Equal Opportunity Plan. Significant resources have been allocated to back a law entitling pregnant women and newborn babies to free medical care, and the government has joined local women's groups on programs to curb violence against women. Another municipality, Esmeraldas, has set up a fund for local women's micro-enterprises and created an Equity Council to advise on and monitor municipal gender policies. Salitre has allocated more resources to women's organisations. Quito has established a Secretariat for Gender and Social Equity.

In Bolivia: After an advocacy campaign coordinated by the Instituto de Formacion Femenina Integral of Cochabamba with the support of UNIFEM, the Ministry of Finance included in the Guidelines for the Elaboration of the Annual Operational Plans of Municipalities an obligation to allocate resources for programs and projects aimed at achieving gender equity. The guidelines also stated that municipalities must specify who is responsible for the different gender equity activities.

In India: Several years of sustained advocacy and partnerships between the Department of Women and Children, UNIFEM and women's organisations have encouraged the national government to affirm the importance of gender budgeting. This was initially done through the inclusion of a gender budget statement in the 2003 Union Budget and through official studies of the issue. In 2005, the Finance Minister committed to moving forward on implementation. Twenty-one national ministries have now set up gender-budgeting cells. For the fiscal year 2005–2006, 18 departments are rolling out detailed specifications of allocations and targets benefiting women. At the state level, in West Bengal, UNIFEM supported the organisation Sachetana to prepare a gender budgeting manual that the group has used to train over 1,000 women councillors in local governments. In Karnataka, another state, elected women representatives in the city of Mysore used gender budgeting to prevent a proposed budget cut targeting women's programs. They ended up securing a 56% increase in funding instead, and started advocacy for more transparent public information in the future.

In Mexico: Extensive mobilisation of women's groups, spearheaded by UNIFEM partners, persuaded the government in 2003 to earmark 0.85% of the total national budget for programs to promote gender equality. Since then, 14 ministries have been required to report quarterly on these programs. In the states of Morelos, Queretaro and Chiapas, the Ministry of Health has used a guide for integrating gender issues in health budgets—produced by the national health ministry with UNIFEM assistance—to improve the health services it offers to women and to channel more resources into priority health needs.

In Brazil: UNIFEM has carried out a range of activities, including offering courses on gender and macroeconomic policy to senior policy makers, helping to establish links between GRB advocates and parliamentarians, and sponsoring a well-respected NGO to conduct a four-year gender review of legislative policies and budget allocations. The national government has carried out a preliminary gender analysis of the federal multi-year plan that will assist them in ensuring that the national budget incorporates gender-sensitive planning and allocations. The government has already used similar tools to tailor services described in the National Health Plan to the needs of different racial groups. Through an advocacy campaign, the Centro Feminista de Estudios y Servicios de Asesoría achieved the inclusion of key programs for gender equality and women's rights in the expenditure monitoring system SIGA-BRASIL. This program is an initiative of the Brazilian Federal Senate to create a public information system (available through their website) that allows any person to access databases on planning and budgeting information.

In the Philippines: GRB started in 1995, with a Gender and Development (GAD) budget policy that stated that government agencies must allocate 5% of their budget for activities related to gender and development. More recently, UNIFEM has supported the national women's machinery, the National Commission on the Role of Filipino Women, to intervene in the budget reform process which aims to transform the budgeting process from line item to performance-based budgeting. The aim of the intervention is to create tools to institutionalise gender-responsiveness in the process. At the local level, an NGO has assisted local communities to work with local government units in the preparation of local budgets that are gender-responsive.

BUDGET WORK AND RIGHTS

Budgets reflect planned government spending at national and sub-national level spending. With respect to reproductive health, they reflect intended spending on delivering services. Rights discourse addresses, among other things, equitable access to quality services in a range of areas. When discussing women's rights, rights work also raises the issue of spending to address discrimination and disadvantage. Over recent years the discourse on human rights has increasingly recognised the importance of looking at resource availability, and thus budgets. This section clarifies some of the issues identified in human rights discourse that have implications for government budget policy making.

“Dignity Counts” is a publication that reflects collaboration between three organisations – the International Budget Project, the International Human Rights Internship Program, and Fundar, a Mexican organisation working on both rights and budgets. The introduction explains what human rights advocates and budget analysts can gain by working together.

For human rights advocates, adding the budget angle to their work can:

- add the technical strengths of budget work to the moral arguments of human rights;
- help identify practical problems and solutions;
- help assess whether government is using available resources as effectively as it could;
- provide developed proposals, including estimates of costs, for government consideration;
- strengthen advocacy with legislators, communities and other groupings.

For budget analysts, adding the human rights angle can:

- be a reminder that the ultimate goal is the welfare of human beings;
- provide the values against which to assess budgets;
- give legitimacy to the work because of widespread recognition of the need to look at issues of poverty and social justice;
- assist in choosing between different budgetary and policy options;
- strengthen the demand for transparency and accountability;
- find more partners and thus have greater impact.

BOX 3: USING RIGHTS CONCEPTS IN HEALTH-RELATED BUDGET WORK

“Dignity Counts” uses the health budget in Mexico as a case study to illustrate how budget and rights work can be combined. The analysis focuses on government’s obligation with respect to:

- **progressive achievement** of the right to health;
- **full use of maximum available resources** to achieve fulfilment; and
- **specific guarantees** in the health-related article (number 12) of the International Covenant on Economic, Social and Cultural Rights (ICESCR).

“Progressive achievement” and “**full use of maximum available resources**” are key concepts in budget-related rights work. Progressive achievement recognises that governments have limited resources (money) and may not always be able immediately to guarantee a right. But it says that they must not move backwards with respect to the right. Full use of maximum available resources again recognises that resources may be limited, but says that government must use what is available to its fullest potential to achieve rights.

In terms of **progressive achievement**, the analysis showed that the federal government increased the amount allocated to health between 1998 and 2001, but that by 2002 the amount had fallen back near to the level of 1998. The Mexican NGO Fundar then disaggregated the total amount into the different institutions as each type of institution serves a different part of the population. They found that in 2002, 65% of total health spending went to people who fell under the social security system, despite the fact that these people accounted for only half the total population.

In terms of use of **maximum available resources**, Fundar found that spending on health had decreased relative to gross domestic product (GDP) and relative to total government spending. In contrast, they found that spending on areas not directly related to human rights (such as Finance, Foreign Affairs and Tourism) had increased.

For the ICESCR analysis, Fundar looked at what government had allocated for the reduction of stillbirths, infant and child mortality; for prevention and treatment of diseases; and for creating conditions to ensure that health services and care were available. Regarding the program which covers maternal health, the organisation found that the budget allocations were biased against the poorest states.

Fundar has a project which focuses on budgets and maternal mortality. It works on this project in alliance with women’s organisations which focus on reproductive health and rights. The alliance has achieved very concrete results. In the first year of the project, decentralised (state) allocations for maternal health increased by 900%. The Ministry of Health’s national program to fight maternal death (Arranque Parejo en la Vida) also issued a series of manuals on how to address possible emergency events.

In addition, a new strategy is being followed by the Mexican NGOs involved. They are now advocating for a change in the mainstream maternal mortality strategy (which is follow-up of high risk pregnancies and qualified attention during delivery) so that it includes emergency obstetric care.

Reference: Fundar–Centro de Analisis e Investigacion, International Budget Project and International Human Rights Internship Program. Dignity Counts: A guide to using budget analysis to advance human rights. Fundar, 2004

GRB AND CEDAW

The 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is the key international instrument on women's rights. CEDAW consists of a preamble and 30 articles. Article 12 relates to women and health. There are also recommendations on violence against women. By March 2005, 180 states had ratified CEDAW. However, some of these states did so with "reservations," on the basis that their national law, tradition, religion or culture conflict with particular articles. The USA is one of the few countries that has not ratified CEDAW.

In 1983 CEDAW issued a general recommendation (GR) (no 24) on article 12 of CEDAW dealing with women and health. Paragraph 2 of the recommendation deals directly with reproductive health. It calls for the elimination of discrimination in women's access to health care services "throughout the life cycle, particularly in the areas of family planning, pregnancy, confinement and during the post-natal period." A later paragraph of the recommendation stresses the issues of life cycle by clarifying that the word "women" includes adolescents and girls. The recommendation also cross-refers to previous recommendations related to female circumcision, HIV/AIDS, and violence against women, among others. The recommendation says that country reports to CEDAW must state whether and how free services are provided to ensure safe pregnancies, childbirth and post-partum periods for women.

Paragraph 11 of GR 24 states that if providers refuse to perform particular services (such as abortion) because of conscientious objection, the state must ensure that alternatives are offered to the women concerned. More generally, the recommendation requires that states must report on how both public and private (including non-governmental) providers are meeting their duties to respect women's rights to health care. Monitoring in this respect should cover quality of care as well as access.

Paragraph 17 of GR 24 obliges states to take appropriate measures, including budgetary ones, "to the maximum extent of their available resources" to ensure that women realize their rights to health care.

You can check <http://www.un.org/womenwatch/daw/cedaw/states.htm> to see whether a particular country has ratified CEDAW and, if so, whether there were any reservations.

References: Elson, Diane. Budgeting for Women's Rights, Monitoring Government Budgets for Compliance with CEDAW. New York: UNIFEM, 2006. www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24. For summary recommendations see http://www.gender-budgets.org/en/ev-72845-201-1-DO_TOPIC.html

BOX 4: USING BUDGET INDICATORS TO ASSESS FULFILMENT OF CEDAW

UNIFEM's publication *Budgeting to Fulfil International Gender and Human Rights Commitments* complements other manuals on CEDAW by suggesting budget questions and output indicators for each of the CEDAW articles. With respect to the health Article 12, it suggests the following budget input indicators:

- The amount of money allocated by government for reproductive health services, and the division of this amount between different types of services, between different levels of delivery (for example, clinic versus hospital), and between rural and urban
- The amount of money allocated by government to buy the necessary equipment and supplies for childbirth
- The amount of money allocated by government to provide free services to women and young children rather than their having to pay fees
- The amount of money allocated by government to pay village and community health workers, and the ratio of the salary/stipend for these workers to the salary of nurses and other health staff
- The amount of money allocated by government for anti-retroviral treatment to prevent mother-to-child transmission of HIV and for adults with HIV and AIDS

The suggested output indicators are:

- The number of women and men who used each of the different reproductive health services at the different levels in rural and urban areas
- The number of women who had to bring their own supplies with them when they went to give birth in public facilities
- The number of women, men and children who received free health services, and the number who paid user fees
- The number of village and community health workers employed by government
- The number of women and their babies who received anti-retroviral treatment to prevent mother-to-child transmission
- The number of women and men who received anti-retroviral support funded by government

Reference: *Budlender, Debbie. Budgeting to Fulfil International Gender and Human Rights Commitments. Harare: UNIFEM, 2004.*

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND THE ICPD

The International Conference on Population Development (ICPD) of 1994 was a key event in defining sexual and reproductive health and rights. The ICPD cornerstones for gender, population and development programs as well as for reproductive health services and rights are:

- ensuring women's control of their own fertility;
- achieving women's empowerment;
- achieving gender equality and equity; and
- eliminating all forms of violence against women.

The ICPD's Program of Action provides the following definitions of reproductive and sexual health:

Reproductive health is complete physical, mental and social well being in all matters related to the reproductive system. It implies (a) the ability to have the number of children desired when desired and (b) access to the medical care needed to ensure reproductive health, namely:

- family planning services;
- antenatal, postnatal and delivery care;
- neonatal and infant care;
- treatment for reproductive tract infections and sexually transmitted infections (STIs);
- safe abortion services where they are legal and management of abortion-related complications;
- prevention and appropriate treatment for fertility;
- information, education and communication (IEC) on human sexuality, reproductive health, responsible parenting, and the discouragement of harmful practices; and
- treatment for reproductive system cancers and HIV/AIDS.

(ICPD Program of Action, 7.5)

Sexual health includes:

- healthy sexual development;
- equitable and responsible relationships;
- sexual fulfilment; and
- freedom from illness, disease, disability, violence and other harmful practices related to sexuality.

(ICPD Program of Action, 7.36)

Adolescent sexual and reproductive health refers to the physical and emotional well being of people 10–19 years old. It includes their ability to remain free from:

- too early or unwanted pregnancy;
- unsafe abortion;
- STIs including HIV; and
- sexual coercion or violence.

(ICPD Program of Action, 7.47)

In terms of services, the ICPD Program of Action uses the term “comprehensive reproductive health services.” However, the fact that items such as treatment of sexually transmitted infections and sex education are included means that we can also use the term “sexual and reproductive” health services. UNFPA’s MYFF has as one of its goals that all couples and individuals should enjoy “good reproductive health, including family planning and sexual health, throughout life.”

Rights are the benefits or privileges a person gets from simply being. ICPD and the Platform for Action of the Beijing Conference help with definitions for sexual and reproductive rights.

Reproductive rights involve the right of couples and individuals to:

- decide freely and responsibly the number, spacing and timing of their children;
- have the information, education and means to make these decisions;
- attain the highest standard of sexual and reproductive health; and
- make decisions about reproduction free of discrimination, coercion and violence.

(ICPD Program of Action, 3)

Sexual rights are the rights of all people to:

- decide freely and responsibly all aspects of their sexuality, including protecting and promoting their sexual and reproductive health;
- be free of discrimination, coercion or violence in their sexual lives and in all sexual decisions; and
- expect and demand equality, full consent, mutual respect and shared responsibility in sexual relationships.

The **human rights of women** include their right to have control over, and decide freely and responsibly on, matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

(Fourth World Conference on Women Platform for Action, 96)

Reference: Rights and Reforms materials www.wits.ac.za/whp/rightsandreforms/training.htm

GENDER-BASED VIOLENCE AND REPRODUCTIVE HEALTH

In 1993, the UN Declaration on the Elimination of Violence against Women defined gender-based violence (GBV) as: “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life.” The Declaration continues that the definition includes physical, sexual, and psychological violence in the family, community, or government. GBV acts include: spousal battery; sexual abuse; dowry-related violence; rape (including marital rape); female genital mutilation/cutting and other traditional practices harmful to women; non-spousal violence; sexual violence related to exploitation; sexual harassment and intimidation at work, in school and elsewhere; trafficking in women; and forced prostitution. The 1995 Beijing Platform for Action added to this definition violations of the rights of women in situations of armed conflict.

A recently published study based on 24,000 interviews with women in 10 countries found that abused women were twice as likely as non-abused women to have poor health and physical and mental problems.

In particular, GBV negatively affects reproductive health. In the study, women in abusive relationships were more likely than other women to report that their sexual partners refused to use a condom. They were also more likely to report that they had had an induced abortion or miscarriage. More generally, GBV can result in unwanted pregnancy, unsafe abortion, maternal death, miscarriage and stillbirth, delayed access to antenatal care, premature labour, foetal injury and low birth weight. Abused women are also at greater risk than others of contracting STIs, including HIV.

Reproductive health services can offer women a convenient and unstigmatised opportunity to get assistance with respect to GBV. In Brazil, Colombia, the Dominican Republic, and Peru, the International Planned Parenthood Federation (IPPF) has included a GBV component in their reproductive health services. The services have resulted in a significant increase in detection and referral rates for abuse.

References: UNFPA. State of World Population 2005: The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals. New York: UNFPA, 2005.

WHO. "Multi-country Study on Women's Health and Domestic Violence against Women". WHO, www.who.int/mediacentre/news/releases/2005/pr62/en/index.html.

HIV/AIDS AND REPRODUCTIVE HEALTH

Today, more than 20 years into the epidemic, women account for nearly half the 40 million people living with HIV worldwide. In sub-Saharan Africa, 57 per cent of adults with HIV are women, and young women aged 15 to 24 are more than three times as likely to be infected as young men. Despite this alarming trend, women know less than men about how HIV/AIDS is transmitted and how to prevent infection, and what little they do know is often rendered useless by the discrimination and violence they face.

Source: UNAIDS, UNFPA and UNIFEM. 2004. Women and HIV/AIDS: Confronting the Crisis, p.v., UNFPA, <http://www.unfpa.org/hiv/women/report/index.htm>

Women are both biologically and sociologically more vulnerable to HIV infection than men. Biologically, a greater surface area is exposed to infection during sex. Sociologically, their lesser power in society, and in particular their lesser ability to control sexual relationships with men, render them vulnerable. Women's vulnerability to HIV/AIDS relative to men has increased over the course of the pandemic as sexual activity has increasingly become the main mode of transmission. In addition to greater vulnerability to infection, women tend to be more "affected" by HIV/AIDS, in that it is usually women who bear the burden of care for those who are ill in their households and communities as well as in health facilities.

Today more than three-quarters of HIV infections are sexually transmitted, and many of the approaches used for HIV prevention, treatment and care overlap with those used for reproductive health (RH). From a budget perspective, integrating HIV services with RH services can keep costs down and deliver more effective services from both a provider and user perspective. For the provider, the same facilities, equipment and staff can be used to deliver a wider range of services, rather than having to budget for and manage two separate streams. For the many users who might need both services, they will not need to go to different service points, perhaps on different days, to have related needs addressed. Being treated by staff who have knowledge of both RH and HIV will also mean that they are more likely to be properly diagnosed at an early stage and get treatment for the full range of possible problems.

The ICPD recognised HIV/AIDS as a central issue on the RH agenda, but integration has nevertheless often not happened. Too often HIV services are delivered separately from RH services. In some cases this is motivated on the grounds that HIV is a "new" and priority problem, requiring a nationally-controlled "vertical" service. RH services are meanwhile delivered as part of general primary health services, or as a separate vertical program. In this and other cases separate programs might be encouraged by donors who want to know that "their" resources are being directed at the particular problem (HIV/AIDS or family planning or something else) that they are interested in. In addition to the systemic reasons suggested

above, Stop Aids Now suggests two further reasons for this: (a) resistance among RH service providers to dealing with HIV/AIDS because of the stigma, and (b) lack of engagement of HIV/AIDS activists with family planners because they were focusing on people infected through gay sex and injecting drugs. The latter point is probably less relevant in developing countries where from early on, heterosexual sex was the main mode of transmission. However, it could be a factor to the extent that the AIDS movement is affected by international trends, as well as in developing countries where drug injections are still a major route of infection.

If HIV/AIDS is to be dealt with mainly through RH programs, there are gaps in coverage that must be addressed. For example, “family planning” services in many countries focus on married women and leave out men, younger women, and unmarried women of all ages. Often they are excluding those who should be the main targets of HIV prevention efforts, such as heterosexual men, men who have sex with men, and sexually active, unmarried women. These gaps again point to the need for integration of RH and HIV/AIDS services, and for RH services to broaden their concept of whom they are targeting.

A 2004 publication of UNFPA, UNAIDS, IPPF and the Alan Guttmacher Institute acknowledged that there had been limited collaboration between the World Health Organisation (WHO) and UNAIDS on the interlinkages between HIV/AIDS and sexual and reproductive health. UNAIDS’ theme for 2004 was “Women and HIV,” but their campaign did not plan to look at reproductive health and rights beyond GBV. Berer (2003) notes that the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) also does not cover RH issues. It ignores even HIV-related anaemia, tuberculosis and malaria in pregnant HIV-positive women.

Meanwhile RH services often do not offer HIV/AIDS services even to the married women who are their traditional users. Thus a 2003 survey conducted by the POLICY Project across 73 countries found that overall only about one in 10 pregnant women had been offered HIV counselling and testing, antiretrovirals to prevent mother-to-child transmission or advice on breastfeeding options. Many family planning services also do not advise women that they need to use condoms to prevent HIV/AIDS if they choose other ways of preventing pregnancy. Where HIV-related services are added, often it is only the simplest and less sensitive ones such as clinical management of STIs.

Some RH advocates may feel wary of focusing on HIV/AIDS because they feel that HIV/AIDS is getting too much attention and resources, and this is decreasing what is available for “standard” RH services. This view has been encouraged by the fact that a lot of AIDS funding has been done “vertically,” as a separate program, rather than integrated into mainstream expenditures. The vertical approach discourages linkages.

Checklist for integrating SRH and HIV/AIDS programs

An editorial in *Reproductive Health Matters* (Berer, 2003) includes a detailed list of issues related to sexual and reproductive health (SRH) and rights that must be addressed in HIV/AIDS prevention and treatment. A few of the items on this list are:

- access to HIV counselling and testing in all RH services and referral to RH services in HIV counselling, testing and treatment;
- promotion by RH services of condoms as a primary form of contraception, and discouraging the use of intra-uterine devices if there is any risk of HIV;
- family planning and safe abortion services that take the needs of HIV-positive women into account;

- attention to the needs of HIV-positive women in antenatal, delivery and post-partum care;
- screening and treatment of HIV-positive women for cervical cancer as they are at risk at a younger age than non-infected women; and
- services for survivors of rape and sexual assault which include anti-retrovirals, STI screening and treatment, emergency contraception and abortion services.

BOX 5: MOTHERS' VS WOMEN'S VS CHILDREN'S NEEDS

Some people assume that addressing children's needs automatically implies gender sensitivity. This tendency is aggravated when policy—and even the MDGs—puts women's health and child health together in a single category. It is replicated in the structures and budgets and programs of many countries, where there is a department or division called “mother and child health.”

Children are a gender issue and a women's issue to the extent that women bear the main burden of caring for children. Women are, probably, generally also more concerned about children's welfare than the average man. Children thus become a gender issue because of women's reproductive role and their related responsibilities, duties and burdens. However, this does not necessarily mean that what is good for children is automatically good for women. Women's own individual rights need to be given due consideration, rather than their being seen only in relation to others.

The report on a WHO expert consultation noted that sometimes the focus of MTCT programs is on preventing HIV transmission to the unborn baby without any consideration of the rights of the mother. These include her right to information, and to choice regarding what should be done for herself and the baby: whether she wants to be tested, whether she wants to terminate the pregnancy, and whether she wants treatment for the baby and/or herself. Once the baby is born, there can be further implicit and explicit restrictions on the woman's rights regarding breastfeeding. If she chooses not to breastfeed, she might have to face the stigma of being “recognised” as HIV-positive. Unless her right to access to safe water has been fulfilled, she must face the choice of endangering her baby through breastfeeding or endangering the baby through mixing formula with unsafe water.

World Health Organisation. Integrating Gender into HIV/AIDS Programs: A Review Paper. Geneva: WHO, 2002.

References: Berer M. 2003. HIV/AIDS and reproductive health: intimately related (editorial). Reproductive Health Matters 11 [22]: 6–11.

[Also at <http://www1.elsevier.com/homepage/sab/womenshealth/doc/journals/pdf/RHM11%2022%20ed.pdf>]

Stop Aids Now, WPF and Share-Net. 2004. Integrating HIV/AIDS and Sexual and Reproductive Health into Policies, Programs and Services.

UNAIDS, IPPF, Alan Guttmacher Institute, UNFPA. Issues in brief: the role of reproductive health providers in preventing HIV (2004). UNIFEM/UNAIDS Gender and HIV/AIDS web portal. <http://www.genderandaids.org>.

WHO, UNFPA, UNAIDS and International Planned Parenthood Federation. Linkages between sexual and reproductive health and HIV/AIDS (2005). <http://www.who.int/reproductive-health/stis/linking.html>

BOX 6: COMBINING ADVOCACY AND LEGAL ACTION AROUND HEALTH RIGHTS

The Treatment Action Campaign (TAC) is an activist South African non-profit association which works on HIV/AIDS issues. TAC has some big aims, such as improving the health system and living conditions of poor people in South Africa. But its most successful campaigns focus activities around specific goals.

The mother-to-child transmission campaign was TAC's first campaign. TAC took up this campaign because it realised that if government provided drugs to prevent mother-to-child transmission (MTCT) it could save the lives of about 65,000 babies each year. TAC also did research which showed that it is cheaper to test, counsel and provide treatment and formula feeding to infected mothers than to care for children who become HIV-positive. Despite these facts, in 1998 South Africa's Minister of Health cancelled pilot projects that would provide anti-retroviral (ARV) drugs for pregnant women with HIV. It was at this time that TAC was formed to fight this issue.

In December 1998, TAC started a petition which called on government to give free ARV drugs to HIV-positive pregnant women. In a period of six months TAC collected more than 100,000 signatures. TAC did not hand in this petition because the Minister promised that government would establish a program to prevent MTCT. However, she did not take further steps to do this.

In March 1999, on National Human Rights Day, TAC organised a Fast to Save Lives in Cape Town, Durban and Soweto. The fast was supported by many religious leaders, health professionals and even some top government officials. About 500 people lay down in front of one of Johannesburg's public hospitals to symbolise the people who were dying. A few days later the Minister of Health said at a meeting that she supported the fight against high drug prices. The next day she met informally with TAC in parliament and said again that she supported TAC's fight against high drug prices.

In April 1999, TAC wrote to Glaxo Wellcome, the manufacturers of AZT, the main drug then used to prevent MTCT. TAC asked Glaxo to sell AZT at cost price. To strengthen the demand, activists protested outside Glaxo's headquarters. The Minister of Health again expressed strong support for TAC's stand. However, very soon afterwards, there was a cabinet reshuffle and the new Minister of Health was much less supportive. Glaxo was unfriendly from the beginning. They refused to say how much it cost to manufacture the MTCT drug.

In September 1999, TAC again held demonstrations outside Glaxo offices in Cape Town and Johannesburg. Some TAC representatives also met drug company officials to demand that the prices of AZT be reduced. Later in September TAC representatives met the new Health Minister. She told them that the government wanted to prevent MTCT, but did not want to start something it could not afford. But she said that the government would start pilot projects to test the drugs.

However, soon after this President Mbeki announced that AZT was "toxic." He said that the "toxicity"—not the cost—was the reason that the government did not provide drugs to prevent MTCT. The new Minister of Health was quick to repeat what the president had said.

In January 2000, TAC lawyers wrote to the Minister of Health asking whether and when the government planned to give drugs to HIV-positive pregnant women. Because of the poor response, TAC decided to take the government to court to force it to meet its constitutional duty to provide health care to women and children.

In August 2000, the Health Ministry announced the establishment of 11 pilot projects to provide drugs to prevent MTCT. TAC said that it would continue with legal action against the government if these pilot projects were not extended into a national program. The government continued to delay, and TAC was forced to take them to court. TAC relied in court on the strong clauses of the country's constitution regarding socio-economic rights. The Constitutional Court ruled in TAC's favour.

Reference: www.tac.org.za

PRIMARY HEALTH CARE AND REPRODUCTIVE HEALTH

What is 'women's health'? Many interviewees assumed that a study for the Women's Budget Initiative must be concerned with reproduction. Government policy also often equates 'women' with 'mothers' and 'reproduction'. [These equations are incorrect.] Firstly, girls' and women's needs in relation to health services begin long before adolescence and end in old age. Reproductive matters are an important, but not the only, component. Secondly, in addition to women's individual needs, women are the main caregivers in society. As caregivers they come into contact with the health services both when bringing the sick, whether children or the elderly, to use health services, and in caring for them in the home. Finally, the vast majority of health workers are women. Their role as workers is not fully valued because it is seen as 'women's work'.

Source: Klugman, B. and McIntyre, D. From Policy, through Budgets, to Implementation: Delivering quality health care services Women's Budget Initiative: Cape Town, 2000.

Many GRB initiatives select the health sector as one of the first to focus on. In doing so, they often focus primarily on expenditure and revenue-raising (e.g. user fees) related to reproductive health. This focus is obviously important from a gender perspective. It is also often relatively easy to isolate these expenditures in budget documents. For example, they might be separately classified as "Mother and Child Health."

The focus on reproductive health is important. However, the above quotation expands the notion of women's health beyond their reproductive functions. It suggests that while our focus in this resource pack might be on reproductive health, we must not forget that this in no way covers the full span of women's health needs. A gender-responsive budget initiative should thus ideally look beyond this. For poor women, in particular, we also need to think about primary health care more generally. In this respect, we again come back to the question of integration. In the previous section, we looked at the integration of HIV/AIDS-related services and RH services. There is also the question of the extent to which RH services are integrated into primary health care (PHC) services.

There is widespread agreement that PHC services are particularly important for poor people. And by enhancing the health of the majority of the population, PHC is also good for economic growth and development. PHC is guided by five principles: equitable distribution, community involvement, prevention, appropriate technology and a multi-sectoral approach. Traditionally many health services have tended to focus on tertiary hospitals and high-tech services in the urban centres. What is much more important for poor people is that primary services are available throughout the country. Nevertheless, there is often still a struggle to ensure that adequate financial and other resources are allocated for the local-level low-profile and low-status services.

Similarly, there is widespread agreement that RH services should be available at a local primary health care level, with referral to secondary and tertiary services only when necessary. (Secondary services are usually provided by medical specialists in local hospitals. Tertiary services are usually provided by specialist, regional or national hospitals which have specialised equipment and facilities.) However, there is not always agreement on the extent to which RH and PHC services should be integrated. Very often, there is still a separate "vertical" program such as maternal and child health (MCH) which is run separately from the other services. Sometimes family planning is even separated into a separate ministry. Yet the

ICPD emphasised the need to integrate family planning and other services, so that a woman coming for contraception could receive assistance with other problems, such as influenza or her child's diarrhoea, from the same service point on the same day.

A study conducted in Ghana, Kenya, Zambia and South Africa in 1997–8 found that even where governments speak about the need for integration, this does not always happen. Sometimes integration is understood as meaning collaboration between different (vertical) programs rather than sharing responsibility. In these cases, often there is very little real change to structures and processes.

The study report notes that donors' actions have in the past often encouraged lack of integration, particularly donor preference for establishing "projects" to address the issues they are interested in. The study suggests also that women's health advocates have often neglected to make the links between poverty and health, concentrating only on gender equity and health. As the authors put it, advocacy for PHC has focused on the right to good health, while advocacy or RH has focused on the rights of women and men to safe and voluntary sex and reproduction. The two sets of rights are not the same. Both sets of rights needs to be considered from a gender perspective and adequately provided for in budgets.

Reference: Lush, L., Cleland, J., Walt, G. & Mayhew, S. 1999. Integrating reproductive health: myth and ideology. Bulletin of the World Health Organization (WHO): The International Journal of Public Health 77 (9): 771-777. <http://www.who.int/docstore/bulletin/pdf/issue9/bu0042.pdf>.

POVERTY AND REPRODUCTIVE HEALTH

As noted above, GRB work should ideally not consider gender in isolation from other axes of disadvantage. In particular, we should be concerned with ensuring that the government budget reaches those who need it most—those who are least able to provide for themselves. Poor people—and poor women in particular—obviously constitute an important category of those who are generally least able to meet their own needs fully without outside assistance.

Millennium Development Goals (MDGs) documents point to the linkages between poverty and high fertility. They note, like the MYFF, that fertility rates are highest amongst poor populations. Rapid population growth, large families, and limited resources in turn tend to exacerbate poverty. The Task Force of the UN Millennium Project notes that poverty and poor RH outcomes are not restricted to poor rural areas. Women in poor urban areas sometimes have problems (including in terms of access to services) as severe as those of rural women.

UNFPA's MYFF also refers repeatedly to issues of poverty and inequality. It notes that in all the areas that UNFPA considers as priorities, there are inequalities between and within countries and regions. Within countries, there are usually significant disparities between rich and poor. In fact, RH indicators tend to have even bigger gaps between rich and poor than other human development indicators. The MYFF refers to studies which show that those who are poorest are also those who are least likely to benefit from skilled care at birth, family planning and trained antenatal care. The poorest groups also have the highest levels of fertility (including of adolescents) and infant mortality. Women who are malnourished as a result of poverty are more likely to experience problems during pregnancy, to give birth to babies who are small and underweight, and to experience problems in breastfeeding. The MYFF makes the link with the budget explicit by stating: "An increase in public expenditure will not by itself improve health outcomes, unless it reaches the poorest."

Improvements in health can contribute to growth and poverty reduction in a range of different ways. For example, better health results in fewer workdays lost, a better-fed and healthier worker is likely to be more productive, and better-fed and healthier children will learn better than hungry and ill ones. When a population is healthy, individuals and families need to allocate fewer resources to health care. In particular, women and girls need to allocate less of their time to caring for the sick.

Attention to reproductive health should be especially important as RH problems currently constitute the leading cause of death and disability for women internationally. Globally, 20% of the burden of disease among women of reproductive age is related to sex and reproduction. In sub-Saharan Africa, the percentage is 40%. Virtually all (99%) of maternal deaths occur in developing countries. Improved RH can directly help achieve at least three of the MDGs—reducing child mortality, improving maternal health, and combating HIV/AIDS—and can help indirectly with most of the others. In terms of actual lives, UNFPA estimates that most of the maternal deaths that occur could be saved through providing emergency care to all women rather than only to rich ones. Further, if women were given the means to prevent unintended pregnancies, a further 20–35% of maternal deaths could be avoided.

Yet relatively little is being spent on RH services. In 1994 the World Bank estimated that it would cost US\$6.75 per person in poor countries to provide a basic package of RH services which included family planning, prevention and treatment of STIs, antenatal and delivery care and health education. In that same year, poor countries were spending only about US\$2.00 per person. The commitments made at the ICPD did not help to solve that problem. By 2000, less than half of the US\$5.7 billion which the ICPD said was needed by that date had been raised.

Poverty, inequality and economic dependency also increase vulnerability to HIV/AIDS. For example, those who are poor can be forced into selling sex for money, and thus risk infection. The risk will be increased if, as is common, they are offered a higher “price” for having sex without a condom. Some people migrate in search of work. If they do so without partners, they and their partners might seek sex elsewhere and be exposed to infection.

References: UNFPA. State of World Population 2005: The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals. New York: UNFPA, 2005.

Stop Aids Now, WPF & Share-Net. Integrating HIV/AIDS and Sexual and Reproductive Health into Policies, Programs and Services, 2004.

HEALTH SECTOR REFORMS AND REPRODUCTIVE HEALTH

During the 1990s many developing countries introduced a range of health sector reforms (HSRs). These reforms were meant to address problems of poor quality care, limited access, inequity, insufficient funds, inefficiencies, and lack of responsiveness to needs. Sometimes the reforms were part of broader structural adjustment programs in Africa and Asia. The reforms were strongly promoted by the World Bank, which saw them as meeting the need for increased efficiency and cost effectiveness.

Common aspects of health sector reforms in the 1990s included:

- Changes in **financing mechanisms**, i.e. in the share of taxes, social and private insurance, user fees and other sources of revenue, a bigger role for the private sector, and new approaches to donor funding;

- Changes in how **priorities were set**, with a shift of some services to the private sector;
- Changes in **roles**, with the state focusing on regulation and less on direct provision of services;
- Changes in **organisational mechanisms**, such as decentralisation.

Most of these aspects have direct budget implications. An examination of the nature of HSR in a particular country, and its likely budget implications, should thus form part of the situation analysis that informs the design of any GRB intervention.

HSR is usually accompanied by privatisation of different kinds. The move to privatisation built on development in the 1980s when health workers established informal and formal small-scale private practices to supplement salaries which had been cut during structural adjustment programs. Some introduced “informal charges” even for their services in the public facilities.

Health sector reforms do not happen in the same way in every country. How they happen depends on the economic, political and social situation in a country, and the influence of multilateral and bilateral agencies. However, some broad patterns are usually found.

In the foreword to a new publication looking at HSR and its impact on reproductive health and rights, Marge Berer, editor of *Reproductive Health Matters*, concludes that in general, HSR had not improved the efficiency of sexual and reproductive health services. Often they have made things worse for poor people, and women in particular. Financing reforms have generally not increased the funds available for SRH services. Public-private initiatives mean that integrated and comprehensive services are less likely to be delivered, and services in general are less likely to be available for poor people who cannot pay. Accountability to the public also tends to decrease as the private sector’s role increases. The impact of decentralisation depends on the extent to which the national government sets conditions and standards for lower level jurisdictions. Often decentralisation and the removal of vertical health programs means that sexual and reproductive health services are in competition for funding with many other needs of people at local level.

BOX 7: COMBINING RESEARCH, ADVOCACY AND TRAINING

Rights and Reforms is a research and advocacy initiative which brought together organisations and individuals from Africa, Asia and Latin America to look at how health sector reforms have affected the access of poor people, and especially women, to quality sexual and reproductive health services. The group carried out research in each of the continents on six key aspects of health sector reform, namely (a) financing; (b) public-private interaction; (c) priority setting; (d) decentralisation; (e) integration of services; and (f) accountability. The findings were brought together in a global book and also turned into training materials. All the material has been made available on the Internet.

Reference: www.wits.ac.za/whp/rightsandreforms

References: Ravindran, T.K.S. and de Pinho, H.. Sector Reforms and Sexual and Reproductive Health: The right reforms? Parktown: Women’s Health Project, eds., 2005.

Mackintosh, M. & Tibandebage, P. Forthcoming. Gender and Health Sector Reform: Analytical perspectives on African Experience. In Gender and Social Policy in a Development Context: Mothers, workers and citizens, ed. S. Razavi and S. Hassim. Basingstoke: Palgrave.

WHAT ARE THE ECONOMIC CONSIDERATIONS?

This section elaborates the economic arguments that can be used to advocate for UNFPA's concerns and for the allocation of adequate budgets to address them effectively. These arguments can be used in advocating for GRB-related work as well as for UNFPA's objectives more generally. The section includes arguments that draw on traditional economic approaches and concepts, as well as arguments that are likely to be less familiar to orthodox economists. In particular, the section introduces the concept of unpaid care work. This is an issue which is usually overlooked in economic and budget discussions, but which needs to be addressed if one wants gender-equitable outcomes. It is especially important in the area of health, where caring is a core activity.

GRB, REPRODUCTIVE HEALTH AND ECONOMICS

Budgets are more than economic policy

Budgets are part of the overall macroeconomic policy of a government and are referred to in technical terms as “fiscal” policy. Monetary policy, which attempts to influence the exchange rate and inflation rate, constitutes another important part of a country's macroeconomic policy. Together, the various parts of the macroeconomic policy of a country usually aim to achieve goals such as economic growth, full employment, and low and stable inflation rates. Sometimes forgotten is the further aim of ensuring that these things happen in a way that provides benefits to everyone in the population, rather than to a few.

Because the budget is one of government's macroeconomic tools, descriptions of GRB sometimes refer to GRB initiatives as being about “economic policy.” While it is true that the budget is one of government's macroeconomic tools, and that the overall budget approach is part of government's overall macroeconomic strategy, budgets are also about much more than economic policy. In terms of what they do, budgets are about the raising of revenue and allocation of that revenue (which is economic policy); however, the money is then used to implement all government policies, whether in the economic, social or protective sectors. Thus, budgets can also contribute to much more than the “economic” goals of full employment, low inflation rates and economic growth.

Economic impacts of reproductive health

From another angle, though, there are several points that one can make about RH and economics, and about how adequate funding for reproductive health and rights can affect the economy of a country and economic well-being of the people who live in it.

UNFPA's State of the World's Population argues that investments in girls and women (including RH investments) offer a “double dividend” because they have pay-offs in terms of women's reproductive roles as well as their (economic) productive roles. Family planning allows women to delay childbearing, which gives them more time to complete their education and participate in the economic workforce. RH services can enhance women's productivity by resolving RH problems. Freedom of choice and ability to

choose should result in smaller families, with less pressure on the country's resources. In Thailand and Egypt, it was estimated that every dollar spent on family planning saved \$16 and \$31, respectively, in health, education, housing and other social service costs.

Many countries have well-developed government programs with respect to children's health and primary education. However, many neglect the needs of adolescents. When this happens, countries are in danger of losing the benefit of the resources invested in children, such as the vast amounts generally allocated to education.

Unsafe abortions result in approximately 68,000 deaths each year. Women who survive unsafe abortions often suffer permanent injuries. Unsafe abortion also places an immediate burden on health services. In sub-Saharan Africa, between one-fifth and one-half of all gynaecological beds are filled with women needing post-abortion care. It would be far cheaper to provide these women with contraceptives.

UNFPA's State of the World's Population notes that currently violence kills and harms as many women and girls, between the ages of 15 and 44, as cancer does. This results in costs related to health care, police and court services, as well as losses in educational achievement and productivity.

When adequate resources are not allocated to reproductive and other health services by government, there is a further cost imposed on the women who step in to do the caring "for free." At first glance this may appear costless to government. However, the time and other burdens this unpaid care work imposes on women prevents them from engaging in other activities, including income-earning, and raises the chances that they will become reliant on government in some way. The unpaid care work also means that the country cannot take advantage of their other skills and the contributions these could make to the country's economic progress.

Moving beyond instrumentalist arguments to a rights-based approach

All the above are strong arguments in favour of allocating resources for RH services. However, we should not use only instrumentalist arguments that point out how better health for women will be good for the country. Women have a right to health for their own good, not only for what it can bring for others.

As the report of the MDG task force on child and maternal health states, the term "women and children" should not be "a tag line for vulnerability, an SOS for rescue, a trigger for pangs of guilt." Instead women and children must be seen as "the present and future workers in their economies, caregivers of their families... They are human beings. They have rights—entitlements to the conditions, including access to healthcare, that will enable them to protect and promote their health; to participate meaningfully in the decisions that affect their lives; and to demand accountability from the people and institutions whose duty it is to take steps to fulfil those rights." (2005:4).

Reference: UNFPA. State of World Population 2005. The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals. New York: UNFPA, 2005.

BOX 8: MONEY ALONE IS SOMETIMES NOT ENOUGH

UNFPA has been supporting Ecuador to implement the 1998 Law on Free Maternity Care. The law provides for free access to a package of pregnancy-related services, family planning and health care for children under five years of age. The government allocated a budget to pay for the costs of these services, but this was not enough for the law to be effective. Government therefore established local committees to manage the local health funds in collaboration with the Ministry of Health, municipal authorities, the National Council of Women and community organisations. They have also established service users' committees, and there are regular meetings with women from surrounding communities to raise awareness about the law and monitor implementation.

Reference: UNFPA. State of World Population 2005: The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals. New York: UNFPA, 2005.

THE “DEMOGRAPHIC DIVIDEND”

One of the particular economic benefits that is postulated from provision of RH services has been called the “demographic dividend.” Proponents explain that when fertility and mortality rates fall, the structure of the population changes. The size of families decreases, and a greater proportion of the population consists of young productive people with relatively few child and elderly dependents. The demographic dividend thus focuses on the shape of the population rather than simply its size.

Economists have calculated that the demographic dividend accounts for about a third of the exceptional economic growth that East Asian countries experienced between 1965 and 1990. There is also a “gender dividend” in that women who have fewer children should find it easier to be part of the economic workforce.

Some economists argue that today’s developing countries could enjoy similar benefits. Other economists and demographers are not so sure. They point out that the existing evidence for the demographic dividend is based on macro patterns rather than an understanding of the behaviour of individuals and households. Others point out that economic growth is not enough. To be effective in poverty reduction, the extra wealth generated must be equitably distributed among the population.

There seems to be an emerging consensus that countries will not automatically enjoy a demographic dividend when fertility and mortality decline. For this to happen, the right policies need to be in place. For example, with respect to the “gender dividend,” governments need to find ways of making it easier for women to participate in the paid labour force, as having many children is by no means the only discouraging factor. In Japan, for example, there has been a sharp decline in fertility, but relatively few women have entered the paid labour force.

Analysts also caution that the demographic dividend is currently not relevant in a large number of countries—especially in Africa—which are currently experiencing a “demographic deficit” in the productive age groups as a result of HIV/AIDS.

GRB, REPRODUCTIVE HEALTH AND UNPAID CARE WORK

Budgets are generally seen as being about money, and those who construct budgets focus on money costs. As a result, they tend to be blind to unpaid care work—the work that is done mainly by women bearing, caring and rearing children and other family and community workers. Unpaid care work includes housework and childcare which people do unpaid for their own families. Importantly for our purposes, it also includes unpaid care of those who are ill.

The System of National Accounts (SNA) is the set of internationally accepted rules that state how countries must calculate their gross domestic product (GDP). The SNA rules recognise unpaid care work as “productive” and as “work.” However, the rules state that these unpaid care services should not be included in calculations of GDP. This encourages the reluctance of economists and planners to take unpaid care work into consideration.

There are nevertheless many ways in which government budgets are subsidised by unpaid work. For example, when government cuts back on public budgets for health services, it is people (mostly women) in the home who have to make up for the shortfall. This care may appear “free” to government, but imposes a cost on those who provide it and on their families.

A WHO pamphlet designed for nurses and midwives suggests that as much as 90% of care for those who are ill is provided in the home. The need for care tends to increase if a country is affected by HIV/AIDS or other similar epidemics. It becomes particularly acute as those infected increasingly become ill and a country moves from an HIV epidemic to an AIDS pandemic. Yet most of the high-profile funds available for HIV/AIDS tend to concentrate on costs of treatment rather than the costs of care.

To cope with the increasing demand for services generated by HIV/AIDS, many countries are moving towards home-based care (HBC) systems. In these systems, voluntary or low-paid workers visit homes to provide care rather than people being cared for in clinics and hospitals. The apparent benefits for the health budget seem obvious. For example, one estimate found that if all Tanzanian AIDS patients were treated in public health facilities and provided with adequate drugs, the expenses would absorb half of the public health budget. Yet the HBC systems are in fact being subsidised by the care workers who visit homes. And there is usually almost no thought given even in these programs to the time, opportunity and other costs borne by family members. Yet a study in Zimbabwe found that time costs account for the bulk of household costs involved in caring for bedridden family members.

BOX 9: THE COSTS OF HOME-BASED CARE

In 2003 UNIFEM funded and coordinated research in Botswana, Mozambique and Zimbabwe on the time and money costs to government, organisations and carers in organisations and households of the home-based care model of dealing with HIV/AIDS. The research was planned and implemented by a combination of government representatives, people from NGOs involved in HBC, people from NGOs which have done budget work, representatives of women's organisations, and academics.

The research used a case study approach, with three HBC projects in each of three countries serving as the cases. Each country used similar tools so that the findings could be more easily compared and so that it would be easier for advocates and their audiences to learn from the different cases.

At the end of the project, researchers and representatives of organisations from the three countries came together to share findings, and to come up with country-based and regional advocacy messages. The group agreed on the following as region-wide concerns:

- The very limited participation of men in HBC work;
- The complete lack of incentives for some HBC workers, the low level of incentives where they existed, and disparities between workers in terms of incentives received;
- A lack of recognition of the work done by HBC workers, particularly by government;
- Abuse of the HBC worker by some beneficiaries;
- Unequal access to home-based care for those who needed it;
- The need for more integrated approaches to HBC, encompassing a range of actors and covering health, nutrition, social and financial factors.

The researchers calculated the value of the work done by a typical HBC worker in their country by multiplying the number of hours worked by the average wage paid to nurse aids, domestic or similar workers. The monthly value was 270 Pula in Botswana, US\$ 130 in Mozambique and Z\$ 403 550 in Zimbabwe. However, researchers felt that using the wages of nurse aids and domestic workers trivialises the work of the HBC workers, given the range and variability of HBC tasks as well as the psychological and other stresses. In addition, they noted that the wages for all these jobs are based on assumptions about women's work, which generally tends to undervalue the work done whether in the market or at home.

Unpaid care work is not only a consideration of HBC and HIV/AIDS. It can be found, if you look for it, in many other social programs that base their operations on unpaid work done by the public.

BOX 10: THE UNPAID CARE WORK IN A GLASS OF MILK

A UNIFEM-funded GRB initiative in the municipality of Villa El Salvador, Peru, calculated the value of the unpaid work done by women in delivering what the municipality calls “self-managing” services. One example of such a service is the Glass of Milk program. In this program the municipality pays for basic materials and the milk, but women in the community provide the labour involved in organising the program and distributing the milk to beneficiaries. This program accounted for more than a third of the municipal budget, or US\$ 3 million, at the time of the research.

The research team interviewed women beneficiaries to find out how much time they spent working on the program. They then multiplied the number of hours by Peru’s minimum wage. When they compared this amount with the total budget for the Glass of Milk program, they found that if the women’s work had been paid for, it would have added 23% to the total budget. This unpaid care work contribution was in addition to contributions by the community to cover expenses such as fuel, sugar and utensils.

In effect, in this program the women are subsidising the government budget. If they were not prepared to offer their services for free, government would need to employ staff to do the work. Similar subsidisation happens when women provide health care to other members of their households and the community. If this care was not provided free by women as part of their family and community duties, those who are ill would be more likely to consult government health services for care, and thus increase the burden on the government budget.

References: Andía-Pérez, B & Beltrán-Barco, A. Analysis of the Public Budget with a Gender Approach: Villa El Salvador, Lima, Peru. In Gender-Sensitive Budgets in Latin America: Accountability for Equity and Transparency, ed. Bethsabé Andía-Pérez et al. United Nations Development Fund for Women, 2004. www.idrc.ca/uploads/user-S/11281061151Gender-Sensitive_Budgets_in_Latin_America-Accountability_for_Equity_and_Transparency.pdf.

Pearl, R. The Andean Region: A multi-country program. In Gender Budgets Make More Cents: Country studies and good practice, ed. D. Budlender, and G. Hewitt. London: Commonwealth Secretariat, 2002.

References: Budlender, Debbie. Why should we care about unpaid care work? Harare: United Nations Development Fund for Women, 2004.

Ogden, J., Esim, S. & Grown, C. Expanding the Care Continuum for HIV/AIDS: Bringing Carers into Focus. Health Policy and Planning 21 (5) (2006): 333–342.

USING THE BUDGET ANGLE TO ADVANCE OTHER WORK

This section describes how the GRB approach can be used to strengthen advocacy and effectiveness in a wide range of different programs, campaigns and activities. Possible arenas for using the GRB approach include national development agendas such as the poverty reduction strategy papers (PRSPs) which are found in many developing countries and the Millennium Development Goals (MDGs). Also discussed is the use of the GRB approach for work on particular issues such as maternal mortality and gender-based violence. The last part of the section describes how GRB work can form part of an agenda of increasing public participation in policy making.

REPRODUCTIVE HEALTH, BUDGET WORK AND MDGS

Reproductive health in the MDGs

The MDGs are the world's targets for addressing different dimensions of extreme poverty by 2015. Goal 5 focuses on maternal mortality and reproductive health. But there is no formal MDG with targets for sexual and reproductive health beyond this. Adolescents are not mentioned at all in the UN Millennium Declaration.

The UN Millennium Project (www.unmillenniumproject.org) serves as an advisory body to the UN Secretary-General. Its ten task forces bring together participants from academia, government, UN agencies, IFIs, NGOs, donor agencies, and the private sector. Several of these task forces, not only the one for Goal 5, have recognised that access to sexual and reproductive health (SRH) services and protection of reproductive rights is important for the achievement of other MDGs, including poverty and hunger, gender equality and the empowerment of women, educational attainment, environmental sustainability, and the improvement of the quality of life of slum dwellers.

The outcome document from the 2005 World Summit raises RH issues under the HIV/AIDS heading and refers to the need to achieve “universal access to reproductive health by 2015,” in line with the ICPD. When discussing the goal of gender equality and empowerment of women, the document refers to the need to ensure “equal access to reproductive health.”

Appendices 1 and 2 of the Millennium Project's Investing in Development include a variety of SRH-relevant interventions. Examples include universal access to sexual and reproductive health services and information (including family planning; safe motherhood as well as prevention, treatment and care of STIs including HIV/AIDS); age-appropriate education and services; attention to men's involvement; adolescent reproductive health; parental education; ensuring contraceptive choice; improving counselling; combating gender violence; discouraging early marriage; eliminating female genital mutilation and other harmful traditional practices; expanding access to safe abortion (where permitted by law), and reviewing such legislation to protect women's health.

Task Force on Child Health and Maternal Health

The Task Force on Child Health and Maternal Health emphasised the need for fundamental changes to systems, including budgets. It came up with the nine key recommendations, of which the second focused on financing. The Task Force stated that significant additional funds were needed. It said that countries should increase allocations to their health sectors. It also said that user fees for basic health services should be abolished. The fourth key recommendation dealt with sexual and reproductive rights and stated firmly that these are “essential” in order to meet all the MDGs. In elaborating, the Task Force recommended that HIV/AIDS initiatives be integrated with SRH programs, that adolescents should receive explicit attention, and that in all countries women should have access to quality services for the management of complications arising from abortion. The sixth recommendation, on maternal mortality, advocated that efforts to establish a “functioning primary healthcare system” must include provision for emergency obstetric care. The final recommendation states that universal access to RH services should be added as a target to MDG 5.

The emphasis on “universal” is in line with the task force’s consistent emphasis on equity and on addressing the needs of the poor. The task force notes that although poor people generally experience greater levels of ill-health than rich people, they generally have worse access to health services. They add that the fact that a particular health intervention addresses a disease that is more prevalent among poor people does not necessarily mean that it will benefit poor people most. Specific strategies are needed to ensure that this happens.

Budget analysts often complain about the large proportion of budgets spent on salaries. They ignore the fact that without the workers paid by these salaries, no services will be available. In contrast to these analysts, the task force states that salaries, career paths and working conditions of health providers should be “substantially” increased. They suggest that this can help, among others, to address the “brain drain” of nurses and doctors from poor to rich countries—a drain that transfers skills developed through third world budget allocations to the first world.

The task force also questions some of the other common aspects of HSR and, in particular, the shift towards privatisation. It notes that “even the most ardent health sector reformers ... recognize that market-based reforms based on the commodification of healthcare will end up failing to reach the poor, who simply do not have sufficient cash or other assets to purchase the care they need.”

References: UN Millennium Project. Who’s Got the Power? Transforming Health Systems for Women and Children. Summary version of the report of the Task Force on Child Health and Maternal Health. New York: UNDP, 2005.

*United Nations Development Program. Population, Reproductive Health and the Millennium Development Goals: Messages from the UN Millennium Project Reports. UNDP, 2005
<http://www.unmillenniumproject.org>*

Draft resolution referred to the High-level Plenary Meeting of the General Assembly by the General Assembly at its fifty-ninth session 2005 World Summit Outcome. A/60/L.1. September 2005 World Summit Outcome document*

BOX 11: MATERNAL MORTALITY AND EMERGENCY OBSTETRIC CARE

The Millennium Project Task Force's recommendation to include emergency obstetric care (EmOC) in primary health care services reflects the growing realisation of the importance of EmOC in addressing the high maternal mortality rates which are found in many countries.

The International Classification of Diseases, Injuries and Causes of Death defines a maternal death as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes.”

Of the estimated 529,000 annual maternal deaths in the world, 99% occur in developing countries. For every woman who dies from complications related to childbirth, approximately 30 more suffer injuries, infections, and disabilities such as urinary and foecal incontinence, infertility, and neurological damage. The direct causes of maternal deaths are haemorrhage, sepsis, obstructed labour, pre-eclampsia and eclampsia or the hypertensive disorders of pregnancy, and complications of unsafe abortion. Direct obstetric complications affect an estimated 15% of women during pregnancy, at delivery, or in the postpartum period. Indirect obstetric complications are caused by illnesses that are aggravated by the pregnancy such as anaemia, malaria, tuberculosis and HIV/AIDS.

The complications that result in maternal death generally cannot be predicted or prevented. The complications are as likely to affect a healthy pregnant woman as one who is less healthy. When complications occur, what is needed is EmOC, which can often save the woman's life.

In the late 1980s experts believed that **family planning** was the most cost-effective way to reduce maternal deaths. Family planning reduces the number of times that a woman is pregnant, and decreases the risk in this way. However, family planning does not affect the degree of risk once a woman is pregnant.

Antenatal care is based on the “risk” approach to preventing maternal deaths, through identifying those pregnant women most at risk of complications. In 1934, FN Reynolds wrote that more than 80% of maternal deaths were due to complications for which no antenatal screening was possible: puerperal sepsis, postpartum hemorrhage, and shock.

In 1987 WHO, UNFPA, and the World Bank launched the Safe Motherhood Initiative. The Initiative includes antenatal care, birth kits, making family planning services available, distributing iron pills, training health workers and traditional birth attendants, organizing communities, launching information and education campaigns, and empowering women. However, maternal death ratios did not decline significantly over the following decade. A focus on EmOC might have been more effective. To save women's lives, the pivot is functioning health referral systems that deliver quality health care, including EmOC.

Reference: Adapted from information provided by Marilen Danguilan, UNFPA

COSTING THE MDGS

There have been several attempts to estimate the costs of the MDGs. These initiatives are intended to inform both national governments and the international donor community as to the amounts that they will need to allocate in their national or aid budgets. The costing has been done both at international and country levels. It has also been done for specific goals.

Global estimates

Global estimates of what it will cost to achieve the MDGs vary widely. For example, Reddy & Heuty (2004) note that the Report of the High Level Panel on Financing for Development (the “Zedillo Report”) estimated the (international) cost of achieving the 2015 goals at about \$50 billion a year, while the World Bank put the cost to donors at between US\$ 35 and \$76 billion per year. A background paper for UNDP’s Human Development Report 2003 estimated the cost of reaching only Goal 1 at US\$ 76 billion.

UNFPA’s MYFF records an estimate by the World Bank that 20–25 billion dollars per year would be required to reach all the health-related MDGs. However, in 2001 international financial resource flows for population-related assistance amounted to only \$2.5 billion, far below the agreed targets.

National estimates

The fact that the outcome document from the 2005 World Summit clearly states the need to achieve universal access to reproductive health by 2015 presents a major opportunity to discuss with governments how they are planning to achieve this. A costing which is based on solid data might assist in showing governments what achieving this target would entail.

The Millennium Project has developed costing tools that are intended to assist countries in estimating the cost of achieving the MDG targets for 2015. Separate spreadsheets and supporting materials are available for the different sectors and/or goals.

The RH costing model is intended to help countries estimate how much it would cost to deliver universal access to a basic package of RH services. The package includes ten interventions related to family planning, five for antenatal care and delivery, seven related to obstetric complications, three for other maternal conditions, three for newborns, and five related to STIs. For each intervention, the model calculates the cost per average case, the number of potential beneficiaries for a particular year, and the total annual cost. It includes provisions for staff, drugs and other supplies required to provide the services. It does not include the cost of facilities, equipment and other overhead costs.

To use the model effectively, countries need five categories of data:

- Demographic data, for example number of women of reproductive age and number of births;
- Epidemiological data, for example on incidence of complications of pregnancy and STIs;
- Current coverage rates for the different services;
- Information on drugs and supplies required;
- Cost data related to staff, drugs and other supplies.

The model provides default data for 200 countries for most of these items.

Costing gender equality

A separate costing module is provided for gender equality. The inclusion of a separate gender “sector” is presumably partly a response to the inclusion of a gender goal among the MDGs. However, the gender costing module goes beyond the MDG gender goal to include gender-specific interventions covered in the needs assessment for other sectors. This is in line with observations from a wide range of observers that gender should not be confined to goal 3. The costing module also provides for a gender needs

assessment to what is needed to make gender policies (such as national plans) operational. The latter allows the authors of the costing module to cover elements not (fully) covered in needs assessments for the other sectors. It thus potentially goes beyond the MDGs. This is appropriate if we want to mainstream gender and the accepted gender policies of the country in the PRSP.

Separate costing of gender interventions is intended to highlight and encourage such interventions. It could, however, potentially have the opposite impact. If gender interventions are seen as “separate,” it could mean that they lose out when resources are limited and choices need to be made between different interventions. Gender could be seen as a “nice to have” rather than an essential part of mainstream policies. A better approach (and one in line with mainstreaming) might be to check that the gender interventions are included as part and parcel of the main sector interventions.

References: Reddy, S. & Heuty, A. Achieving the MDGs: A critique and a strategy. Working Paper Series, Harvard Center for Population and Development Studies, Volume 14 Number 3 (2004)

*UN Millennium Project. Reproductive Health Costing Model.
<http://www.unmillenniumproject.org/policy/needs03.htm>.*

BUDGET WORK AND PRSPS

In 1999 the World Bank and International Monetary Fund (IMF) introduced the idea of poverty reduction strategy papers (PRSPs) as one of the preconditions for poor countries to get access to the Highly Indebted Poor Country (HIPC) debt relief and concessional loans. The idea of PRSPs later spread to other countries which were not part of the HIPC. By early 2005 the HIPC countries which had PRSPs were Benin, Bolivia, Burkina Faso, Cameroon, Chad, Ethiopia, Gambia, Ghana, Guinea, Guyana, Honduras, Laos, Madagascar, Malawi, Mali, Mauritania, Mozambique, Nicaragua, Niger, Rwanda, Senegal, Tanzania, Uganda and Zambia. Non-HIPC countries with PRSPs were Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Cambodia, Djibouti, Georgia, Kenya, Kyrgyzstan, Moldova, Mongolia, Nepal, Pakistan, Serbia and Montenegro, Sri Lanka, Tajikistan, Vietnam and Yemen. Angola, Bangladesh, Bhutan, Cape Verde, Dominica, Lesotho and Macedonia were in the process of developing PRSPs.

A PRSP presents the overall poverty reduction plan of the government and should cover all sectors of government, the economy and society. A PRSP covers a three-year period, after which it is reviewed. Both the development of the initial strategy and all revisions are meant to involve widespread participation, including both civil society and ordinary citizens.

Because of this requirement of participation, the international financial institutions and bilateral donors describe the PRSPs as “country-owned” strategies. Critics respond that the participation and ownership is often not real. Even parliaments have no real say in the PRSP because they know that if they insist on significant changes to the document, this could jeopardise external aid. Real participation in decision-making beyond a small group of people is further restricted by the fact that the Articles of Agreement of the World Bank and IMF state that they will only deal directly with Ministries of Finance and Central Banks.

Critics of PRSPs also note that the policy prescriptions of PRSPs are remarkably similar across countries, despite differences in history, politics, economic and social conditions. In 2005 the World Development

Movement (WDM) examined the extent to which nine standard policy prescriptions appeared in 42 publicly available PRSPs. None of these prescriptions related directly to the health sector although some, such as privatisation (of water supply services as well as other areas) and trade liberalisation, could have affected health services. The WDM found that 30 of the 42 PRSPs talked about extending trade liberalisation, 38 referred to privatisation, 26 referred to deregulation of investment, and 40 referred to fiscal stringency. The latter directly affects budgets in that less money is likely to be available for social sector expenditures. The WDM pointed out that the figures above were under-estimates because in some cases where the PRSP did not include a policy, this was because the country had already introduced it. There were very few instances of countries introducing “unorthodox” policies in the nine areas studied.

Gender analysts and activists have also criticised many PRSPs for not mainstreaming gender issues. The World Bank’s gender unit produced a detailed Sourcebook describing how to ensure that PRSPs are gender-sensitive. Many PRSPs will describe some gender problems, such as lower female enrolments or high maternal mortality. But most do not look systematically at the gender differences across all sectors or build gender into the proposed solutions. There are, however, some exceptions. Rwanda’s PRSP, for example, is generally seen as having been successful in mainstreaming gender, largely as a result of concerted effort by women in the country. One part of this work focused on collecting and incorporating sex-disaggregated data for use in the report. The groundwork done in describing the situation of women, men, girls and boys in the different sectors was later carried through into Rwanda’s Gender Budget Initiative.

Despite their weaknesses, the PRSP should usually be a focus of GRB work in any country which has such a strategy. Because the PRSP is meant to provide the overarching framework for government action (and action of non-government players), it should also be the driving force behind the shape of the budget. For GRB, this means that if gender is not adequately incorporated in the PRSP, it will be difficult to achieve a gender-responsive budget. And it means that if gender is not built into the monitoring and evaluation system for the PRSP, it is unlikely to be part of evaluating budget implementation.

References: World Development Movement. Denying Democracy: How the IMF and World Bank take power from people. World Development Movement, 2005. <http://www.wdm.org.uk/democracy/index.htm>
Whitehead, A. “Failing women, sustaining poverty: Gender in Poverty Reduction Strategy Papers”. Report for the UK Gender and Development Network. GAD and Christian Aid, 2003.

BOX 12: CIVIL SOCIETY TRACKING EDUCATION POLICY AND BUDGET IMPLEMENTATION IN MALAWI

Malawi's Civil Society Coalition for Quality Basic Education (CSCQBE) was established in 2000. By 2005 it had 58 members, which included NGOs, community-based organizations, teachers unions, religious based organizations, and 10 District Networks. From the start, monitoring of government education policies, plans and strategies, including how they are implemented, became one of CSCQBE's main activities.

Each year CSCQBE conducts a tracking exercise implemented by its member organisations. The exercise aims to see whether the resources allocated for basic education are sufficient to achieve measurable change in equitable access, quality and relevance of basic education as a right for all children. The exercise is also part of holding government accountable—seeing whether implementation is in line with policy and whether resources are reaching the intended beneficiaries in line with the country's PRSP.

The 2004 report covers 322 primary schools spread across the six educational divisions of Malawi. The questionnaire focuses, in particular, on tracking the "priority poverty expenditures" of the PRSP, namely teaching and learning materials, special needs education, teacher training and recruitment, supervision and inspection of schools, and rehabilitation and construction of schools. The tracking compares what the Coalition finds at school level with what is recorded in the budget. The tracking includes gender issues, for example by looking at male/female enrolments and dropouts, provision of materials (such as desks) seen as especially important in retaining girls, and gender patterns among teachers in rural and urban schools.

Reference: *Nsapato, L. Are Public Funds making a Difference for Pupils and Teachers in Primary Schools. Report on Civil Society Basic Education Budget Monitoring For Financial Year 2003/4. Lilongwe, Ed. 2004.*

BOX 13: COMMUNITY TRACKING OF POVERTY FUNDS IN UGANDA

The Uganda Debt Network (UDN) was originally formed to campaign for debt relief for Uganda under the HIPC initiative. In 1997–8, after Uganda joined HIPC, the government created the Poverty Action Fund (PAF) as a way of ensuring that the resources released through debt relief would be spent on priority sectors for reducing poverty. In 2001–2, the PAF accounted for 35% of the national budget. Primary health care and control of HIV/AIDS are included among PAF-funded programs.

PAF funds are provided to districts in the form of conditions grants and are meant to be spent according to guidelines issued by the central Ministries. In 2000 UDN started establishing grassroots structures, called Poverty Action Fund Monitoring Committees (PAFMCs), to ensure that these funds were being received by districts and used properly. The committees are made up of volunteers from civil society groups. In 2005 UDN was supporting PAFMCs in seven districts of the country.

UDN provides training for committee members. District officials are invited to workshops and meeting to provide information and to get buy-in. In contrast to Malawi's monitoring, monitoring in Uganda uses mainly qualitative methods. Where committees discover problems in PAF implementation, UDN forwards these to the relevant authorities such as the Auditor General, Ministry of Ethics and Integrity, the Parliamentary Committee on Public Accounts or local officials. Problems reported in the first years included many different forms of embezzlement and bribing, over-charging of fees, and sub-standard work by contractors on infrastructure projects.

Reference: *Uganda Debt Network. Monitoring of the Poverty Action Fund Annual Report May 2001–April 2002. Kampala: Uganda Debt Network, 2002.*

BUDGET WORK FOCUSING ON PARTICULAR ISSUES

The best way to explain how the GRB approach can be used to strengthen advocacy around specific issues is to provide case study, and of ongoing budget work in a single country, South Africa, regarding GBV.

BOX 14: MONEY TO REDUCE MATERNAL MORTALITY

In November 2004 the International Budget Project, Fundar Centre for Analysis and Research in Mexico, and the Population Council co-hosted a three-day dialogue between experts and activists in the areas of maternal health and applied budget analysis.

Case studies from Mexico, Ecuador, India and Uganda illustrated three main challenges to reducing maternal mortality:

- human and infrastructure resources needed for skilled care;
- equity in access to services; and
- effective and efficient service delivery.

Participants felt that discussing across countries was useful if the methodology was flexible enough. But they stressed that researchers and advocates need to avoid generalising and making comparisons when there are big differences in country situations.

The work of Fundar and other organisations in Mexico is especially interesting on two counts. Firstly, Fundar has regularly tried to do its budget analysis in collaboration with other organisations such as the women's organisation Equidad de Genero. This strengthens the possibility that the findings will have a loud voice behind them. Secondly, the research done by Fundar resulted in a very concrete achievement. In 2002, the amount allocated to Arranque Parejo en la Vida, a new program focused on maternal health that involves a public-private partnership, increased by almost 900%.

Reference: Keith-Brown, K. "Investing for Life: Making the link between public spending and the reduction of maternal mortality". The International Budget Project, Fundar, 2004.

www.internationalbudget.org/Investingforlife.pdf

BOX 15: WHAT IS THE COST OF COMBATING DOMESTIC VIOLENCE?

NGO examination of budget allocations for GBV started in the second year of South Africa's Women's Budget Initiative (WBI), with a chapter that looked at how the budgets of the Departments of Safety & Security (police) and Justice catered for this problem.

In 1999 South Africa got a new and improved Domestic Violence Act. In June 1998 the Gender Advocacy Program (GAP) organised an information session for NGOs about the WBI and how government budgets are allocated. At a second workshop GAP and its partners agreed that research was needed to see how much government was allocating to implement the new Act.

The research found that some new money was allocated to train police officers and court officers on the new Act. The government also allocated money to produce posters and brochures and for other publicity and awareness-raising. Much of the money for these purposes was provided by donors.

Three years later, the NGO Centre for the Study of Violence and Reconciliation (CSVR) did research in which they asked police officials how much they allocated to implement GBV-related work. Again, the allocations were mainly for training and awareness raising. But there were also some general allocations, for example for infrastructure, that police said would help in implementing the act.

In 2005 CSVR decided to find out how much ought to be allocated to implement the Domestic Violence Act. They did this by asking all the different government officers involved in implementation how long they spent on a typical case. The time was then multiplied by the relevant salary, and the total amount for a single case multiplied by the estimated number of cases in the country.

*Reference: Vetten, L. "Show Me the Money": A Review of Budgets Allocated towards the Implementation of South Africa's Domestic Violence Act. *Politikon* 32(2) (2005): 277-295.*

BUDGET WORK AND GOOD GOVERNANCE AND PARTICIPATION

Some GRB initiatives focus only on the content of budgets. Others include a focus on the process of budget-making. Some of these initiatives look at what opportunities there are for members of the legislature, as elected representatives of civil society, to influence the budget. Where opportunities exist, the GRB initiatives can try to assist the representatives (and the female ones in particular) to engage meaningfully by helping them understand budgets and budget process. Thus the Forum for Women in Democracy (FOWODE) in Uganda first assisted women to stand for local government elections. Once they were elected, FOWODE provided training for the women councillors in GRB so that they could effectively represent women's interests in their new role.

Some GRB initiatives also look at opportunities for civil society organisations to engage with budget processes. Uganda is again an example of good practice on this matter. The Ugandan government has established sector working groups which are involved early on in the planning and budgeting cycle. These sector working groups include representatives from civil society organisations with expertise in the sector. FOWODE is one of the civil society organisations that are part of a sector working group.

It is more common, however, for government to provide opportunities for civil society participation at the local rather than the national level. For the most part, these initiatives focus on the investment side of the budget rather than the recurrent budget that covers items such as salaries. Latin America has been the leader in participation at the local government level. Some of the processes do not make special efforts to ensure that all voices—and particularly those of women—of women—are heard. However, there are some examples where special efforts are made as a result of advocacy.

A system that allows civil society to participate in planning the budget clearly provides good opportunities to make a real impact on allocations. The planning stage is, however, not the only stage at which participation can and should happen. Where civil society has participated in the planning stage, it needs to follow through in monitoring implementation to ensure that resources are allocated and used in the ways planned. Where civil society has not yet won the right to participate in the planning stage, it can still play a role in influencing how the allocated money is used. By monitoring implementation, civil society also gains useful information that it can use to advocate for future allocations.

The GRB initiatives that focus on participation can draw on general concerns about good governance, as good governance requires that ordinary people as well as their representatives have a say in public policy, and in how it is implemented. The initiatives can also draw on Article 7 of CEDAW. This Article further affirms that States Parties shall ensure that women have the right “to participate in the formulation of government policy and the implementation thereof.”

BOX 16: GENDER AND THE PARTICIPATORY BUDGET IN RECIFE

In 1995, the municipal government of Recife, Brazil introduced a system of popular consultation on the budget. However, in its early stages, participation in the budget process was restricted to members of particular organisations and largely failed to address issues of gender inequality.

In 2001 a newly elected municipal government set up *Coordenadoria da Mulher* (Women’s Coordinating Group) to coordinate the state’s gender policies. This group works alongside a civil society body, the Municipal Council of Women. The new government also developed ways of increasing participation in the budget process.

The new participatory budget has two main strategies. Firstly, area meetings are held in different neighborhoods of the city to discuss problems and budgetary needs. Each region of the city then forms a regional forum of representatives from the area meetings. Secondly, thematic forums have been set up to address problems such as education and health. Two representatives from each forum (regional and thematic) take part in the General Council of the Participatory Budget.

At the same time, *Coordenadoria da Mulher* introduced three activities aimed at increasing women’s participation in the participatory budget process:

1. Mobile recreation spaces for children are installed where the budget meetings are held to facilitate participation by women with childcare responsibilities.
2. Pamphlets outlining the importance of women’s participation have been distributed at the area meetings to promote greater representation of women in regional and thematic forums
3. Special women’s meetings were organised with government officials, members of the women’s movement, and activists dealing with race issues, to find ways to achieve broader mobilisation around women’s participation in the budget. Activities included composing music for community radio stations. In 2002 the Women’s Meeting became one of the thematic forums of the participatory budget. This gave it a voice in the official structure of the budget-making process, and allowed it to elect members to the General Council of the participatory budget.

Reference: www.bridge.ids.ac.uk/dgb12.html#3

PARTICIPATORY BUDGETS AND GENDER

UNIFEM has come up with proposals for incorporating a gender perspective in participatory budget processes at the local level. The proposals are based on the work done by UNIFEM in the Andean Region with UNDP and the Presidential Council for the Equality of Women of Colombia.

UNIFEM's document starts by noting that because public involvement in budget-making constitutes a radical change in the way communities relate to government, there need to be mechanisms to support active participation. In particular, there needs to be support for groups such as women who are traditionally marginalised. Communities also need to be sensitised about public policy related topics such as redistribution and equality that go beyond individual needs. They need to be given knowledge and tools that allow them to discuss and work with budgets. They also need to learn skills such as negotiation.

The document puts forward several reasons why women might not participate adequately in participatory processes unless special efforts are made.

- Government often assumes that when it allows the “community” to participate, all members of that community will automatically be represented. Government does not recognise that unequal power relations between women and men, and men's traditional leadership role in local organizations, will mean that women's voices are not heard strongly.
- Women are less accustomed than men to operating in “public” spaces.
- Women still carry the main responsibility for household tasks, and so have less time to participate. It is especially difficult for them if meetings are held at times such as early evening when many women are seeing to the needs of their children.
- When women participate, they often put their own needs second, and those of their children, families or the community first.

The recommendations proposed for ensuring a gender perspective in the participatory process include mechanisms for increasing participation of women, promoting prioritisation of gender-responsive projects, and ensuring the use of a gender-sensitive approach during implementation and monitoring. The document suggests that these various mechanisms be institutionalised, for example, by including them in regulations. It also recommends that there be sensitisation sessions for government officials so that they understand why gender responsiveness is necessary.

Suggested mechanisms to increase women's participation include:

- creating a list of women's organisations, and ensuring that they are invited to all meetings;
- providing childcare facilities at meetings, and holding them at times that suit women with young children;
- holding separate meetings with women before the main process to allow them to define their own agenda and to learn budget and negotiation skills;
- ensuring budget documents use non-sexist language; and
- having rules to ensure equal representation of men and women

In terms of prioritisation, UNIFEM's suggestions include:

- recording the number of women and men that support each proposal, and prioritising projects with strong female support; and
- prioritisation of projects that contribute in some way to diminishing gender or other inequalities, or that reduce unpaid care work.

To assist with implementation, UNIFEM suggests the development of an explanatory guide which explicitly requires information such as the number of women and men beneficiaries, the probable impact on women and men, and the contribution of the project to alleviating the burden of unpaid care work. For monitoring, UNIFEM suggests a range of indicators.

Reference: Cremades, R.C. Propuestas y recomendaciones para incluirla perspectiva de genero en los procesos de presupuestos participativos. UNIFEM, 2004.

BOX 17: GENDER AND THE PARTICIPATORY BUDGET IN VILLA EL SALVADOR

In Villa El Salvador, Peru, the part of the budget used to implement the integrated development plan has been prepared in a participatory way since 2000. The main players in the process are the municipality, territorial management committees and thematic commissions.

The process starts when the municipality determines the distribution of funds among the territories. It does this on the basis of unmet basic needs criteria, population size and the residents' taxpaying record. Later, all citizens over 16 years of age and all the community's public and private organisations are invited to participate in formulating and approving the budget, and then managing and evaluating implementation.

The municipality's roles include coordination of the process of discussion, approval and implementation of the participatory budget. The territorial management committees determine, in each territory, the top priority investments to be made with the amount allocated to the territory. They must supervise the projects that are implemented and take responsibility for maintenance expenses.

The thematic commissions act as consultative bodies on specific issues. At present, Villa El Salvador has six thematic commissions: trade, healthy community, gender, youth, education, and small and medium enterprises. The gender commission is made up of the Grassroots Women's Federation and a number of NGOs. It is meant to advise all other commissions on how to incorporate a gender-sensitive approach.

The El Salvador participatory budget thus already makes some provision for gender equality. However, gender advocates want to see further provisions. They would like to have a minimum quota for women's participation in the leadership of each territory, in decision-making and in project implementation. They have also proposed that a gender-gap change indicator be included in the criteria for project selection and appraisal.

Reference: Andía-Pérez, B., Beltrán-Barco, A., Coello-Cremades, R., Gutiérrez, M, Palán-Tamayo, Z and Zabalaga-Estrada, C. "Gender-Sensitive Budgets in Latin America: Accountability for Equity and Transparency." United Nations Development Fund for Women, 2004 www.idrc.ca/uploads/user-S/11281061151Gender-Sensitive_Budgets_in_Latin_America_Accountability_for_Equity_and_Transparency.pdf

WHAT DO BUDGETS LOOK LIKE?

This section introduces the different ways that budgets can be presented and formulated in different countries. It is intended, firstly, to help demystify the technicalities of budget formats and presentation to make them less intimidating. Secondly, it describes the related issue of the different approaches used in formulating budgets. In particular, it discusses performance, or activity-based, budgeting and medium-term expenditure frameworks. Over recent years these two approaches have increasingly been introduced in developing countries, often in tandem. The section includes discussion of the challenges and opportunities for GRB provided by the different formats and approaches.

BUDGET PRESENTATION

Different ways of presenting budgets

Because budget books contain so much information, the information needs to be classified in some way. Common ways of classifying expenditure in a budget are:

- Economic
- Administrative
- Functional
- Programmatic.

Often governments will present the budget in more than one way.

Economic classification

The main expenditure categories in this classification are usually current and capital expenditures. Current expenditures are expenditures for services and goods which are likely to last less than one year and which are necessary to carry out government operations. They include salaries of government employees, subsidies to firms, households and individuals, and expenditure on operations and maintenance. Capital expenditures are for goods and services that will be used for longer than a year. They include spending on technical assistance and training, as well as on land, buildings, infrastructure and goods such as textbooks.

Administrative classification

Here expenditures are classified under the agency responsible for the expenditure. For example, national budgets will be classified according to the different Ministries or Departments. Usually this classification is used in combination with another classification.

Functional classification

This classification groups expenditure according to the function or purpose for which it is spent. It uses standard function categories. There is usually some similarity between the administrative and functional classifications, but they are not exactly the same. For example, the Ministry of Defence may spend money on medical services for its staff. This expenditure will be classified under Health in the functional classification, but under the Ministry of Defence in the administrative classification.

Programmatic classification

A program is a set of activities that a government undertakes to reach a goal. Often this classification is used together with an administrative classification, in that each agency's budget is divided into several programs, each with their own budget. Sometimes the programs are further sub-divided into sub-programs or projects, again each with their own budget.

BOX 18: CHANGING REPRODUCTIVE HEALTH BUDGETS IN PARAGUAY

In both functional and program classifications, one sometimes finds that the categories are not disaggregated in a way that allows identification of the amounts allocated for the thing you are interested in. In particular, the topic of interest is sometimes grouped with other services.

Paraguay's Senate Commission on Equality, Gender and Social Development encountered this problem when they attempted to find out how much was allocated for sexual and reproductive health by the Ministry of Public Health and Social Welfare. By raising the problem, they succeeded in persuading the Ministry to introduce a separate line item for allocations for purchasing contraceptives. The Commission found that donors were covering 100% of the amount spent on contraceptives.

The Municipality of Asuncion was inspired by what was being achieved at national level and asked for UNFPA assistance in doing GRB work at municipal level. This initiative resulted in the dropping of user fees for pre- and post-natal care at municipal polyclinics for pregnant adolescents under 20 years of age. The municipality also increased by 300% the amount allocated for the costs of family planning methods.

Reference: www.presupuestoygenero.net/s28/paginas/iniciativas.htm

How many budgets?

In many developing countries the budget is divided into two parts. The recurrent, operating or "revenue" budget covers mainly operating expenses. Indeed, a very large proportion of these budgets consists of salaries and allowances for civil servants, but it should also provide for other operating expenses (such as drugs and other supplies) and maintenance of capital assets. The development or investment budget is meant to cover longer-term expenditure, such as capital investments. In practice, the development budget is often used mainly to reflect the donor part of the budget, i.e. the part financed by donor grants and loans, as well as any required counterpart funding. When this happens, the development budget often includes some allocations for operating expenses for various donor projects.

Some GRB analysts have focused on the development budget on the basis that there is very little room for manoeuvre within the operating budget because it is dominated by salaries. In contrast, in Rwanda civil servants argued that they wanted the GRB initiative to focus in the first place on the operating budget, as government had so little control over the development budget.

One problem with splitting the operating and capital budgets in this way is that planning does not easily provide for the implications of one type of allocation for the other. For example, it is of little use to budget for the construction of a new clinic in the development budget if the operating budget does not provide for the operating expenses of this clinic. Another problem is that the operating and capital budgets

often use very different formats, which makes them more difficult to plan and analyse in a sensible way. Because of these and other problems, over time most governments will probably move towards having a single consolidated budget that shows both operating and capital expenditures.

The development budget approach is based on the assumption that all donor funding should come through the government budget. In practice, this is usually not the case. For one reason or another, donors and government players may try to avoid money coming through official channels.

BUDGET FORMULATION

Traditional budgeting

Traditionally budget making was largely an incremental exercise. Each year the responsible officials would take the budgets of the previous year and adjust most of the allocations by a similar percentage, for example a percentage equal to the inflation rate. Incremental budgeting of this sort tends to promote the status quo. It treats budgeting as if it were simply a bookkeeping exercise.

New forms of budgeting take seriously the fact that budgets should reflect policy, rather than simply involving bookkeeping. Further, new forms of budget recognise that policy should not be static—that policies should change as the situation changes, or as government priorities change, or as thinking about the best way to address problems changes.

Zero-based budgeting

Zero-based budgeting is probably the most radical form of budgeting. This approach states that each year, one should start with a clean slate and think about each and every allocation before including it, rather than simply copying what happened the previous year. This is obviously an ideal. Firstly, government cannot suddenly stop paying for ongoing programs such as education, provision of electricity, and so on. Secondly, government does not have enough time and energy to reconsider each and every expenditure on an annual basis.

Nevertheless, the idea behind zero-based budgeting—that it should not just be “business as usual” each year—is a good one. Performance budgeting (discussed below) reflects this idea by requiring that budgets are accompanied by text that describe changes in the situation and changes in policy and use these to explain shifts in budgets.

Performance budgeting

Program performance budgeting (sometimes called activity-based budgeting) is being introduced in many countries, often together with medium-term expenditure frameworks (MTEFs). This type of budgeting tries to address many of the weaknesses of traditional budgeting.

For an inside government GRB initiative, program performance budgeting can provide a **good format for producing the gender-aware budget statements** which are one of Diane Elson’s tools. Learning to understand program performance budgeting can also be useful for people outside government (a) so that they know how to interpret government budgets and the underlying policy and (b) because some of the ideas can be useful in outside-government GRB work.

When we ask governments to start doing GRB, they might respond that they already have too much work to do and GRB work will be an unbearable extra burden. Arguments which suggest that GRB will not mean a lot of extra work for government officials are therefore important. If a country is using a performance budgeting format, it is generally easier to incorporate gender into the existing format than if there is a traditional format. One can also argue that adding the **gender element “adds value”** to what government is already trying to achieve with performance budgeting.

Just as performance budgeting is useful for one of the Elson tools; it also usually reflects at least four of the five steps of GRB outlined elsewhere in this resource pack. Outcomes are sometimes not included in the format because they are not easily measured on an annual basis.

In performance budgeting, government planners and budgeters are meant to start with the policy objective and, from there, move to determining budget allocations and assessing their **Economy, Efficiency and Effectiveness** (the three “Es” to which budget specialists often refer). Economy looks at the link between money and inputs—how much the inputs cost. Efficiency looks at the link between inputs and outputs—how many inputs are used in producing each output. Effectiveness looks at the link between outputs and outcomes—whether what is produced really makes a difference.

Traditional budgeting ignores an important **Fourth E—Equity**. While Economy, Efficiency and Effectiveness are each considered only at one of the steps, Equity must be considered at all steps. For example, using an education example—are female and male teachers paid the same salary (funds to inputs), are there equal number of boy and girl students (inputs to outputs), and are boy and girls equally equipped on leaving education to earn good incomes and succeed in the outside world (outputs to outcomes)?

Adding gender in program budgeting is not difficult. The budget page which follows was drawn up by Ministry of Health officials in Rwanda in one of the first years that they used performance budgeting. The budget page uses a format which elaborated on the standard performance budget format being used in Rwanda by adding a column for “gender dimension.” The other columns already existed in the standard format. They were made gender-sensitive by the way the items were specified under each heading.

Reference: Sharp, Rhonda. Budgeting for Equity: Gender budget initiatives within a framework of performance oriented budgeting. New York: UNIFEM, 2003.

MINISTRY OF HEALTH	GENDER DIMENSION	OUTPUTS	ACTIVITIES	INDICATORS
1. Fight against HIV/AIDS	<p>Due to biological reasons, women and girls are more vulnerable to HIV/AIDS than men.</p> <p>Furthermore, in most cases, pregnant women suffering from AIDS transmit the virus to their baby.</p> <p>Current gender relations do not give women and girls a great deal of power to protect themselves against unsafe sexual relations.</p> <p>Sexual violence constantly exerted on little girls exposes these latter to great infection risks.</p>	<ol style="list-style-type: none"> 1. The vertical transmission program is integrated in 10 health facilities; 2. 20 VCT sites are open by December 2003; 3. Support HIV/AIDS research; 4. A surveillance of syphilis cases of pregnant women is conducted every year; 5. A disintegrated national survey on HIV-positive cases linked to HIV/AIDS is undertaken annually; 6. The Laboratory to complete an analysis of the HIV molecular biology, each year. 	<p>The HIV/AIDS prevention program that targets specifically men, women, girls and boys.</p> <p>Undertake a HIV prevalence study at national level.</p> <p>Promote access to female and male condoms.</p> <p>Undertake a syphilis prevalence study.</p> <p>Awareness programs to people at risk such as prostitutes, lorry drivers, military men, etc.</p> <p>Make treatment to men and women available.</p> <p>Take the necessary measures to avoid vertical transmission of HIV</p>	<p>Percentage of infected women and girls, men and boys.</p> <p>Number and percentage of HIV positive women/girls and men/boys who have access to treatment.</p> <p>Number of women/girls and men/boys specifically targeted by HIV/AIDS prevention/awareness</p> <p>Availability and accessibility (affordable price) of the female condom.</p>

MEDIUM TERM EXPENDITURE FRAMEWORK (MTEF)

Performance budgeting is often introduced at the same time as a medium-term expenditure framework (MTEF). The MTEF is a multi-year system of budgeting. The legislature votes only on the coming year's figures, but estimates are provided for a further 2–4 "outer" years. This form of budgeting is intended to help government plan better. It should also provide greater opportunities for legislatures and civil societies to intervene as government's intentions are known in advance, including the delivery targets that they are planning. From a GRB perspective, the MTEF is useful in calculating how much is being planned for programs most important for gender equality. It also allows requesting that targets are sex-disaggregated where appropriate, and that systems are established to collect the data necessary for accurate reporting.

BOX 19: PERFORMANCE BUDGETING IN THE MINISTRY OF POPULATION WELFARE, PAKISTAN

The government of Pakistan is currently moving towards performance budgeting within a medium-term expenditure framework. At the national level, the Ministries of Population Welfare and Health were chosen as pilot ministries. The Ministry of Population Welfare's MTEF for the period 2005–8 had the following high-level indicators for the (national) Ministry and (provincial) Departments of Population Welfare.

Description	Target June 2008	Performance measure		Strategy in brief
		June 05	June 06	
Estimated contraceptive users (millions)	10.757	7.748	8.716	Service delivery expansion and improvement of quality combined with a strong advocacy campaign
Total fertility rate (children per woman)	3.37	3.90	3.73	Service delivery expansion, advocacy and fertility control research activities
Contraceptive prevalence rate	44.9	38.4	40.6	Advocacy, interpersonal communications through community based services and service delivery expansion and improvement
Population growth rate	1.72	1.92	1.83	All above contribute to achieve this objective

In terms of physical targets for service delivery, the MTEF proposed the following:

Interventions	2005–6	2006–07	2007–8
Family Welfare Centres	2,436	2,626	2,803
Reproductive Health Centres	176	218	269
Vasectomy Units	14	18	21
Mobil Service Units	294	298	302
Male Mobilizers	5,280	5,980	6,324
HoHD/PLDs	6,811	6,916	7,011
RMP/Hakeem/Homeo	48,995	49,860	50,935

FRAMEWORKS AND TOOLS

This section gives some examples of different frameworks and tools that have been used in GRB initiatives around the world. It includes illustrations of how they have been used in relation to reproductive health or other issues of interest to UNFPA.

The frameworks and tools should not be seen as “rules” about how one must approach GRB work. Instead, they should be regarded as ideas on which to build. Where appropriate, the different frameworks and tools can be used simultaneously. There are also a range of other tools which are not included here. This section thus emphasises, through examples, the need to use existing frameworks as a starting point and generator of ideas rather than as a blueprint.

SHARP'S THREE-CATEGORY APPROACH

The South Australian women's budget of the 1980s used a three-category format developed by economist Rhonda Sharp, who assisted government in its efforts. The three-category approach was designed to assist government officials with analysis of the budget and as the basis for presentation in the annual budget statements. It was not intended to be the basis for formulation of budgets. These three categories have since been used in several other GRB initiatives. The South Australian government tabled a gender budget statement each year on budget day which divided expenditures into three categories, as follows:

- **Women-specific expenditures:** allocations to programs specifically targeted at groups of women and girls. Examples included aboriginal women's health initiatives, and programs to increase young women's access to non-traditional job training;
- **Equal opportunities in the public service:** allocations targeting existing or prospective civil servants that promote the equal representation of women in management and decision-making, equitable pay and conditions of service. Examples included mentoring programs for women public servants and the review of job descriptions to remove gender bias;
- **General or mainstream expenditures:** all the rest of the allocations not covered in the two categories above. Examples include identifying the users of health services, legal aid and recipients of government contracts.

Later initiatives which used the three-category approach sometimes changed the category “women” to “gender.” The first category could then include, for example, allocations for gender focal points as well as for initiatives to address particular problems faced by male groups.

Some GRB initiatives have focused on the first category because they are the easiest to see and measure. These allocations can be important as a form of “affirmative action” or “positive discrimination” when there are big gaps, disparities and resistances. However, focusing on the first category means focusing on the crumbs while someone else eats the cake.

Some GRB initiatives have re-interpreted the second category to mean the proportion of the salaries and allowances bill which go to women and men. Because a large part of the budget is spent on salaries, especially in sectors such as health, this can seem an important question. It is, however, not the most important question in budget terms as the main objective of the budget should be to deliver services and promote the welfare of the general population, not of the middle class who are candidates for most civil service posts.

Within health, though, there are often questions to be asked about health workers. Elsewhere in this resource pack we look at home- and community-based care work for those affected by HIV/AIDS in Southern African countries, and how the carers who deliver these services are receiving very low or no pay at all. In other countries, too, there are often village health workers, women health workers, or similar posts, often dominated by women. GRB work needs to check whether these workers are being adequately remunerated for the work they do and whether they are working under decent conditions. In many countries there might also be questions of the pay and conditions for the “ordinary” nursing staff. In most countries, nursing is a female-dominated profession. How they are paid is an important policy issue not only in terms of rewarding these workers properly for the work that they do, but also because the current low pay and poor conditions results in many of these workers going to work overseas, leaving ordinary citizens without proper care.

BOX 20: EXPLICIT VS. IMPLICIT GENDER CONTENT

Deciding what is gender-relevant and gender-sensitive and what is not is not always obvious. The UNIFEM-funded GRB research into the plans and budget of Quito Metropolitan District Authority distinguished between programs and projects with “explicit” gender content and those that had “implicit” gender content. In the health sector, the research lists as explicit content, initiatives which aimed at improvements “in terms of urban and rural equity, gender and generational equity, preventive services to protect physical and psychological health.” As implicit gender content, it lists an initiative to encourage the training of midwives and primary health care assistants, especially in rural areas, presumably on the basis that these workers are likely to be female and will be delivering services primarily to women.

Reference: Palán-Tamayo, Z. Gender Analysis of the Budgets, Plans and Programs of the Quito Metropolitan District Municipality. In Gender-Sensitive Budgets in Latin America: Accountability for Equity and Transparency, ed. Andía-Perez et al. UNIFEM, 2004.

www.idrc.ca/uploads/user-S/11281061151Gender-Sensitive_Budgets_in_Latin_America-_Accountability_for_Equity_and_Transparency.pdf.

THE FIVE STEPS OF BUDGET ANALYSIS

The South African GRB initiative developed a simple five-step approach to policy and budget analysis which has since been used in other initiatives. This approach fits well with a performance-oriented approach to budgeting. Step 2 equates to “activities” in budget-speak, step 3 to “inputs,” step 4 to “outputs” and step 5 to “outcomes.” The approach also fits well with a rights-based approach. The five steps are:

1. An analysis of the situation of women, men, girls and boys in a given sector;
2. An assessment of the extent to which sector policy addresses the (gendered) situation described in the first step. This step includes an assessment of legislation, programs and policies. It includes an assessment of both written policy and the implicit policy reflected in government activities. It can include an assessment of the extent to which the legislation, programs, policies and activities meet the socio-economic, women's and other rights which citizens have;
3. An assessment of the adequacy of budget allocations for the implementation of the policy which has been found to be gender-responsive in step 2;
4. Monitoring of whether the money was spent as planned, what was delivered and to whom;
5. An assessment of whether the policy as implemented changed the situation described in the first step in the direction of greater gender equality.

The first two steps had been common in gender work before GRB was introduced. The third, fourth and fifth steps brought the added value of looking at budgets and resources.

BOX 21: ADDRESSING PROBLEMS AT STEP 4 IN MEXICO

Since 2003, the Mexican NGO Fundar has had a project which analyses government spending on HIV/AIDS. When Fundar looked at the 2005 federal budget, they discovered that the government was giving some national hospitals HIV/AIDS funding, even though some of these hospitals did not specialise in treating the epidemic. The organisation therefore decided to monitor how the money was used.

During 2005 Fundar used the IFAI (Federal Institute of Access to Information) to submit more than 200 formal requests for information to the Finance Department, the Federal Health Department, the National AIDS Centre and the National Commission for the Seguro Popular. Fundar asked institutions that received HIV/AIDS funds to explain how they used the resources. The organisation's main purpose was to launch a public campaign to inform those who require HIV/AIDS health services about the availability of additional resources in hospitals.

After analysing the information obtained from the institutions, Fundar realised that the Ministry of Health had allocated some of the HIV/AIDS resources to hospitals that had general operational cutbacks, even though they had no HIV/AIDS component. The hospitals were often not using these funds for HIV/AIDS-related purposes. Three out of seven institutions that received HIV/AIDS resources reclassified their funds for "General Services." So they spent the HIV/AIDS money on financial services, cleaning and security, and maintenance of buildings and vehicles.

Fundar then developed an advocacy strategy for the time when the Finance Ministry tabled the Budget Proposal for 2006. The strategy included work with IFAI as well as with the Internal Comptroller and congressional commissions, as well as with other civil society organisations.

Their advocacy resulted in noticeable increases in allocations for HIV/AIDS. These included an increase of 71 million pesos for HIV/AIDS research and treatment program of the National Institutes of Respiratory Diseases and Cancer. Both these institutes had worked with Fundar and the other organisations explaining their work and how much they needed to deliver adequate services. It also included 100 million pesos for CENSIDA, the National AIDS Centre, to be spent on prevention. In addition to the extra funds, Fundar hopes that their intervention will result in better checks in future that HIV/AIDS allocations are spent for this purpose.

Source: Personal communication, Helena Hofbauer

ANDEAN UNIFEM'S ELABORATION OF STEPS AND QUESTIONS

When groups in countries in the Andean region started doing GRB work at the local level, they adapted the tools that had been used in other countries. They found that they could not use some tools because of lack of the necessary information. With other tools, they felt that there were important gaps that needed to be filled.

In particular, the researchers felt that the standard tools did not cover institutional issues such as the budget process, how budgets are formulated, whether this happens centrally or is decentralised, and what the mechanisms are for implementing public spending. They also wanted to know the extent to which different expenditures were pre-set (for example, because there was already a large staff establishment, or because central government said how money should be used) or had flexibility that would allow re-allocation to gender-related priorities.

With respect to the institutional framework, the researchers suggested the following questions, which can be regarded as a further tool:

- What financial administration systems are there and how are they related to each other?
- What is the budget system's legal framework?
- What type of information does the budget system generate? How is it presented (by items, by programs, etc) and to what level is it disaggregated?
- What are the stages of the budget process?
- How does the process of budget formulation and approval work? (schedule, stakeholders involved, and their jurisdictional areas)
- Does budget formulation include mechanisms for territorial distribution? (For example, does it use poverty indicators?)
- What methodology is used to formulate the budget (by expenditure items, by programs, or otherwise?)
- What mechanisms are there for budget reprogramming? (Once the opening budget is approved, what mechanisms are used to reprogram it?)
- What conditions are required to implement projects with private or outside funding? (for example, whether government counterfunding, and what percentages, are required)
- What state budget control and oversight mechanisms are there?

They also suggested a set of questions to be asked in a situation where government is decentralised. And they suggested questions about civil society participation, and participation of women in particular, in budget formulation, oversight and evaluation.

Reference: Andía-Pérez, B., Beltrán-Barco, A., Coello-Cremades, R., Gutiérrez, M, Palán-Tamayo, Z and Zabalaga-Estrada, C. "Gender-Sensitive Budgets in Latin America: Accountability for Equity and Transparency." United Nations Development Fund for Women, 2004.

www.idrc.ca/uploads/user-S/11281061151Gender-Sensitive_Budgets_in_Latin_America-_Accountability_for_Equity_and_Transparency.pdf.

MEXICAN GUIDE TO FORMULATING HEALTH SECTOR BUDGETS

In 2004 the Mexican Ministry of Health published its *Guide for the Formulation of Gender Sensitive Budgets in the Health Sector*. The guide was a joint effort of the Ministry and two Mexican NGOs: Fundar, a budget analysis organisation, and Equidad de Género: Ciudadanía, Trabajo e Familia, a women's rights organisation. The guide was intended to assist government planners in designing gender-sensitive policies and budgets.

The introduction to the guide is clear that formulating gender-sensitive budgets is not about counting how much money is spent on services for women. Instead, it is about allocating money to activities that eliminate gender barriers to (mainly) women and (some) men accessing health services.

The guide proposes six steps—two in each of three categories—for formulating gender-sensitive budgets:

- Diagnosis 1: Revision of the Health Ministry's diagnosis of the health issue using a gender equality perspective
- Diagnosis 2: Analysis of gender inequalities which are not addressed
- Programming 1: Determination of program components and actions to address the identified inequalities
- Programming 2: Determination of priorities using the gender-sensitive diagnosis of the health issues
- Budgeting 1: Allocation of resources for addressing gender inequalities
- Budgeting 2: Design of indicators to measure and monitor outcomes

The three categories for this framework match very closely the first three steps of the five-step approach. Here, however, the steps are more clearly expressed as things to be done by civil servants when formulating budgets, whereas the five-step approach is intended for analysis as well as formulation of budgets.

The Mexican guide stresses prioritisation of strategies and actions that will have the most impact on gender equality. The guide notes that, especially in the first stages of GRB, this is not about completely reformulating existing programs. Instead, it is about incrementally incorporating gender equality criteria within each step and over time so that subsequent steps take gender into account. The guide suggests several questions for assisting with the incorporation of gender into what already exists. These include:

- In which of the existing headings can funds for actions directed towards achieving gender equality be included?
- In which of the established components of budgeting can new headings (or sub-programs) be included for allocating resources for gender equality?
- Is it necessary to allocate resources to create data (in existing or new information systems) that reflect possible gender inequalities that affect health in the aspects covered by the program?
- Do some resources need to be directed to particular groups to address their specific needs?

Reference: Fragoso, L.P., and Granados, R.L.R.. *Guide for the Formulation of Public Budgets in the Health Sector using a Gender Perspective*. Mexico City: Ministry of Health, 2004.

CATEGORISATION FOR GENDER ANALYSIS OF HIV/AIDS PROGRAMS

In 2002, a World Health Organisation consultation proposed a framework for gender analysis of HIV/AIDS-related activities. The framework does not refer directly to budgets, but could nevertheless be useful for GRB analysis.

The framework suggests that there is a continuum of approaches to addressing gender in HIV/AIDS programs. These range from gender-harmful to gender-empowering, as follows:

- interventions that cause harm by strengthening gender stereotypes that directly or indirectly fuel the epidemic;
- gender-sensitive interventions that recognise that male and female needs often differ and find ways to meet those needs differently;
- gender-transformative interventions that address gender differences but also go further by creating the conditions in which women and men can try out new behaviours to create more equitable roles and relationships;
- structural and transformative interventions that go beyond health interventions to empower women and girls and so change the economic and social dynamic of gender roles and relationships.

The WHO publication which presents this framework recognises that “in every society there are many kinds of masculinity and femininity that vary by social class, ethnicity, sexuality and age.” The report points out the possible damage done by designing interventions which treat women and men in exactly the same way, and ignore the differences in their situation, needs and responsibilities.

Reference: World Health Organisation. Integrating Gender into HIV/AIDS Programs: A Review Paper. Geneva: WHO, 2003.

SOME PROPOSED TOOLS FOR GRB ANALYSIS

Diane Elson's six tools

In the mid-1990s the Commonwealth Secretariat commissioned Diane Elson to develop “tools” for GRB analysis. Elson's study of the literature allowed her to come up with the following six ideas for tools:

A **gender-aware policy appraisal** involves an assessment of the budget and related policy and practice. The appraisal is usually focused on a particular sector. It involves both qualitative and quantitative analysis. This tool is commonly used by civil society groups. It can also be used by government, for example when reporting on CEDAW. It is a good tool to use near the beginning of a GRB initiative as it gives the overall “picture” of the sector.

BOX 22: GENDER AND HEALTH BIASES IN MOROCCO'S HEALTH EXPENDITURES

Morocco's Rapport Economique et Financier for the budget year 2006 for the first time included a full chapter on gender. In the discussion on the Ministry of Health, the chapter describes an incidence analysis of public health. Overall, the study found that women get an average of 114 dirhams of benefit from infrastructural investment while men get a benefit of 93 dirhams. However, apart from primary health care, the poorest women benefit less from health service expenditures than men. For example, the poorest women benefited from only 7% of the hospital expenditures reaching women while the poorest men benefited from 12–13% of the hospital expenditures reaching men. Overall, the poorest fifth of women received only 11% of all health expenditures reaching women while the richest fifth received 40%.

Beneficiary assessment is a way of hearing the voices of citizens (and non-citizens) about government delivery. Ideally the assessment should include potential beneficiaries as well as actual beneficiaries to learn why some people are not accessing services. The assessment can focus on particular services, or can ask citizens about the services that they think are important. The assessment can use both qualitative and quantitative methods. Government and civil society can use this tool.

Gender-disaggregated public expenditure incidence analysis involves quantitative analysis which multiplies the unit cost of providing a particular service by the number of units delivered to male and female beneficiaries. More sophisticated analysis combines gender with other variables, such as expenditure quintiles. This approach is difficult to do with respect to services that are not delivered to individuals, such as electricity or water. It also depends on having data available on use of services, for example from a household survey. This analysis is usually done by research groups or the World Bank.

Analysis of impact of the budget on time use asks how the budget and the services it pays for affect how women and men, girls and boys spend their time. Accurate estimates of impact require time use data. If time use data are not available, a less accurate assessment can be done on the basis of logical analysis. This analysis will usually be done within civil society but should also be done by government.

Through the term **gender-aware medium-term economic policy framework**, Elson was referring to two sub-tools. The first sub-tool involves inserting gender elements into the macroeconomic models which many countries use to determine what resources are available at the beginning of the budget cycle, and to determine what the economic impact will be at the overall, industry, household and individual levels of different macroeconomic policies. Gender can be inserted by disaggregating the labour supply variables in the model. If time use data are available, the model can also be amended to include the unpaid care economy. Macroeconomic models are usually housed with government or its related agencies. The second tool involves a gender-aware medium-term economic framework, i.e. a multi-year budgeting approach which takes gender considerations into account. Because the introduction of a mid-term budget framework (MTBF) usually happens alongside the introduction of performance budgeting, an important aspect of using this sub-tool involves developing output and outcome indicators that are gender-sensitive.

Gender-responsive budget statements are usually developed by government for tabling on budget day. The statements are an accountability tool through which government can show parliamentarians and civil society what it is doing to promote gender equality. The budget statement can use information from many of the other tools. The statement is most likely to be institutionalised if there is a set format. This is easiest to do when government is using performance budgeting.

Other tools which are being used for GRB

Elson intended her tools as ideas to get GRB started in different countries. Others have developed further ways of looking at budgets from a gender perspective. **Costing** is a quantitative approach that attempts to get an estimate of what a particular policy or program does or should cost. This estimate can then be compared against what government is actually spending on a particular problem or service. The use of costing with respect to MDGs is discussed elsewhere in this resource pack. Here we give an example of a more specific costing of providing interdicts under South Africa's Domestic Violence Act.

BOX 23: COSTING THE IMPLEMENTATION OF SOUTH AFRICA'S DOMESTIC VIOLENCE ACT

In 1999 the South African parliament passed the Domestic Violence Act (DVA). The most important protection provided by the Act is the interdict which an abused person can get against the abuser. In early 2005 the Centre for the Study of Violence and Reconciliation (CSVR) did research at nine courts and police stations in three provinces to find out how much time (and thus government money) was being spent on issuing interdicts. CSVR interviewed clerks of the court, magistrates, prosecutors and police officers about the activities they do to implement the DVA, and how long each activity takes. The main activities covered were:

- Clerks of the court usually assist applicants to complete the forms. Sometimes police officers also help women with their applications for protection orders.
- The magistrate decides whether to grant an interim protection order.
- On the return date, the magistrate holds a hearing if both parties are present, and decides whether to grant a final order.
- A sheriff or the police serve the order on the respondent and applicant. The applicant usually pays the sheriff's fees unless she can prove she is very poor.
- Police arrest and charge men reported for breaching the protection order.
- Magistrates and prosecutors play roles when men appear in court for breaching the order.

To calculate what it costs government to implement the DVA, CSVR multiplied the average time taken for each activity by the percentage of cases to which it applied and by the cost of the staff involved. The amount came to R245,03 per case. This only covers the staff costs. It does not cover costs such as stationery, rental, and support staff. It also uses the salary of the lowest possible level of staff for each activity.

Together courts and police at the nine sites must have spent about R6,4m processing nearly 26 000 applications for protection orders in 2004. Government records show that 114 142 protection orders were granted in South Africa between March 2004 and February 2005. This must have cost government about R28m for court and police services. But it was still much too little to achieve the DVA's goal of eliminating domestic violence in the country.

CSVR has taken the results of the research to the different agencies responsible for implementing the DVA and also to Treasury. All have expressed interest in working further with the organisation to draw up guidelines to ensure proper implementation of the Act and adequate budgets to achieve this.

Reference: Vetten, L., Budlender, D. & Schneider, V. "The Price of Protection: Costing the implementation of the Domestic Violence Act." Centre for the Study of Violence and Reconciliation Gender Program, Policy Brief No 02. (2005).

The **community-based monitoring system** (CBMS) is a form of local-level monitoring of community and household welfare that was developed in response to the need for a regular source of up-to-date information at the local level. The system has been developed with financial and technical support from the International Development Research Centre (IDRC) and had by 2005 been implemented in 14 countries. In most of these countries government is the main role-player, but usually there is some form of community involvement as well. In late 2004 UNIFEM and IDRC brought their partners together to discuss how CBMS could be used to facilitate GRB at the local level. The ideas developed through these conversations are being piloted in Senegal and Philippines.

Although the method and instruments differ to some extent across countries, in all countries the main CBMS tools are household- and community-level questionnaires. One of the tasks in the CBMS-GRB pilots is thus to see how these instruments can be adapted (a) to make them more gender-sensitive and (b) so that they provide information relevant for planning and budgeting.

The following examples show some of the ways in which the Senegal household questionnaire has been changed. In terms of health, the questionnaire included questions about individuals' use of health services. A question has been added asking which individuals *accompanied others* when they sought health assistance. This is a gender issue because this is usually a women's task. An option for *reproductive ailments* has been added for the question on the reasons for seeking health care. An option for *care received from others at home* has been added for the question asking why the person, although ill, did not visit health facilities. The section on migration has been changed to cover *internal as well as international migration*. This should make the questionnaire more gender-sensitive as generally, because of social and other factors, Senegalese women are probably less likely than Senegalese men to migrate outside the country. The questions on work have been rephrased to include prompts that are more likely to capture the *informal and non-standard types of work* that women generally do. For children whose mother and father are not living with in the household, the questionnaire now distinguishes between the case where the *parent is living elsewhere* and *the case where the parent is deceased*. The patterns for this are likely to be different for mothers and fathers. In one area of Senegal, a *time use module* has also been added to the CBMS.

Reference: Budlender, D., Reyes, C. & Melesse, M. . "Gender-Responsive Budgeting through the CBMS Lens: Implementing the Community-Based Monitoring System in a way that facilitates gender-responsive budgeting." Poverty and Economic Policy research network (2005). www.pep-net.org.

CALL CIRCULARS AND GENDER-RESPONSIVE BUDGET SUBMISSIONS

Many of the tools described above involve gendered analysis of budget. Such analysis underlies most GRB work in some ways. Ultimately, however, one needs to move beyond analysis and influence budgets. For this, **call circulars and gender-responsive budget submissions** constitute two important tools. Call circulars are the official notices that are issued by the Ministry of Finance or its equivalent near the beginning of each budget cycle. This call circular goes to all spending agencies (ministries, departments, other government-funded institutions). The circular usually tells each agency what its budget “ceiling” for the next year is, i.e. how much the Ministry of Finance is planning to allocate to that agency. The circular also gives a range of other instructions to the agencies about how they should construct and format the draft budget for the coming year and how they should present the motivations for this budget. The agencies then use this format to draw up their budget submissions which are inspected by, and negotiated with, the Ministry of Finance after submission and before going to Cabinet.

The format of budget submissions differs widely across countries. Some submissions consist mainly of tables of numbers. Others—especially where countries are moving towards performance budgeting—include a lot of narrative. These documents are generally not public; they are internal working documents of government. However, if the call circular states that gender should be reflected in the submissions, and will be considered an important criterion during negotiations, this can be an important incentive for agencies to budget in a gender-sensitive way. And the more clearly the call circular specifies how gender should be specified, the more likely it is that agencies will consider the issue carefully and specify in a clear way what they intend to do.

Several countries have now taken the step of mentioning gender in their call circular. Some ask only for agencies to specify women-oriented schemes. Others say simply that “gender should be considered.” Ideally, any call circular that mentions gender needs to have accompanying documentation and capacity building to assist agency officials to “follow the gender instruction.”

ACTORS, ACTIVITIES AND FOCUS

This section discusses the different role-players who could be involved in GRB-related activities and presents some of the options in terms of the focus of budget work. While other sections talk about focus in terms of the issue, this section discusses focus in terms of scope (sectors, level of government, etc) as well as in terms of activities (research, advocacy, etc). Finally, the section points to the typical stages of the budget cycle and suggests possible interventions for different stages, in particular for civil society.

ACTORS AND ACTIVITIES

The ultimate aim of GRB is that a country has and implements budgets and programs that take into account the needs of men and women, girls and boys. At this point, no country has a perfectly gender-responsive budget, but GRB has helped some countries develop budgets that are more sensitive than they used to be, at least in some aspects.

In order to achieve the ultimate goal, GRB work involves a range of different strategies, tools and activities. Some of these activities involve different forms of *analysis* which unpack the extent to which the budget and programs are currently gender-responsive. Analysis can be done from outside government, by researchers, academics and civil society organisations. It should also ideally be done by parliamentarians and by government officials responsible for drawing up budgets.

Some of the GRB activities involve *setting up systems and processes* that help reveal to what extent programs and budgets are gender-responsive and thus assist those who want to move in the direction of gender equality. Civil society can advocate for systems and processes that are gender-responsive, but ultimately it is government and parliament that set them up.

For example, a gender budget statement is an *accountability document* produced by government to show what its programs and budgets are doing with respect to gender. Having a gender budget statement does not, by itself, mean that government has a GRB. But in the process of drawing up a gender budget statement, government officials may realise the gaps in what they are doing. Further, when parliamentarians and the public read the gender budget statement, they will be able to see both the strengths and weaknesses and take action such as advocacy to try to address the weaknesses.

Because GRB initiatives have different aims, they can include a range of different activities. Most GRB initiatives do not include all activities, although an initiative will usually need to include more than one activity if it is to be successful. Common activities of GRB initiatives include:

- Research: Usually conducted from outside government, as the basis for advocacy;
- Advocacy: Usually conducted from outside government, but players inside government and parliament might also need to advocate for GRB;

- **Monitoring:** This is a key role of parliament, but government itself should monitor as part of its management function, while civil society will want to monitor budget implementation;
- **Training:** Training can involve all role-players, but should usually do so in separate workshops because of the different knowledge and functions of different actors;
- **Awareness-raising:** Usually targeted to those who are not expected to play a key role, but whose support is needed. Targets could thus include the public (to get support for advocacy demands) and top government officials (to get buy-in for GRB activity within their agencies);
- **Policy analysis and design:** This is government's role. GRB is a form of policy analysis, and one of the aims of most GRB initiatives is to have government institutionalise GRB in their daily and annual budget-related activities.

As illustrated by the above list, GRB actors can include government, parliament, civil society, academia and international players such as donors and the IFIs. Within each of these categories, there are further sub-categories. For example, within government, GRB initiatives can involve the Ministry of Finance, gender/women's ministries and line ministries. Within line ministries, they can involve the top decision-makers, the budget officials, the middle-level policy makers, and gender focal points.

Who is involved in a particular country will depend, among other factors, on who initiates the GRB, what their aims are, what the main gender issues in the country are, the strengths and weaknesses of different constituencies in the country, the political and gender stance of different constituencies, and the existing development initiatives. Finding the right people, and assisting them where necessary to gain the necessary expertise, would fit in with the broader goal of UN agencies and others of increasing country ownership of the development process.

BOX 24: CHOOSING WHO SHOULD DO THE RESEARCH

The publication which brings together analysis of GRB work in several Andean countries reflects on the strengths and weaknesses of using different actors as researchers. They found that although external consultants produced high-quality documents, there were limitations on the sustainability and political impact of the work because government and civil society organisations might see the research as coming from "outside." Research by NGOs was sometimes less "expert" in terms of quality, but was more likely to be sustainable as NGOs tended to continue to work on the issues after funding stopped. In Cuenca, where a municipal official was one of the researchers, the project had greater access to information. However, the official had limited time to devote to the project because of her other responsibilities.

Reference: Andía-Pérez, B., Beltrán-Barco, A., Coello-Cremades, R., Gutiérrez, M, Palán-Tamayo, Z and Zabalaga-Estrada, C. "Gender-Sensitive Budgets in Latin America: Accountability for Equity and Transparency." United Nations Development Fund for Women, 2004

www.idrc.ca/uploads/user-S/11281061151Gender-Sensitive_Budgets_in_Latin_America_Accountability_for_Equity_and_Transparency.pdf

BOX 25: PUBLIC REPRESENTATIVES ARE NOT ALWAYS IN FAVOUR OF TRANSPARENCY

Mazdoor Kisan Shakti Sangathan (MKSS) is an organisation of peasants and workers based in Central Rajasthan, the largest state in India. One of MKSS's strategies is to organise public hearings in which residents discuss development funds spent in government-sponsored projects in their communities. Before the hearing, MKSS gathers and collates information, and then, through volunteers, takes the information house to house to share it and to check that it matches with what villagers know. After each hearing, MKSS prepares a formal report which it sends to senior state government officials, the media, and other groups engaged in the campaign.

Despite the fact that they are supposed to represent citizens, the elected representatives in Central Rajasthan are not always happy about MKSS's work. In 2002, 300 elected village representatives demonstrated in front of the state legislature demanding that the law on the right to information be overturned. They said that citizens were using the law to "harass" them.

But the state government supports what MKSS is doing. It has introduced a requirement that village-level public hearings be held every year. As part of these hearings, village residents vote on a resolution to verify whether the development projects in their village have been successfully completed.

Reference: Ramkumar, V. Case Study, Part 2: The Right to Know Movement in India. Making Change Happen series. Just Associates, 2002.

<http://www.justassociates.org/MKSS%20Case%20Study%20Section%20II.pdf>

THE FOCUS OF GRB WORK

In addition to different actors and activities, GRB initiatives can have different foci. Some focus on the budget process, and who participates at different phases. Others consider the budget process in terms of what activities are most appropriate at each stage, but do not see participation as their main concern. Some GRB initiatives focus on the national budget, while others look at the budgets of sub-national levels. Some look at the full budget at a particular level, while others focus on a particular sector (such as health), or a particular issues (such as HIV/AIDS or GBV) which may involve parts of the budget of several different agencies.

When focusing on a sector, some GRB initiatives examine the full budget of the sector. Others choose a few programs to focus on. For example, in Rwanda the GRB initiative looked at four ministries. Within each ministry, the government officials identified the six sub-programs that were allocated the largest amount of money and analysed these from a gender perspective. This approach was chosen to ensure that the GRB work focused on where the main money was going rather than doing a lot of analysis of a few "crumbs" that might be being allocated for a gender project.

The main focus of GRB work is government budgets. However, especially in a sector such as health, it is important to understand the role of non-government providers. These might include private for-profit providers as well as non-profits. Aspects to be investigated include the relative range and quality of services provided by different actors, who uses different services, what subsidies are provided by government to different providers for different services, in what ways government regulates other providers, and user fees for different providers and services.

BOX 26: DECISION-MAKING IN A DECENTRALISED SYSTEM

In 2000 the South African Women's Budget Initiative commissioned a paper which looked at how national, provincial and local governments relate to each other in policy making, budgeting and implementation of new policies in relation to health. The paper was written six years after the end of apartheid, when there were many changes still happening both in terms of policies and in terms of the structure of government. The paper noted that most of the changes were implemented through structures that operated in a top-down way. This has a gender dimension because the people "below" in the structure are mainly women, while men are clustered at the top level.

The paper looks at relationships and power both within the health services and between service providers and users. It asks who makes decisions, particularly about financial resources. It asks whether there is transparency in decision-making; whether people at all levels are valued, and whether their experience and knowledge is taken into account.

Reference: Klugman, B & McIntyre, D. 2000. From Policy, through Budgets, to Implementation: Delivering quality health care services. Cape Town: Women's Budget Initiative.

THE BUDGET CYCLE AND OPPORTUNITIES FOR INTERVENTION

Why understanding the budget cycle is important

Budgets are political tools. A range of players are involved in the process of drawing them up, and each of the players will promote his or her own agenda. One of the aims of many GRB initiatives is to promote greater participation in the budget process, especially by ordinary people living in the country as well as by parliamentarians, particularly women parliamentarians. Greater participation by (women) parliamentarians, reproductive health and other gender-aware groups could help in raising gender issues at an early stage.

For initiatives that are interested in increasing participation, it is essential to understand the existing budget process and to explore opportunities for greater participation. Examining the budget process (or "cycle") is also useful for GRB initiatives with other objectives, to see where opportunities exist for intervention, and to avoid leaving the intervention until it is too late and the only option available is critique.

Descriptions of the budget cycle tend to differ according to who is describing it. For example, the Ministry of Finance will usually describe a process where they are the central player but may not mention some other players who can or do play an important role. The particular actors will differ across countries. For example, in some countries the World Bank and International Monetary Fund play powerful roles, even if they are not shown in descriptions of the formal budget process.

Standard steps of the national budget process

The time when the budget is tabled in parliament is the part of the process that is most public. However, this tabling constitutes only one stage in the budget process. In all countries the national level budget process will include the following stages:

- Estimation by the Ministry of Finance of the available revenue for the coming year. Available revenue is based on the macroeconomic situation of the country and what the country can obtain in revenue from taxes, grants, loans and other sources. The available revenue, together with a decision on the budget deficit, sets the “ceiling” of money available for expenditure.
- Sending out by the Ministry of Finance of a “call circular” to all agencies (e.g. ministries and other public institutions), asking them to submit budget proposals for the next year. The call circular will often indicate a budget “ceiling” for each of the agencies. In some cases separate call circulars will be sent out for the recurrent and development budgets, with the Ministry of Finance usually taking the lead for recurrent expenditure and the Planning Commission or similar body taking the lead for the development budget.
- Preparation of budget proposals by the agencies, and negotiations with the Ministry of Finance (and perhaps Planning Commission or equivalent agency) about these.
- Review by Cabinet of the consolidated proposal prepared by the Ministry of Finance (and perhaps Planning Commission).
- Tabling and discussion of the budget in parliament, followed by passing of the Budget Act.
- Implementation of the programs and projects by government agencies, using the allocated funds.
- Auditing of expenditure by the Auditor-General.

Opportunities for participation

Most budget processes provide very limited opportunities for participation. Even line ministry officials often feel they have little room for manoeuvre. They point out that they are given a budget “ceiling” by the Ministry of Finance and it is very difficult to shift this. They point out that a large percentage of this amount will be needed to cover the salaries of existing civil servants, so there is very little “discretionary” money left to move around. This is especially true of the recurrent budget.

Parliamentarians usually also feel they have little opportunity to influence budgets. Often, the first time they see the budget is on budget day. There is then very little time to debate the budget before the next budget year begins. In many countries there are limits on the type of changes that parliaments can make. In some countries they must either accept the budget as it is tabled, or reject it totally. Few governments want to reject a budget totally as this will mean the end of that government! In other countries, parliamentarians can make changes, but only if the changes do not change total expenditure, or do not change expenditure distribution between Ministries.

For civil society, there are usually even fewer opportunities. Sometimes civil society can make presentations at parliamentary budget hearings. In a few countries, the Ministry of Finance consults with particular interest groups when the budget is being drawn up. However, usually these are interest groups that represent business or other powerful interest groups rather than ordinary people.

Examples of civil society engagement in the budget process

Nevertheless, there are possibilities for engagement that already exist in some countries and can be fought for in others. These include:

- In Uganda and Kenya, the government has established sector working groups for the different ministries. These groups include representatives from civil society, including women's groups. The groups meet with ministry officials to discuss what policies and programs should be budgeted for before the line ministry submits its proposal to the Ministry of Finance.
- In some countries, each portfolio committee in parliament has hearings on the relevant ministry's budget to which it invites interested stakeholders to comment on the budget. There is also sometimes provision for written submissions, whether spontaneous or by invitation.
- In some countries, the Ministry of Finance tables its broad fiscal framework in parliament several months before the end of the budget year. This framework shows the broad shape of the budget planned for the next year—or even for several years if the government has a medium-term expenditure framework (MTEF). This early tabling allows parliamentarians and members of civil society to start advocacy early. If there is an MTEF, advocacy can focus on what should be changed in the following years' budgets.
- In countries such as Uganda, India, Brazil and Malawi, civil society groups and ordinary citizens have found ways of monitoring how money is spent, for example through holding public hearings at which government officials are called to account, conducting surveys of facilities, and organising local monitoring committees.

The last example, in particular, shows that civil society does not need to wait to be invited in. It also should not be despondent if the official system does not provide for formal ways of engaging in the process. If civil society is effective in raising good points from outside the official process, its ideas might well be taken up by those who have a place in the official system. The effectiveness will depend in part on how civil society frames the messages for different target audiences. Effectiveness also requires that civil society's actions happen at the appropriate time in the budget process, when the targeted actors are mostly likely to be thinking about the issues and have the most opportunity to insert civil society views.

THE REVENUE SIDE

This section looks at the revenue side of the budget. Revenue has not been the focus of GRB work as often as expenditure, especially in developing countries. However, the section points to a range of aspects of the revenue side of the budget that require attention if we are interested in achieving gender-responsive budgets in the area of reproductive health. The section begins with a brief description of the main sources of health financing. This is followed by a discussion of user fees, which are commonly introduced as part of health sector reforms. The next sub-sections discuss different aspects of donor funding, as this is usually a major source of health financing in developing countries. The final part on intergovernmental fiscal relations talks about issues related to the flow of money between different levels of government. This topic is especially important in countries where health services are being decentralised.

HEALTH FINANCING

There are a range of issues related to “health financing,” or how revenue is raised to meet the costs of health care services. The Rights and Reforms project on health sector reform investigated these issues in Asia, Africa and Latin America. They identified the following as the main mechanisms for financing the health sector: tax revenue, social health insurance, user fees, private (for-profit) health insurance, and community funds. Tax revenue and social health insurance are “public” sources of financing, while the others are private sources of financing. To complicate matters, there can be private financing (e.g. user fees) for public sector health provision, and public financing (e.g. social insurance) for private sector health provision.

Tax revenue can be collected through direct taxes on income of individuals or companies, or through indirect taxes such as sales tax (including value-added tax [VAT]), payroll taxes, import duties and export levies. In developing countries, indirect taxes are usually a far more important source of revenue than direct taxes because there are not enough people with enough money to pay tax. In some countries a proportion of revenue from particular taxes, such as those on cigarettes and alcohol, may be “ring-fenced” for the health sector. Because men are more likely than women to use cigarettes and alcohol, this can constitute an implicit transfer from men to women.

Social health insurance usually happens in the form of a public fund set up by the government. In the mid-1990s, eight sub-Saharan African countries had some form of social health insurance and five were considering it. Membership is usually compulsory for all people with formal employment, with contributions from both employers and the worker concerned. The amount of payment is usually based on the amount earned by the worker, but the benefits are the same for everybody. This results in a cross-subsidy of lower-paid workers by higher-paid workers. However, because women are less likely than men to be formally employed, they are less likely to benefit from social health insurance. Some women are covered as dependants of employed men who are members. However, in countries such as Senegal, a married man cannot be covered as the dependant of his employed wife. In Algeria, the husband can be covered, but not the children. In a few countries, informal sector workers can choose to be part of the fund.

User fees are almost always found in the private sector, although sometimes they can be paid through insurance or other funds. User fees are also sometimes charged for government services, although usually in this case they do not cover the full cost of providing the service. Governments usually describe this as “cost sharing.” User fees are likely to discourage people—and especially poor people—from using services. This will happen especially with preventive services, where there is not such an obvious immediate need for services. So, for example, women might avoid going for antenatal checkups if there are charges for these checkups.

Where user fees are charged for government services, there is sometimes an exception scheme for particular groups of people. These exemptions schemes often do not work effectively. Firstly, those who are eligible often do not know the rules and so do not claim their rights. Secondly, providers sometimes try to give as few exemptions as possible. This happens, in particular, if the health facility can keep all the money it gets from user fees.

Private for-profit insurance schemes such as medical aid schemes require payments by the individual, or sometimes by the individual and his or her employer, to buy the insurance. Some of these schemes cover all types of health services, while others cover only certain kinds, or only a certain percentage. Some exclude certain costs, for example contraception. Private insurance schemes sometimes don't allow people with particular conditions, such as HIV/AIDS, to join their scheme, or charge them higher fees than other members.

Community funds have household-based membership, where households pay a fixed amount each month which then gives household members access to a range of health services. Some funds are organised by government and some by non-profit organisations. Often the poorest households in a community are not members of the fund because they cannot afford the membership fees, even if they are very low.

Donor funding is another very important source of revenue for many developing countries. This source of funding needs to be examined even if the main interest is how government is using its own money. Aid is fungible, meaning that a dollar or shilling or peso spent for one purpose looks exactly the same as a dollar, shilling or peso spent for another purpose. So an increase in donor contributions to health could allow government to allocate less of its own revenue to health. Similarly, where donors give money specifically for gender equality purposes, this could result in government giving less for this purpose. If the funds “saved” through donor spending in a particular area are used productively in another sector, such fungibility is not necessarily a problem. The key question is what will happen when the donor money is no longer available.

An examination of donor funding is also important because of the influence that donors and the international financial institutions have not only over how their own funds are used, but also on how governments spend more generally.

References: Ravindran, T.K. Health financing reforms in Asia and the impact on reproductive and sexual health services. Paper prepared for the Initiative for Sexual and Reproductive Rights in Health Reforms, Women's Health Project, South Africa, 2003.

Mackintosh, M & Tibandebage, P. Forthcoming. Gender and Health Sector Reform: Analytical perspectives on African Experience. In Gender and Social Policy in a Development Context: Mothers, workers and citizens, ed. S. Razavi and S. Hassim. Basingstoke: Palgrave.

USER FEES

User fees for government services shift these services from being defined as a public good and right to being a commodity.

Those in favour of user fees say that they generate more money for the health sector, which allows more and better services to be provided. They say that poor people can be exempted, so that it does not burden them unduly. Advocates of user fees also say that charging fees will discourage people from using health services when it is not necessary, and so avoid overburdening the services and thus result in resources being available for services that are really needed.

Those against user fees point out that user fees usually generate only a very small proportion of money. They argue that the effort spent on collecting this money, and the negative impacts it can have, are not worth it. User fees can be particularly harmful for women because they are less likely than men to have control over how household money is spent. Exemptions are of limited use because they are usually not well advertised, and providers generally make it very difficult for people to get exemptions.

Some exemptions are based on income, i.e. they are “means” tests. In countries such as Tanzania, illnesses such as HIV/AIDS and TB can be treated free, no matter how rich or poor the person is. In many countries, young children and babies, pregnant women, and breastfeeding mothers get free services. But other types of reproductive health services such as contraception are often not exempt.

BOX 27: EVIDENCE ON THE IMPACT OF USER FEES FOR HEALTH SERVICES IN AFRICA

- In Kenya, the introduction of a small fee for outpatient visits to a health centre resulted in a 52% reduction in outpatient visits. When the fee was lifted, visits increased by 41%.
- In Tanzania, attendance at three public district hospitals dropped by 53% after user fees were introduced.
- In Nigeria, maternal deaths increased by 56% and hospital deliveries fell by 46% after user fees were introduced.

In Tanzania, research by Duke University found that more people were tested, more became aware of their HIV status, and more became involved in prevention efforts when HIV screening tests were available free. The University conducted an experiment together with the women's NGO KIWAKKUKI, in which they offered free HIV tests instead of beneficiaries having to pay the standard fee of 1,000 Tanzania shillings. During the experiment, the number of people coming to the clinic to be tested increased from four to 15 per day. After doing this experiment, they used the results to advocate for funding to allow KIWAKKUKI to continue to offer free testing.

Reference: <http://usinfo.state.gov/xarchives/display.html?p=washfile-english&y=2006&m=January&x=20060131131831cmretrop0.3781549&t=livefeeds/wf-latest.html>

During the 1990s, the World Bank moved towards supporting the elimination of user fees for basic education, but continued to advocate for user fees for health services. Towards the end of 2000, the World Bank announced that it would no longer promote user fees for basic health care.

Reference: Braam, T. The impact of health sector financing reforms on sexual and reproductive health services in Africa. Paper prepared for Rights and Reforms, 2005. www.wits.ac.za/whp/rightsandreforms

DONOR FUNDING

UNFPA's MYFF notes that the ICPD Program of Action estimated that \$18.5 billion would be needed in the year 2005 to implement specified basic programs in reproductive health as well as collection and analysis of basic data. Even more than this would be needed to strengthen health systems, emergency obstetric care and HIV/AIDS treatment and care. The ICPD Program of Action estimated that at least one-third of this amount, or \$6.1 billion in 2005, would need to come from external sources.

UNFPA's MYFF notes that the organisation will need to focus on how reproductive health and related issues can be built into the main approaches used by the major donors if the ICPD agenda is to be realised. These approaches include PRSPs, MDGs, as well as the sector wide approach (SWAp) to funding.

This observation in the MYFF is important because over the years donor funding has increasingly moved away from project funding to other **modalities**. Currently, the main modalities are:

- **Sector-wide approach (SWAp)**, which involves the development of a comprehensive sector policy, strategy, and expenditure framework, and management, planning and reporting framework. Donors participate in the elaboration of the policy, strategies and framework and put their money into the “pool” that will be used to fund it;
- **Common pool or common basket funds** which involve different donors contributing to a common account which is reserved for particular purposes, usually within a particular sector. The use of the funds is agreed between government and the contributing donors;
- **Direct budget support** which involves donors contributing towards a government program such as poverty reduction, fiscal adjustment, reform of the budgetary process or a particular sector reform. The difference between this and other forms of donor support is that the money becomes part of general government funds, and is managed through the general budget systems.

SWAps are a way for donors to ensure that their money is spent on health where they are not confident that health will be adequately prioritised in the use of money from general budget support. In 2005, UNFPA was participating in SWAps in 27 countries, and in pooled funding in seven countries.

The September 2005 World Summit at the United Nations endorsed the **Paris Declaration on Aid Effectiveness** which called on donors to increase the amount of aid. The declaration also set out four principles for a new approach to aid, namely (a) country ownership, (b) alignment of aid with country plans and budgets, (c) harmonisation of donor actions with those of other donors, and (d) mutual accountability of donors and recipient countries. While there are many positive aspects to these principles, the approach has a hidden danger with respect to gender in that alignment with a country's own budgets will mean that donors cannot help to compensate for weaknesses in the way the country itself addresses gender issues as easily as they could in the past.

Donor funding often comes together with **conditionalities**. The form of the conditionality depends to some extent on the modality. For example, where loans or general budget support are provided, the conditionality might be that the fiscal deficit (the difference between expenditure and revenue) must be reduced, or that a certain percentage of public expenditure must be allocated to the social sectors. Conditionalities which say nothing specific about health services may, nevertheless, have an impact. For example, reduction of the deficit may be achieved through making less money available for the delivery of health services, or through charging user fees. Where sectoral support is provided by donors, they

might stipulate that a certain proportion of the government's own revenue must be allocated to that sector, or that user fees must be imposed, or that certain institutions or services must be privatised. The implications of these conditionalities are often easier to see than those for general budget support.

References: Paris Declaration on Aid Effectiveness.

<http://www.aidharmonization.org/ah-wh/secondary-pages/Paris2005#declaration>

UNIFEM. Promoting Gender Equality in New Aid Modalities and Partnerships. UNIFEM, March 2006

http://unifem.org/resources/item_detail.php?ProductID=64

SECTOR WIDE APPROACH

SWApS are a way for donors to ensure that their money is spent on health where they are not confident that health will be adequately prioritised in the use of money from general budget support. SWApS are also meant to improve financial management, improve efficiency and reduce duplication, and reduce bureaucracy and reporting requirements. Because there is a single coordinated strategy, outcomes should also be better.

The sector program that is funded is usually drawn up by the Ministry of Health in combination with donors, and perhaps other stakeholders, such as people and groups in the country. One of the weaknesses of some health sector SWApS is that NGOs are not involved, despite the key role that they play in the delivery of health services. Usually one of the donors is regarded as the “lead” for a particular SWAp. UNFPA has led several of the health sector SWApS.

SWApS provide several opportunities for UNFPA and RH and gender advocates:

- There is the potential to influence the national approach to RH and gender, rather than the approach of a single project;
- There is the possibility to increase the visibility of RH and gender issues among health sector officials and donors;
- There is the opportunity to address the system-wide issues that hamper progress in achieving reproductive health for all; and
- There is the opportunity to secure funding for particular budget line items, such as contraceptives.

However, SWApS also have their challenges. The first involves the extent to which donors buy into the idea. There are almost always some donors—most often USAID and Japan International Cooperation Agency—who refuse to become part of the SWAp and continue to fund the programs and projects that they choose. Even donors who contribute to SWApS often have funds going through other “modalities” in the same sector simultaneously. To extend the metaphor, they are not putting all their eggs in one basket. A further problem is that often significant amounts of the SWAp money are not disbursed through the government system. Such off-budget funding seems to contradict the idea of a coordinated plan.

There are often “transition” problems as countries shift from vertical (project) funding to pooled funding. These problems tend to affect vertical programs that deal with diseases such as TB, malaria and HIV/AIDS, and will most likely affect the poor more than the rich. Overall, though, donors are generally happy with the shift to SWApS. Governments can be more ambivalent. In particular, SWApS tend to give donors even more power than before, in that they can now influence the total sector program rather than only some parts of it.

Finally, SWAPs may present challenges when trying to address cross-sectoral issues, such as violence against women, because they focus only on one sector. This can be a serious weakness given that gender issues often span several sectors.

Some SWAPs have resulted in increased financing for primary care rather than curative, and for better coverage and utilisation. These are good developments from an equity perspective, and probably also from a gender perspective. However, SWAPs can also result in less donor money being channelled to non-government providers, such as delivery-oriented NGOs. This is bad for poor people who are often heavily reliant on NGOs for access to basic health services.

References: HLSP Institute. Sector Wide Approaches: A resource document for UNFPA staff. Prepared for UNFPA, United Kingdom. HLSP, 2005.

Ravindran, T.K.S. & Maceira, D. Health financing reforms. In Sector Reforms and Sexual and Reproductive Health: The right reforms?, ed. T.K.S. Ravindran and H. de Pinho. Parktown: Women's Health Project, 2005.

UNFPA. Being effective in the new aid environment: Leading the ICPD Agenda. Issues and Recommendations from the UNFPA Workshop on SWAPs and Budget Support 8–10 June 2005, Geneva. UNFPA, 2005

SPECIAL DONOR INITIATIVES ON HIV/AIDS

The AIDS pandemic has sparked a range of international funding initiatives intended to assist those countries that are most severely affected. This section summarises the main aspects of the most well-known initiatives and, in particular, what their scope is, for example in type of activities funded, and countries covered. The summaries include some of the critiques that have been raised about particular aspects of some of the initiatives.

World Bank's Multi-Country HIV/AIDS Program for Africa (MAP)

In 2002, the World Bank introduced its Multi-Country HIV/AIDS Program for Africa (MAP). The aim for the first five years was to establish institutional mechanisms, build human capacity to implement large-scale programs of prevention, care, treatment and research, and scale up existing programs. The Bank allocated \$500 million for the MAP in September 2000 and a further \$500 million in February 2002. By the end of 2003, MAP projects had been approved for 24 countries.

An evaluation of MAP in early 2004 felt that “by almost any measures, in its concept and design, the MAP Program has been a major achievement.” There were, however, some weaknesses. One of these was political leadership. National HIV/AIDS Councils (NACs) were not providing the hoped-for leadership. Some countries had not allocated the 5% of counterpart funding required.

Secondly, since the establishment of MAP, many other major funding initiatives had emerged, such as the Global Fund, US PEPFAR and private foundations such as the Gates Foundation. However, some donors were not using the common structure. For example, the Global Fund was using a separate country co-ordinating mechanism for submission of proposals for funding. Some of the funds also seemed to focus on treatment and to neglect other aspects of care.

Thirdly, the process of approving community-based programs often led to delays and even possibly corruption. Fourth, while the program spoke about “multi-sectoral” action, many government agencies were

focusing on programs for their own employees rather than for members of the general public. Fifth, while MAP talks about the need to tailor the program to a particular country, the projects were very similar across countries at very different stages of the epidemic. Last but not least, partners in only one of the six countries visited by the evaluation team mentioned gender.

Reference: World Bank. Interim Review of the Multi-Country HIV/AIDS Program for Africa. World Bank, 2004. <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20450745~menuPK:717173~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html>

The Three Ones

On 25 April 2004, UNAIDS, the United Kingdom and the United States co-hosted a high-level meeting at which donors restated their commitment to strengthening national AIDS responses that are led by the affected countries. The donors endorsed the "Three Ones" principles, which they felt were most likely to result in rapid, effective and efficient use of resources, namely:

- One agreed HIV/AIDS action framework to coordinate the work of all partners;
- One National AIDS coordinating authority, with a multi-sectoral mandate.
- One country-level monitoring and evaluation system.

The Three Ones are not about giving new money, but instead about how the donors felt that they could ensure that the new money already being made available would be used most effectively.

In 2005 the Three Ones initiative was providing focused support to twelve countries which are considered to be either at a critical stage of their epidemic or at a critical stage in terms of developing a national response. The twelve countries were Ethiopia, Haiti, India, Indonesia, Kenya, Malawi, Mali, Mozambique, Tanzania, Ukraine, Viet Nam and Zambia.

Reference: http://www.unaids.org/en/Coordination/Initiatives/three_ones.asp

The Global Fund for HIV/AIDS, TB and Malaria (GFATM)

In April 2001, at the UN General Assembly Special Session on HIV/AIDS, UN Secretary General Kofi Annan called for the creation of a "war chest" to fight the pandemic. Soon after this, the G8 countries decided to establish the Global Fund as an international, independent public-private partnership to raise new money for the fight against AIDS, tuberculosis and malaria. The GFATM was launched in 2002. The "public-private" principle operates both at the giving and receiving ends in that the Fund accepts country-level applications from governments and non-governmental agencies, as well as groups of people living with HIV/AIDS. The Framework for the GFATM states that proposals are funded on the basis of "the most appropriate scientific and technical standards that take into account local realities and priorities."

In its first two funding "rounds," the Fund approved funding to 160 HIV, TB or malaria programs in 85 countries around the world. By mid 2002, the GFATM had raised more than \$2 billion but was \$1.6 billion short of what it needed for the third round.

Donors said that money for the Global Fund would be additional to existing funding for health care. In practice, this has not always been the case.

From a global perspective, a gender audit of the GFATM could involve a desk review to examine both approved and rejected proposals from one or more rounds to see to what extent proposals take gender and women's issues into account. At the country level, a gender-aware policy appraisal could look at whether the way funds are used addresses gender issues and fits in with the national strategy for combating HIV/AIDS.

Reference: www.theglobalfund.org

President's Emergency Plan for AIDS Relief (PEPFAR)

In January 2003 the US's President Bush announced an allocation of US\$15 billion over five years to combat the HIV/AIDS pandemic beyond the US's borders. He said that the PEPFAR money would be directed to the most affected countries in Africa and the Caribbean. Congress approved the plan and funding in May 2003. Congress stated that there would be a "particular focus on the needs of families with children (including the prevention of mother to child transmission), women, young people, and children (such as unaccompanied minor children and orphans)." The US meanwhile planned to spend US\$17.5 billion inside the country in 2005 alone.

Congress said that over half (55%) of PEPFAR money should go for treatment (especially anti-retrovirals), 15% for palliative care, 20% for prevention and 10% for helping orphans and vulnerable children. At least one third of the money for prevention was to be spent on promoting abstinence before marriage.

Before PEPFAR was announced, the US government was already giving some AIDS funding through bilateral country-to-country funds. This funding became part of PEPFAR. Overall, US\$ 5 billion of PEPFAR money would represent the continuation of earlier funding, US\$9 billion would be new funding, and US\$1 billion would be given to the Global Fund.

President Bush and Congress said that US\$15 billion would be allocated. However, budgeting is done on an annual basis, not for a five year period, so the final amount could be less or more than US\$ 15 billion. In 2004, Bush proposed allocating US\$ 1.9 billion for HIV/AIDS, TB and malaria, but Congress increased this to US\$ 2 billion.

Fourteen countries were chosen as "focus" countries for PEPFAR. They are Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia. In 2004 Congress decided that Vietnam should be added. PEPFAR also provides some funding for HIV/AIDS work in other countries.

Both President Bush and Congress set targets for PEPFAR—for example, the number of people to receive ART. The targets were not achieved in the first period, in part because the initial money was disbursed late. For subsequent periods, the figures suggest that PEPFAR did better in many countries. However, the figures can be misleading. For example, the reported numbers include a third of all Global Fund figures on the basis that one third of Global Fund money comes from the US. In some countries, such as Botswana, people receiving treatment are claimed by PEPFAR even though PEPFAR has made only a minimal contribution to these programs.

PEPFAR will only provide funds for drugs that have been approved by regulatory agencies in the US, Canada, Japan or Western Europe. It says that pre-qualification of drugs by the World Health Organisation is not enough. The PEPFAR documents say that the money can be used to buy generics (which are usually much cheaper), but most generics only have pre-qualification from WHO.

The Brazilian government refused US\$ 40 million in PEPFAR funds in May 2005 because PEPFAR says that it will not provide assistance to any organisation that does not explicitly oppose prostitution and sex trafficking. The Brazilian government said that if they agreed to this rule, it would prevent their helping sex workers protect themselves and their clients.

Organisations do not have to publish any details of money received from PEPFAR. PEPFAR itself published some information, but not all details.

Reference: <http://www.avert.org/pepfar.htm>

BOX 28: PEPFAR CONDITIONS IMPOSE UNNECESSARY COSTS

The Joint Civil Society Monitoring Group in South Africa brings together a range of NGOs concerned with monitoring the rollout of ARVs in the country. The NGOs work together with sympathetic donors and government officials. At its meeting of November 2005, the Group was informed that PEPFAR money came with two conditions—that (a) the recipient organisation had to produce a signed declaration that it did not support sex work; and (b) that the funds could only be used for drugs approved by the US Federal Drug Authority. The meeting resolved to demand that PEPFAR also allow the purchase of drugs approved by the South African Medicines Control Council, as the Council has approved generics which are far cheaper than US-approved drugs.

Reference: www.hst.org.za

The World Health Organisation's 3 by 5 Initiative

On World AIDS Day in December 2003, WHO and UNAIDS released a plan to provide antiretroviral treatment to three million people in developing and transition countries by the end of 2005. This became known as the 3 by 5 Initiative.

WHO and UNAIDS chose to focus on anti-retrovirals as these drugs can change HIV/AIDS from a death sentence into a managed chronic disease. However, while ARVs have helped developed countries achieve a 70% decrease in HIV/AIDS deaths, thus far developing and transition countries have not been able to do this.

The 3 by 5 Initiative is based on five “pillars”:

- simplified, standardised tools to deliver ARVs;
- a service to ensure a reliable supply of medicines and diagnostics;
- rapid identification, dissemination and application of new knowledge and strategies;

- rapid and sustained support for countries; and
- global leadership, partnership and advocacy.

In order to distribute ARVs to 3 million people in developing countries, WHO estimated that 100,000 lay and professional health workers had to be trained, and health systems, infrastructure and standards developed. In 2005, WHO estimated that it was still short of US\$ 5.5 billion to reach its goal.

Reference: <http://www.who.int/3by5/about/en/>

William J Clinton Foundation HIV/AIDS Initiative

The Clinton Foundation has HIV/AIDS as one of its central funding foci. Funds are allocated to countries to assist with planning and implementing large-scale integrated care, treatment and prevention programs. Descriptions of the Initiative suggest that there is a special emphasis on provision of ARVs.

The Foundation has provided funding to Lesotho, Mozambique, Rwanda, South Africa, Tanzania, China, India, the Organisation of Eastern Caribbean States, Bahamas, Dominican Republic, Haiti and Jamaica.

Reference: <http://www.clintonfoundation.org/programs-hs-ai.htm>

Melinda and Bill Gates Foundation

The Gates Foundation's support focuses on helping prevent transmission of the virus rather than on provision of care. It allocates funds for:

- developing a safe, effective, and affordable HIV vaccine;
- developing microbicides in the form of gels or creams that women can use to protect themselves from sexually acquired infection;
- expanding access to existing HIV prevention tools; and
- advocacy to build support for a science-based approach to stemming the epidemic.

Among others, the Foundation has allocated US\$200 million for its India AIDS initiative, Avahan, which works with high-risk groups and the general population. It has also supported the establishment of a Global HIV Prevention Working Group which brings together nearly 50 AIDS experts to discuss policy and practice in HIV prevention.

Reference: http://www.gatesfoundation.org/GlobalHealth/Pri_Diseases/HIVAIDS/default.htm

BOX 29: ENSURING THAT WOMEN BENEFIT

The Center for Health and Gender Equity has suggested a checklist of questions to ensure that women receive equitable access to drugs from US-funded treatment initiatives, as follows:

- Ensure that eligibility criteria reflect both biomedical and socio-economic vulnerabilities;
- Ensure that eligibility criteria do not discriminate on the basis of pregnancy status;
- Ensure that criteria and processes for expanding access are transparent;
- Develop equitable pricing for drugs;
- Ensure drug adherence programs are gender-sensitive;
- Ensure that primary health systems are developed and improved;
- Invest in quality of care and efforts to eliminate bias within the health care system;
- Expand gender-sensitive counselling services as a part of treatment and prevention programs;
- Ensure equity in access to ARV therapy through more sensitive health-financing mechanisms;
- Address gender inequities in health staffing and personnel policies;
- Ensure ARV services are provided as part of a system of integrated comprehensive health care;
- Ensure all women and adolescent girls and boys have access to comprehensive reproductive and sexual services and education, including efforts to address gender-based violence; and
- Ensure access to female-controlled prevention technologies.

The document elaborates on what each of these issues involves. Although some of them might require special or additional allocations of money, most simply require that existing allocations be spent in a gender-sensitive way.

Center for Health and Gender Equity. Gender, AIDS, and ARV Therapies: Ensuring that Women Gain Equitable Access to Drugs within U.S. Funded Treatment Initiatives. Takoma Park, MD: Center for Health and Gender Equity, 2004.

THE GLOBAL GAG RULE

The global gag rule was first announced by the Reagan Administration at the 1984 United Nations International Conference on Population in Mexico City. It is therefore sometimes referred to as the Mexico City Policy. The gag rule states that NGOs in other countries that receive funds for family planning from USAID may not use any of their own funds to provide abortion services (whether legal or illegal), lobby their governments for abortion law reform, or provide public education, counselling or referrals regarding abortion. It does not prevent anti-choice groups from lobbying for stricter anti-abortion laws. In 1993, the Clinton Administration ended the Global Gag Rule by executive order. But on 22 January, 2001, his first business day in office, President George Bush re-imposed the global gag rule.

The global gag rule is particularly serious because NGOs which are restricted by the rule are often the only providers of health care in remote, rural areas. The global gag rule does not explicitly prevent the NGOs from providing life-saving abortions and post-abortion care if these are legal in a country. However, often NGOs will stop providing these services because they fear that USAID will stop funding them because they are linked with abortion. Other bilateral donors can also be affected because the NGOs that they fund cannot work on abortion-related projects if they are also funded by USAID.

By 2003, NGOs in at least 56 countries had been affected by the rule. The rule restricts their right to free speech and public participation. It also prevents providers from meeting basic medical ethics by providing the full range of available services and information. In Ethiopia, Kenya, Zambia and Romania—and

perhaps other countries —some communities were left with no health care provider as a result of the rule. In other countries family planning organisations have lost their supply of USAID contraceptives, including condoms. In Kenya, Marie Stopes International closed a reproductive health clinic in the province with the highest HIV/AIDS rate because of the resultant funding crisis.

In August 2003, President Bush released an Executive Order stating that US's global AIDS funds would be exempt from the gag rule. However, in November 2005 US government officials indicated that President Bush planned to extend the global gag rule to those who received funding from PEPFAR. *The Washington Post* warned Bush that he would be “sacrificing [some] portion of the AIDS package on the altar of controversial abortion politics.... [and] letting domestic political considerations blur the focus on the emergency work at hand.” Nevertheless, the gag rule was included in eligibility criteria for PEPFAR funds in Kenya and perhaps elsewhere.

The government officials said that, as a compromise, agencies might be able to receive AIDS package funds if they completely separated their family planning work from their AIDS work. This would prevent clinics from treating AIDS-related illnesses and reproductive health in the same facility. This will affect women, in particular, because they will need to find the money and time to visit separate facilities for their different needs and the needs of those for whom they care. Separate AIDS clinics will also increase the likelihood of stigma as those who visit these clinics will easily be labelled.

In early 2006 the UK Department for International Development (DFID) announced that they were contributing £3 million towards a new fund, the Global Safe Abortion Program. This fund would be used for the specific purpose of increasing access to safe abortion services and support groups that had been forced to cut back on reproductive health services because of the gag rule.

References: AWID. Clark, C., Sprenger, E., Veneklasen, L., Duran, L.A. and Kerr, J. Where is the Money for Women's Rights? Assessing resources and the role of donors in the promotion of rights and the support of women's rights organizations. Association for Women's Rights in Development, 2005.

Stevens, A. "Bush Extends Global Gag Rule to AIDS Funds." Womens' E-News, Washington Lookout. 10 November, 2005. <http://www.womensnews.org/article.cfm/dyn/aid/1233>.

DFID. UK Government announces support to help combat threat to women's health in developing world. DFID press release, 6 February, 2006. <http://www.dfid.gov.uk/news/files/pressreleases/reproductive-health060206.asp>

INTERGOVERNMENTAL FISCAL RELATIONS

Intergovernmental fiscal relations is the term used to describe how money flows between the different levels of government, i.e. national, provincial or state, and the various tiers of local government. Intergovernmental fiscal relations looks not only at how much money is raised and spent by each level, but also at who decides how much goes to the different units at each level, and who makes the decisions about how the money at each level is spent.

Transfers tend to happen mostly from national government to lower levels because national government usually has more power to raise revenue than lower levels. This is a good thing in many ways as it allows national government to redistribute resources from wealthy areas to those that are poorer and less well serviced.

Transfers consist of two main types: unconditional and conditional. Unconditional transfers are lump-sum payments that are paid across to the lower level, and the lower level can decide how to use the money. Conditional transfers can only be used for the purpose specified by the level that makes the transfer.

There can be gender issues in both types of transfer. In many countries the amount of the unconditional transfer is based on a formula. The variables used in the formula can explicitly or implicitly be gender-biased. One example of an explicit pro-women bias is the formula used in South Africa in the mid-1990s to decide how much should be in the lump sum going to each province. This formula took into account the number of women and young children in the province because these groups were known to be more likely to need health services than others. An example of an implicit bias would be the weight given to the health-related component of the formula because of the greater need that women tend to have for these services.

Gender issues are even clearer with conditional grants where the “giving” level specifies more exactly what the money must be spent on.

With both conditional and unconditional transfers, the amount allocated is not necessarily sufficient to cover the need in a particular locality. This results in what is sometimes referred to as unfunded, or underfunded, “mandates,” where the lower level government is given responsibility for the function but does not have sufficient funds to deliver adequately. In the case of formula-based allocations, the amount allocated to a particular locality might—if the variables of the formula are correctly chosen—reflect the relative need of that locality compared to others. However, the total amount may not be sufficient to meet the absolute need. In other cases, equal allocations are given to each locality. These “equal” allocations are, however, unlikely to be “equitable” as the degree of need usually differs between localities.

BOX 30: LIMITED FLEXIBILITY IN DECISION-MAKING

In their GRB study of Villa El Salvador in Peru, researchers found that up until 2002, 70% of transfers from the central government to local authorities had to be spent on investments. Officials interpreted “investment” to mean infrastructure. The GRB researchers argued that investment in human capacities or improving access to services should also be seen as “investment.”

Reference: Andía-Pérez, B., Beltrán-Barco, A., Coello-Cremades, R., Gutiérrez, M, Palán-Tamayo, Z and Zabalaga-Estrada, C. “Gender-Sensitive Budgets in Latin America: Accountability for Equity and Transparency.” United Nations Development Fund for Women, 2004 www.idrc.ca/uploads/user-S/11281061151Gender-Sensitive_Budgets_in_Latin_America-_Accountability_for_Equity_and_Transparency.pdf.

This section discusses the importance of statistics in GRB work. It argues, however, that the lack of adequate statistics should not prevent GRB work from being undertaken. It suggests creative ways of both working with what is available and encouraging enhancement of statistics over time.

USING STATISTICS IN GRB WORK

A common complaint in writing about GRB is the lack of gender-related data. Gender-related statistics include data disaggregated by sex as well as data on issues important from a gender perspective (such as GBV or maternal mortality) that may affect only one sex. Data on time use, in particular, are often lacking or out-of-date. This prevents quantitative measurements and arguments about the impact of government policies and the related budgets on unpaid care work done by women and men.

The lack of gender statistics should not be allowed to prevent work from happening. Nevertheless, good statistics are of great benefit to GRB at different steps of the process, from the initial description of the situation to be addressed through the monitoring and evaluation.

One aspect of GRB can thus focus on exploring existing data, and helping to generate new data. With respect to the latter, this could involve activities such as conducting a one-off survey. Even better, it could involve establishing systems that generate gender-relevant data on an ongoing basis. In particular, output indicators should ideally come from an administrative system as they should then be more speedily available than results from a survey. This is important because output indicators should relate to the year in which the money is spent, i.e. the budget year that has just finished. For outcome indicators, speed is not quite so important, as outcomes do not usually manifest instantaneously and are not usually tightly related to a particular activity or program.

It is generally easier to use standard indicators because the data for these indicators are more likely to be available and because others are more likely to understand the arguments if you use well-known concepts. Standard indicators should, however, not be accepted without questioning. For example, many countries and organisations measure contraceptive prevalence rates only on the basis of married women of reproductive age (usually 15–45 years). They seem to assume that sex happens only inside marriage and only in the defined reproductive age group. This could indicate that moral or legal concerns are interfering with an understanding of the real situation in the country and the real needs of the people who live in it.

At the advocacy stage, GRB work needs to be especially careful about how statistics are used. Sometimes advocates look for the biggest and most shocking numbers that they can find as a way of convincing people of the need to spend more money. This can be a dangerous tactic because if opponents can show that one or two of the numbers presented are untrue; this can bring the rest of the argument into doubt.

Disaggregation of budget numbers

Finally, we must add a word about disaggregated data within the main budget numbers. GRB analysts are often frustrated by the fact that budget information is presented in a way that makes it very difficult, if not impossible, to separate out the allocations in which they are interested. For example, there is unlikely to be a separate budget line within the police budget for domestic violence interdicts, since the same police personnel that deal with these interdicts deal with other issues. They also, for the most part, use the same offices. Similarly, if you are interested in how much is allocated to deal with people consulting health services in relation to HIV/AIDS, there might be separate allocations for particular items, such as anti-retrovirals, tests, or awareness campaigns. However, the expenditure that goes for staff, materials and the other things necessary to treat those who have opportunistic infections will not be separate from expenditures on treating other ailments. This point is especially true if, as we advocated above, HIV/AIDS services are integrated with RH and primary health care services. In these cases, asking for a separate budget line might work against mainstreaming and should thus be avoided.

The fact that there is no separate budget line does not mean that we cannot monitor whether government is using its budget to deal with our priority issues. The way to do this is to ask for output and outcome indicators that relate to the priority issues. For example, regarding interdicts, one can ask for an indicator showing how many women were assisted. In relation to HIV/AIDS, one can ask for indicators relating to the different types of testing, treatment and care provided.

BOX 31: CREATIVE WAYS OF INVESTIGATING GENDER-BASED VIOLENCE

Policy-makers sometimes justify their lack of policy or budgets for particular problems on the basis that they affect only a small number of people, and can thus not be a priority. This can happen, in particular, in relation to issues such as gender-based violence which, because they are “hidden,” are difficult to count. GRB advocacy for such issues can be strengthened if creative ways are found of generating data that are difficult to dispute.

Government and non-government research institutions in South Africa are collaborating on a national study on femicide—the murder of women. They are using data collected from mortuaries to arrive at estimates of the national femicide rate and the factors associated with murder. After identifying cases, the researchers interview the police investigating officer. They also record details from the case and post-mortem reports. The interview with the police allows the researchers to identify cases where the woman was killed by an intimate partner—for example her current or ex-boyfriend or partner, or same sex partner.

Data for 1999 suggested that 8.8 women in every 100,000 aged 14 years and above were killed by intimate partners in that year. Women who were killed by intimate partners tended to be younger than other murdered women, while the perpetrators of intimate femicide tended to be older. The prison sentences given to perpetrators of intimate femicide tended to be shorter than those for non-intimate murders. 2% of the female murder victims were pregnant at the time of the murder, and 15% had been sexually assaulted.

In addition to finding these patterns, the researchers made findings about inadequacy in the police, court and other systems dealing with these cases. These are being used in ongoing advocacy.

Reference: <http://www.mrc.ac.za/gender/projects.htm#femicide>

DEMOGRAPHIC PATTERNS AND THEIR IMPLICATIONS FOR BUDGETS

Demography and population statistics are key issues for UNFPA. In most countries, the census is the most important source of data for estimating long-term trends in the population. Analysis of the census can reveal a range of patterns that have implications for budget. The issue of sex ratios is discussed below. In some developing countries there is also an ongoing process termed “ageing” of the population. Many people think of this in terms of a higher proportion of aged people in the population. This has gender implications in that usually (a) the majority of the old people are women and (b) it is mainly (younger and middle-aged) women who look after the aged. But ageing of the population has a wider meaning. It also means that the proportion of children in the population will be smaller and the proportion of younger and middle-aged adults greater. This might mean that less of the budget should be allocated for education and more should be allocated for health and other purposes. In countries with HIV/AIDS epidemics, there is a different pattern—with a disproportionately low number of people in the main reproductive and productive age groups.

The census is usually conducted only every ten years or, at best, every five years. In addition, the census tends to have a small number of questions because it is not possible to have a long interview with every household in the country. Many countries conduct periodic demographic and health surveys (DHSs) to provide more detailed information between censuses.

Most DHSs are supported by Macro International and are based on a standard questionnaire and method. Countries can, however, change the questionnaire to suit their specific needs and to investigate particular issues. In South Africa, the DHS of 1999 had additional questions which asked about decision-making at the household level.

BOX 32: EXPLORING SEX RATIOS AND WHAT THEY MEAN

Sex ratios measure the number of males in a population for every female. Biologically one expects that more male babies will be born than female, but that mortality rates for male babies and young children will be higher than those for female babies and children. Biologically one also expects female life expectancy to be greater than for males.

Where these patterns are not found, such as in several countries of South Asia, there can be several reasons. One reason can be the impact of gender inequality—for example, where expectant mothers abort babies who are identified as female because of a preference for sons, where girls and women receive poorer nutrition and health care than boys and men, and where maternal mortality rates are high. Another reason can be that the instruments such as surveys and censuses used to arrive at the population statistics tend to undercount women, because of biases on the part of both interviewers and respondents. While both of these reasons reflect problems, they call for different policy responses and have different budget implications.

Statistics suggest that the sex ratio for births has increased in favour of males in recent years, which seems to indicate increasing rates of abortion of female fetuses. In April 2001 NGOs in India filed a public interest case in the Supreme Court against the central and state government asking what they were doing about the problem. As a result, the Ministry of Health and Welfare then strengthened the Pre Natal Diagnostic Test and persuaded the state government to charge people involved in female foeticide. Government, international agencies, NGOs and the media have also created a network to sensitise the public about the problem.

Reference: Zaman, W. & Chaudhury, R.H. “Engendering Population Census in South and West Asia” Collected Papers. Kathmandu: UNFPA Country Technical Services Team for South and West Asia, 2004.

IN CONCLUSION

As emphasised at the outset, there is no single model of GRB. Instead, GRB represents a perspective and approach for gender mainstreaming that asks: “What is the impact of government budgets on women and men, girls and boys?”

This resource pack brings together materials and ideas from a wide range of different areas and on a wide range of different issues. Only a selection of these materials and ideas will be relevant for a particular initiative in a particular country. The resource pack is thus intended as a helping hand which raises questions and perspectives, and generates ideas for UNFPA CSTs to help them assist countries on how the GRB perspective might be useful for them in taking forward gender equality.

