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The global health financing revolution: why maternal health is missing the boat

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Abstract

The first decade of the new millennium saw an upsurge in global financing for health. When the world took stock of progress on the Millennium Development Goals in mid-2010 the one addressing maternal health showed the least progress. Did maternal health miss the boat? In mid-2010 the Secretary-General of the United Nations launched a "Global Strategy for Women's and Children's Health", also known as the "Every Woman Every Child" initiative. Has the tide now turned in favour of maternal health? The authors try to answer this question by first examining whether maternal health really missed out with respect to increased global funding and why this may have occurred. They then assess whether the new initiative will make a difference by comparing several elements of the approach taken by HIV/AIDS activist to that of maternal health activists. They suggest that real progress requires international financing, thus pledges must become robust and reliable commitments. They conclude that the absence of an organisational structure in the current initiative means the global maternal health financing revolution will probably not happen.

Key words: **Maternal health, global health, international assistance, international regimes, international organisations.**

Introduction

During the first decade of the 21st century, global health became prominent on the international political agenda (Fidler, 2005) and international financial assistance for health increased substantially (Institute for Health Metrics and Evaluation, 2010). According to Fidler (2005) this was nothing less than a global health revolution, which perhaps came to an end with the global financial crisis that started in 2008 (Fidler, 2008). But there is a widely shared belief that maternal health missed the boat: a report developed under the auspices of the United Nations Secretary General in September 2010 argues that the 5th Millennium Development Goal (MDG) – focusing on maternal health – has shown the least progress (United Nations Secretary General, 2010).

That same report launched a "Global Strategy for Women's and Children's Health", also known as the "Every Woman Every Child" initiative, which attracted some US$40 billion worth of pledges, to be spent between 2011 and 2015 (Every Woman Every Child, 2010). If these pledges translate into actual funding, by 2015 maternal health will have caught up with other global health concerns in terms of the volume of funding.

Will maternal health really catch up by 2015? To answer the question, we will analyse four hypotheses about why it has been lagging behind, and how the Every Woman Every Child initiative will address those issues.

But first, we want to clarify that this is a paper about global financing for maternal health, and why. We do not think that financing is the only or even the main factor influencing health outcomes, and we do not think that global financing is more important than national financing. But we do believe that financing is important, and that global financing creates particular challenges which deserve to be discussed separately. We do agree with Austveg, who regrets that in the global health debate, sexual and reproductive health has been side-lined and that maternal health was singled out as a priority, while "maternal health itself has been detached from the

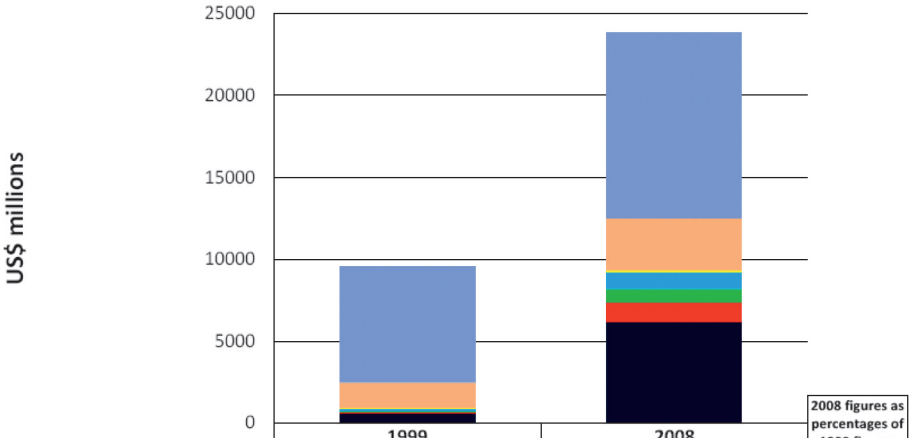
comprehensiveness of reproductive health and framed solely in relation to motherhood" (Repoliticizing SRHR Group, 2010). But maternal health *has* been singled out, separated from far more contentious issues like abortion and birth control – presumably to enhance its attractiveness to international assistance contributors – and was nonetheless relatively unsuccessful at attracting funding. Therefore it merits analysis as such.

Did maternal health miss the boat?

Probably the most comprehensive effort to track international assistance for health over the past decades is conducted by the Institute for Health Metrics and Evaluation (IHME). The IHME's "Financing Global Health 2010" report contains data about international assistance for health from 1990 to 2008, adding rough estimates for 2009 and 2010 (Institute for Health Metrics and Evaluation, 2010). Fidler (2008) argues that the global health revolution "unfolded over the preceding 10-15 years", and in keeping with this definition we will briefly examine the evolution of global health financing from 1999 to 2008.

The IHME disaggregates international assistance for health into six specific categories – HIV/AIDS; Maternal, new-born, and child health; Malaria; Health sector support; Tuberculosis; Noncommunicable diseases – while the remainder is allocated to another (less important) category or considered 'unallocable'. As Figure 1 illustrates, a substantial amount of international assistance for health is considered either 'unallocable or other', that is allocated to a category other than one of the six mentioned above. Furthermore, maternal health is grouped together with new-born and child health. Thus there are two considerable margins of error: the unallocable/other assistance that may or may not include support for maternal health efforts, and the unknown weight of maternal health within the category of maternal, new-born and child health.

Keeping the margins of error in mind, the IHME data does seem to confirm that maternal health has missed the boat. The total amount of international assistance for health was $9,630 million in 1999 and increased to $23,870 million in 2008: or international assistance for health in 2008 reached 248% of its 1999 level. International assistance for maternal, new-born and child health increased too, but by a smaller percentage: its level in 2008 corresponds to 202% of the 1999 level. International assistance to fight AIDS, international assistance to fight tuberculosis, and international assistance to fight malaria all increased by a factor 10 or more. Rather than talking about a global health revolution, it may be more accurate to talk about a global AIDS, Tuberculosis and Malaria (ATM) financing revolution, and ask why the 'fire' from that revolution did not jump to maternal health.



	1999	2008	2008 figures as percentages of 1999 figures
Unallocable/other	7158	11397	155%
Maternal, newborn and child health	1566	3170	202%
Noncommunicable diseases	52	121	233%
Health sector support	122	1000	820%
Tuberculosis	77	829	1077%
Malaria	77	1189	1544%
HIV/AIDS	578	6164	1066%

Source: adapted from IHEM 2010

Fig. 1. — International assistance by category in 1999 and 2008

Or perhaps the fire did jump? The Every Woman Every Child initiative attracted $40 billion worth of pledges for maternal, new-born and child health, to be spent between 2011 and 2015, or $8 billion per year (Every Woman Every Child, 2010). That level of commitment would exceed the volume of global financing to fight ATM in 2008. Yet vital questions remain to be answered. Will the pledges result in funding? Will the Every Woman Every Child initiative effectively address the reasons why maternal health missed the boat until recently? We now turn to four hypotheses all seeking to explain why the ATM financing revolution left maternal health behind.

First hypothesis: exceptional activism, rooted in a human rights approach

Several authors link the global ATM financing revolution with exceptional AIDS activism (Ingram, 2009), rooted in a human rights approach (Nixon & Forman, 2008).

Until the mid-1990s, the absence of effective treatment for AIDS meant that demanding respect for their dignity as humans and for their human rights was more or less the only strategy people living with HIV or AIDS had. This human rights based approach evolved into an understanding that enhancing the human rights of people at higher risk of HIV infection could be an effective prevention strategy (Anonymous, 1996). A further step on this human rights path was Brazil invoking the right to health to justify its production of generic antiretroviral medicines, arguing that the right to health trumps the international intellectual property rights regime (Galvão, 2005). Moving from this position to arguing that the international community as a whole has a shared responsibility to finance life-saving medicines – a responsibility shared with the governments of the countries where the people needing the medicines live – took only a small step. Indeed, a July 2002 modification of the International Guidelines on HIV/AIDS and Human Rights issued by the Office of the United Nations High Commissioner on Human Rights (OHCHR) and UNAIDS, explicitly mentioned that "States should ensure that international and bilateral mechanisms for financing responses to HIV/AIDS provide funds for prevention, treatment, care and support, including the purchase of antiretroviral and other medicines, diagnostics and related technologies" (Office of the United Nations High Commissioner on Human Rights, UNAIDS, 2006).

Whereas the existence of international obligations to provide assistance for the realisation of the right to health remains somewhat controversial (Bueno de Mesquita & Hunt, 2008), the principle has been quite firmly established for the global AIDS response. Somehow, AIDS activists seem to have succeeded in spreading the idea that an HIV positive person not having access to antiretroviral therapy is a human rights violation.

But if an HIV positive person not having access to antiretroviral therapy constitutes a human rights violation – and we agree it does – then surely every woman dying due to lack of access to emergency obstetric care constitutes a human rights violation too. Why did maternal health activists not succeed in spreading *that* idea? It is certainly not because they failed to cast maternal health as a human rights issue – they did cast maternal health as a human rights issue. In fact, the historical relationship between human rights and maternal health, as described by Gruskin et al. (2008), does resemble the relationship between human rights and AIDS activism. Both the 1994 International Conference on Population and Development in Cairo, Egypt, and the 1995 Fourth World Conference on Women in Beijing, China – two milestones in the advancement of maternal health – "were explicit about the need to promote and protect women's rights, particularly in matters relating to reproduction and sexuality to improve women's health" (Gruskin et al. 2008). So this hypothesis, on its own, does not provide a sufficient explanation.

Second hypothesis: the fatal attraction of cheaper solutions that may work

Analysing factors shaping global political prioritisation of health issues, Shiffman and Smith mention "Policy community cohesion: the degree of coalescence among the network of individuals and organisations that are centrally involved with the issue at the global level", and – having interviewed 23 individuals centrally involved in the Safe Motherhood Initiative – they report a lack of consensus about appropriate interventions, in particular about emergency obstetric care (Shiffman & Smith, 2007). Since the launch of the Safe Motherhood Initiative in 1987, maternal health advocates have been divided over this question, with some arguing that most maternal deaths cannot be prevented without emergency obstetric care at the referral hospital (access to transfusion and C-section), and others taking the position that there are more cost-effective interventions, like "skilled attendance at delivery", which is about having access to health workers with midwifery skills (at home or in primary health care centres). Although a consensus "about the need to have both skilled attendants at birth and emergency obstetric care if needed" was fostered by a series on

maternal survival in The Lancet in 2006, Shiffman and Smith report that the divide is not completely over: "Some expressed strong concern about what to do in the interim, before such facilities could be established, in view of resource scarcity and the difficulty that poor countries faced in expanding care."

These hesitations related to sustainability are not unique to the maternal health movement. Governments of countries providing international assistance, governments of countries receiving international assistance, and other actors like non-governmental organisations and international financial institutions generally dislike efforts that are clearly out of reach of the domestic financial capacity. They do not want countries to depend on international assistance. If a choice can be made between one particular effort that may work, perhaps, and that is cheap enough for the domestic financial capacity, and another effort that will almost certainly work much better but that creates dependency on international assistance, the cheaper intervention will most often be preferred (Ooms, 2006).

In the AIDS response, the provision of antiretroviral treatment was central, as there were no cheaper efforts that may have worked. For a few years, there was a heated debate as to whether antiretroviral therapy should be provided at all – with some arguing that using all available resources for prevention would save more lives in the long run (Marseille et al., 2002a). But among the people and organisations involved with the global AIDS response, there was consensus. Not aiming for antiretroviral treatment was a death sentence for millions of people, already infected with HIV but still alive. Within weeks of publishing their plea for prioritising AIDS prevention, Marseille and colleagues felt compelled to clarify that both treatment and prevention were needed (Marseille et al., 2002b).

For people involved in the global AIDS response, long term dependency on international assistance is no longer a problem to be avoided, it is a problem to be managed. Hecht et al. (2010) estimate the financing needs of the global AIDS response until 2031 under different scenarios and conclude that in any case, "High Burden Low Income countries" will remain dependent on external funding for decades, creating major financial risks over which they have little control, a problem indeed, but there is no alternative. That kind of thinking has not yet been adopted by all involved in maternal health at the global level, as the interviews done by Shiffman and Smith reveal (Shiffman & Smith, 2007). As long as these hesitations remain, international assistance may not increase as it is the demand for emergency obstetric care that will trigger the international assistance for emergency obstetric care. We will further discuss this under the fourth hypothesis.

Third hypothesis: the securitisation of global health

The global ATM financing revolution coincided with what some have called the "securitisation" of global health (McInnes, 2009). The National Intelligence Council of the United States of America, in January 2000, issued a report in which it stated: "As a major hub of global travel, immigration, and commerce, along with having a large civilian and military presence and wide-ranging interests overseas, the United States will remain at risk from global infectious disease outbreaks, or even a bioterrorist incident using infectious disease microbes" (National Intelligence Council, 2000). The main focus of this report was the HIV/AIDS epidemic and its long-term consequences. Although recent findings suggest that the global HIV/AIDS epidemic does not constitute a security threat, the fear – back in 2000 – may have contributed to the global ATM financing revolution (de Waal, 2010).

As McInnes (2009) argues, "it is not 'health' that has been securitised, but rather a limited range of health issues", and maternal health was not one of them. The main causes of maternal death in developing countries are haemorrhage, hypertensive disorders, sepsis and infections, complications of unsafe abortion, obstructed labour, anaemia, and HIV/AIDS (Khan et al., 2006). Most of these causes are not infectious and create no threat to countries providing international assistance. If the "securitisation" of global health is what explains the global ATM financing revolution, we should not expect anything similar to happen for maternal health, unless we can explain that maternal mortality *does* create a security threat (which may require some imagination).

Fourth hypothesis: the creation of new financing tools for ATM, not for maternal health

Comparing former United Nations Secretary-General Kofi Annan's call, back in 2001, for a "war chest to fight AIDS" (Stephenson, 2001), with present United Nations Secretary-General Secretary Ban Ki-moon's call for a strategy to improve women's and children's health (United Nations Secretary General, 2010), there are similarities but also striking differences. A "war chest" not only sounds more determined than a "strategy", it is a different thing. A war chest was created: the Global Fund to fight AIDS, Tuberculosis and Malaria

(GFATM). No global fund is being envisaged for maternal health.

The Every Woman Every Child initiative created something else: a Commission on Information and Accountability for Women's and Children's Health. This commission was not intended to become a permanent one; it was "tasked to develop a mechanism for holding donors accountable for their pledges and holding countries responsible for how well the money is spent", and it proposed an "independent Expert Review Group" that will be reporting regularly to the UN Secretary-General on results and resources (Commission on Information and Accountability for Women's and Children's Health, 2011).

The seven members of the independent Expert Review Group (iERG) were appointed in September 2011. None of them formally represents a government, which does not come as a surprise as it is supposed to be an independent group. But that also means that they do not have it in their power to commit financial resources – unlike members of the GFATM Board.

It may seem illogical to consider that an organisation like the GFATM, merely a tool at the mercy of voluntary global financing, may have had a real impact on global financing – it seems logical to consider the tool as the result of a willingness to provide the global financing, and not the other way around. But the real dynamics of international assistance are more complex. Allow us to explain this briefly in terms of 'demand' and 'offer' of international assistance.

Obviously, any provision of international assistance starts with a 'demand': a need perceived by a country asking for assistance and acknowledged by a country providing the assistance, followed by an 'offer' and discussions about the terms of agreement. But the 'offer' influences the 'demand' too.

We discussed above that among those involved in the global AIDS response, there was a consensus about the need to provide antiretroviral treatment, even in low income countries, and even if that created long term dependency on international assistance. That consensus may not have lasted long in the absence of the GFATM. If the global financing that funded antiretroviral treatment in low income countries had not started flowing in 2002, very soon some people involved in the global AIDS response may have shifted their attention and energy to efforts that were feasible (in the absence of additional funding). Thus the 'offer' of international assistance for antiretroviral treatment sustained (and increased) the 'demand'. Likewise, the existence of the GFATM demonstrated the feasibility of providing antiretroviral therapy and at the same time how inexpensive it was for high income countries: the GFATM showcased that a person needing antiretroviral treatment and not having access to it is a human rights violation. Finally, at least some low income country governments were quite reluctant to provide antiretroviral treatment using international assistance. To acknowledge that real solutions require international assistance for decades to come is one thing; to adopt those real solutions is another. It requires trust in the continuation of international assistance in the long run, and the track record of international assistance did not warrant such trust. But a new organisation signalled that the international community was serious about its commitment. It was the adoption of antiretroviral treatment as an essential element of the appropriate response, by governments of low income countries, that created the 'demand' – but the 'demand' required a trustworthy 'offer'.

No global fund for maternal health exists. There is a promise of $40 billion for five years, or $8 billion per year, for maternal, new-born and child health (Every Woman Every Child, 2010). But this promise includes domestic resources and pre-existing international assistance flows that have been confirmed or re-confirmed as serving maternal, new-born and child health purposes. According to some observers, the truly additional pledges account for $5 billion at best, or $1 billion per year (Bustreo & Frenk, 2010). If this $1 billion is directed to low income countries – arguably where it is most needed – it means a little bit more than $1 per person per year.

Will maternal health advocates have enough trust in the Every Woman Every Child initiative and in the iERG to leave their hesitations about the feasibility of emergency obstetric care behind; to accept dependency on international assistance as a problem that needs to be managed but cannot be avoided; to confirm, loud and clear, that every woman dying because of not having access to emergency obstetric care is a human rights violation perpetrated by an international community unwilling to finance what it takes to avoid these deaths?

Can we expect the promised global maternal health financing revolution to start?

The four hypotheses explained above do not constitute a comprehensive list of factors that may explain why a global ATM financing revolution happened and why a global maternal health financing revolution did not happen. None of the hypotheses can be dissociated from the others, and they cannot be verified through some randomised controlled research. But in as much as they capture part of what happened, they may be useful for forecasting what the

future might hold with respect to the promised global maternal health financing revolution.

Can maternal health activists be as loud, sharp and intense as AIDS activists are? Can they ground their activism in a human rights approach? The latter, they already have done. The former seems to be a matter of political choices and willingness rather than ability. It is more than twenty years since the Safe Motherhood Initiative was launched and maternal health activism carries with it a history that is much older than the history of AIDS activism, a history that includes some fatalism about poverty being a complex multi-facetted fact of life. Maternal health activists must continue to reject what Yamin (2008) rightfully characterised as "failures of political will that are cloaked in claims of resource scarcity." AIDS activists did not ignore poverty, but they firmly rejected the idea that poor countries had to aim for poor health care. Maternal health activists must reject any argument that low income countries cannot afford to provide essential maternal health services.

Can maternal health activists 'sell' maternal mortality as a security problem? That may be tough. But if security in the 21st century relies on cooperation between states, wealthier states cannot reject responsibility for deaths due to poverty in poorer states, and at the same time expect poorer states and their inhabitants to feel responsible for deaths due to other causes in wealthier states (Ooms, 2010). It probably *does* matter that most causes of maternal death are not infectious – and cannot spread to wealthier countries. But a broader perspective on security, one that acknowledges the need for cooperation between states and between humans across borders of states, not only allows us to cast maternal mortality as a security problem but also to highlight it as the most worrisome example of international indifference.

Can maternal health activists create something like the GFATM, but for maternal health? Some may have hoped that the Global Fund for Women that was created in 1987 – long before the GFATM – would assume that role (Global Fund for Women, 2011). Others advocated for the GFATM to expand its mandate, and to embrace maternal and child health (Cometto et al., 2009). But it appears that for the near future the Every Woman Every Child initiative may stand in the way of a Global Fund for Women's Health or a Global Fund for Health: why create a global fund when we have $40 billion worth of pledges, and while the GFATM itself is facing financial difficulties?

Unfortunately, we are not optimistic about the promised global maternal health financing revolution. The GFATM is more than the result of a pre-existing willingness to increase international assistance; it also was – and remains, even in difficult times – a mobilising factor; it is the 'offer' that sustains the 'demand'. Without something similar, the global maternal health financing revolution will probably not occur.

This creates an additional responsibility for the iERG. Not only should it track commitments and report on key indicators; it should also critically assess the set-up of which it is part. If a scheme of pledges without a central global fund does not generate enough trust in the reliability of international assistance, and therefore does not trigger the more ambitious strategies that are needed, the iERG should be the first to acknowledge that failing.

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