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Social protection systems, access to public services and sustainable infrastructure for gender equality and the empowerment of women and girls:

Harnessing synergies and securing financing

Universal Health Coverage, Access to Public Services and Sustainable Infrastructure: Women's Human Rights as the Catalyst

By

Gita Sen

Director of Ramalingaswami Centre on Equity and Social Determinants of Health at the Public Health Foundation of India

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

Introduction:

Interconnections between policies to move toward universal health coverage / care (UHC) as a key element of social protection, and those to advance gender equality, women's empowerment and human rights have seen advances in recent years, especially since 2010. These advances have occurred against the backdrop of Agenda 2030 and the Sustainable Development Goals (SDGs) despite difficult economic circumstances, rising inequality, constrained political space, and continuing and new forms of political backlash and resistance (Sen, forthcoming; Tessier *et al.*, 2013; World Bank, 2018a). Social mobilizing and advocacy have opened policy space for global agreements, such as ILO Recommendation No. 202 in 2012, and target 1.3 of the SDGs, which recognize the potential of national social protection floors (SPFs) as tools against poverty and vulnerability.

Recognition of UHC as central to social protection has been relatively recent. It was consolidated with the passing of the Social Protection Floors Recommendation (No. 202) in 2012 by the International Labour Conference (ILO, 2012). This recommendation guides ILO member-states on how to build comprehensive social security systems, starting with national social protection floors (SPFs). The Recommendation calls for applying the principle of "non-discrimination, gender equality and responsiveness to special needs".

Building on Articles 22 and 25 of the Universal Declaration of Human Rights, ILO Recommendation No. 202 includes UHC as one of four minimum elements for an SPF: "…access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality…"(Tessier *et al.*, 2013, p2).

But recognition of UHC as one of the elements of an SPF needs to be matched both by adequate financing, and by ensuring access to all women and girls as well as groups who are vulnerable to exclusion, marginalization and discrimination on grounds, *inter alia,* of poverty, ethnicity, race, caste, age, disability, indigeneity, migrant and refugee status, and location.

Synergies matter. In the case of UHC, its recognition as a key element of social protection will have stronger impact when combined with access for all to needed public services, and to infrastructure that supports such access and is sustainable through adequate budgets and spending.

Gender equality matters. It can be the catalyst for the realization of synergies by ensuring access and sustainability.

Women's and girls' human rights matter. A grounding in the human rights of girls and women not only puts the spotlights on their needs and rights, it identifies duty bearers in states and governance systems. It foregrounds their own voices and agency. It makes real the slogan of social mobilizing, "Nothing about us without us".

Much of the debate around social protection, including UHC, has focused on the relative merits of program instruments such as targeting and conditionalities, where human rights concerns do not have pride of place. They tend instead to be excluded and are evaluated (if

at all) on par with efficiency, effectiveness and other criteria. A recent, useful UNDP Primer argues that social protection

> *"…**ensures access** to basic social services to all, especially for groups that are traditionally vulnerable or excluded; **stimulates productive inclusion through the development of capabilities, skills, rights and opportunities** for the poor and **excluded**; **builds resilience and protects people against the risks of livelihood shocks** throughout their lifecycle; and **helps remove structural barriers, including barriers within the household,** that prevent people from achieving well-being…"* (UNDP, p15-16: emphasis added).

Supply side barriers:

From the perspective of UHC, a simple demand-side versus supply-side distinction can help to clarify the nature of the synergies that are possible. **On the supply side,** the provision of infrastructure – available, accessible and affordable primary health centres, emergency transportation, reliable referral systems, as well as basics such as clean water, toilets, waste disposal etc – are well known. These have to be matched by other key elements on the supply side such as adequate staffing and equipment, and quality services.

But these supply side elements may elude women and girls unless they are provided with an eye to tackling the risk of exclusion and discrimination. Infrastructure may be unfriendly to disabled people; services may stigmatize poor women, pregnant adolescents, ethnic, caste minorities, LGBTI groups and others. Disrespect and abuse in service provision, especially but not only in obstetric care, can violate women's dignity and humanity, driving them away from public services, as has been widely documented in many countries. Women and babies held captive until they pay fees or bribes has been noted in multiple contexts. While abortion is actually legal in most countries of the world, stigma and harassment of abortion-seekers violate their human rights and drive them into unsafe services, despite abortion being one of the simplest and safest of procedures when properly conducted. HIV positive girls, LGBTI people, and sex workers face fear, discrimination, violence, and even death when seeking health services.

Demand side bottlenecks:

On the **demand-side** too, many bottlenecks stand between women and access to health services. Poverty and inequality are not only economically driven, but also by exclusion or marginalization due to other sources of deprivation. Such deprivation involves the interpenetrating workings of multiple relations of power, disadvantage and oppression. It is this conjoint working of different social forces that is often the most challenging barrier to policy interventions. *Deep poverty is intersectional.* Its "victims" suffer multiple and reinforcing forms of oppression, some of which, like caste or gender or ethnicity, may be long-standing and deeply embedded in social systems and structures of belief and practice. What is more, because such intersecting and enmeshed power relations and oppression can be

difficult to tackle, program implementers may tend to direct their attention to groups higher up the ladder just because they may have fewer barriers to transcend[1].

An intersectional approach can help us understand why, even if the programs in themselves are delivered well, sustained programmatic attention to the health of those suffering from economic poverty may not yield the desired outcomes, without more nuanced and multidimensional approaches that are sensitive to the intersections of deep poverty. For instance, a conditional cash transfer requiring poor women to bring their children for immunization may be ineffective for women suffering from deep poverty, whose caste, ethnic or indigenous background may mean that they fear disrespect or mistreatment in the health centre, or who live in hamlets that are ill-served by public transport, or do not have help to care for other children, older or sick or disabled people at home. The result is weak program outcomes because such intersections have not been adequately addressed.

Intersecting discrimination against women and girls is reinforced by their weak access to and control over financial resources, weak social networks, and lack of knowledge and information about health and other services. Their time poverty is exacerbated by their highly unequal work burdens and responsibilities for unpaid care of children, the old and the infirm. IPV and fear of domestic and public violence keep them away from public spaces including schools and health centres, and this may be increasingly so in the growing atmosphere of religion-, race-, migration-, caste-, and other forms of publicly sanctioned hatred. **(Refer to recent IAP report; 2017 on adolescents; beliefs about IPV among boys 15-19)**

Conclusion:

Synergies between the financing and provision of health services and infrastructure on the one side, and access that transcends both supply- and demand-side barriers are possible. But they will only be realized if the human rights including the voice and agency of girls and women are recognized and realized.

[1] Of course, program implementers may focus on low hanging fruit for other reasons including their own beliefs, practices and biases.