Non-Discrimination

Article 2 & Governments' Budgets

Discrimination in allocations and spending on the basis of geography

The case in brief

At the time Peace and Development Volunteers (PDV) undertook its project, Sudan had one of the fastest growing economies in Sub-Saharan Africa. Despite this, as of 2012 the maternal mortality rate (MMR) was 216/100,000. While this was a significant improvement over the situation in 2006, when the MMR was considerably higher, it still fell far short of the MDG goal of 134/100,000. When these statistics are broken down by geographical area (urban/rural), the picture becomes even more disturbing, as the MMR was 225/100,000 for women in rural areas and 194/100,000 for those in urban areas. These figures parallel 2010 statistics, which revealed that 89 percent of women in urban areas were attended by trained personnel during delivery, compared to only 66 percent of women in rural areas.

In 2008 PDV undertook a study of maternal mortality in a rural locality in Khartoum State. Carried out in conjunction with the Khartoum State Ministry of Health, the study provided a close-up of the disparities evident in these national statistics. PDV focused on one of the seven localities in the state, and surveyed a large number of women to learn about their experiences with health care during pregnancy, delivery and post-partum recovery. It also analyzed the federal health budget as well as the budget of Khartoum State. Primary health care services have been devolved to the states, which are expected to fund them from their own revenue. Such a financing scheme means, in practical terms, that people in poorer states will have access to less-well-funded health services. The study identified analogous disparities within states, with wealthier, more urbanized areas having better facilities and more medical personnel available to them. The fact that hospitals and clinics charge fees for services further aggravates the situation. People in rural areas tend to be poorer and less able to afford the fees.

The human rights issue

The Bill of Rights of the Interim National Constitution of Sudan promises that the State shall:

> […] provide maternity and child care and medical care for pregnant women… [art. 32(4)]; and
>
> […] provide free primary health care and emergency services for all citizens. (art. 46)
>
> In addition, all rights enshrined in international human rights treaties that Sudan ratifies "shall be an integral part" of the Bill of Rights [art. 27(3)].

Sudan has ratified the ICESCR, which in article 12 guarantees the right to health. The CESCR in its General Comment 14 has interpreted this article to mean that health facilities, goods and services should be both geographically and financially accessible. It also says that one of the State's core obligations is to ensure reproductive and maternal (pre-natal as well as post-natal) health care, and the equitable distribution of all health facilities, goods and services. (paras. 43 and 44)

The human rights argument

All levels of government (national, state and local) are responsible for guaranteeing human rights. National governments are also responsible for ensuring that sub-national governments fulfill the rights of people within their jurisdictions.

The availability, quality and accessibility of health care goods, services and facilities in Sudan vary enormously between states and within states, particularly between urban and rural areas. Sudan's federal government currently fails to equalize this situation, because it does not allocate and spend its budget in ways that would address these disparities. The national government also fails to monitor state budgets to ensure that state governments appropriately prioritize health spending. As a result, *per capita* health spending across states is not insufficiently similar, impeding equal access to health care facilities, goods and services. Moreover, there is no system by which state governments ensure that their health care spending treats different areas within their jurisdictions with equity.

The obligation of non-discrimination set out in ICESCR article 2 guarantees equal access to the right to health, and prohibits discrimination on the basis of geography and income, among other grounds. The differential access of women to reproductive health care services between states and within states amounts to a failure by the federal and state governments to comply with their obligation of non-discrimination.

Case study in detail

The health care system in Sudan

Public health services in Sudan were offered free of charge from the colonial period until the 1990s. In response to economic hardship and reform prescriptions by the International Monetary Fund (IMF), from the early 1990s the government encouraged the development of private health care, limited public health spending and introduced user fees for various health services. In the 1990s the government also decentralized the public health system, so that Sudan would have a Federal Ministry of Health (FMoH) and a State Ministry of Health in each State. The FMoH is responsible for developing national health policies and strategic plans, as well as monitoring and evaluating health system activities, including at the state-level. State Ministries of Health (SMoH) have the principal responsibility for state-level plans and strategies as well as detailed health programming and project formulation. Management and financing of most of the health system have been devolved to the states and, within states, to localities (sub-divisions within states).

A range of problems has developed following decentralization, having their roots, in part, in inadequate managerial and administrative capacities at the state and local levels. The system also suffers from insufficient financial resources, even in the more well-off states, as the federal government, in devolving its responsibilities, did not provide resources to support the devolved responsibilities. At the same time states had limited, although varying, revenue-raising capacities. A 2003 report undertaken by an international body estimated that the federal and state governments' health budgets together amounted to approximately 2 percent of total government expenditures.

As a result of this seriously inadequate funding, public health services, particularly in the poorer states of Sudan, have degraded steadily over the years. In many places, facilities and services are either sorely inadequate or non-existent. People's reluctance or inability to take advantage of such poor quality care is further exacerbated by the imposition of user fees. As a result, basic health services in Sudan are estimated to cover less than half of the population.

Human rights do not dictate how a health system should be structured and financed. Government can move to private providers, charge fees, and/or decentralize responsibilities for services. When doing so, however, it cannot rid itself of its human rights responsibilities. Government continues to be obligated to guarantee the right to health, and it must establish effective monitoring and/or regulatory processes to ensure that people continue to have access to health care services on a non-discriminatory basis.

First approach: Comparing official statistics with the results of user surveys

Peace and Development Volunteers focused its study on a limited geographical area, Sharq Alneel locality in Khartoum State. It worked in collaboration with the Khartoum State Ministry of Health (KSMoH), which enabled it to have access to epidemiological, programmatic and budget information. The narrow focus of the study also enabled the organization

to do in-depth surveys and interviews, and thereby present a vivid picture of the impact of the structure and financing of the health system on people, particularly women.

Collaboration by CSOs with government ministries or agencies can prove fruitful for both. CSOs often have substantial access to communities and can thus be a good source of information to government on the effect of government plans and programs. CSOs, on the other hand, may benefit from better access to government information. Moreover, their findings may be considered more legitimate for audiences that might not otherwise take the work of civil society seriously. Such collaboration has its risks, of course, and CSOs must always be ready to take an independent stance, even one that is not well-received by its government colleagues.

The Sharq Alneel Health Office (the government agency with primary responsibility for health care provision in the locality) shared its 5-year strategic plan (2007-2011) with PDV. That plan contained the following statistics:

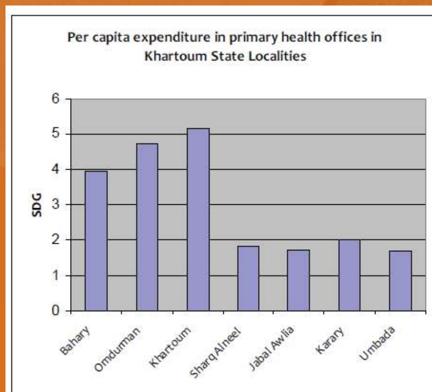
- Roughly 71 percent of the pregnant women in the locality had made one or more antenatal care visit to a health center; only 58 percent made as many as three.
- Only 36 percent of the deliveries in the locality were assisted by trained personnel.
- Most deliveries were in the home, with only 16 percent of women having their baby in a hospital.

The figures arising out of PDV's survey and interviews were somewhat different from those of the Health Office, but similarly grim. Only a third of the women PDV interviewed had had antenatal checkups at a health center during their pregnancy. More revealing, 92 percent of the women said that, because of the fees, they did not have such checkups unless they felt there was something wrong with the pregnancy. In addition, they reported being worried about the delivery fees charged at hospitals. It is fair to assume that these fees thus contributed to the fact that approximately half of the women surveyed delivered their babies at home with the assistance of a midwife. In practice, the fees undermine access to basic health care.

Combining field research and desk budget analysis can render valuable insights into the consequences of budget decisions and the implementation of specific policies. The Sharq Alneel Health Office's statistics about antenatal visits were considerably higher than the numbers reported by the survey of women who should be using the services. Furthermore, these same women shed light on the detrimental effect of user fees on their choices regarding antenatal care and delivery. As a result, a policy of free primary care that, *de facto*, encourages local health facilities to raise much needed revenue at the service delivery point, in reality undermines its ultimate purpose, by driving away potential users.

Second approach: aligning *per capita* spending and health system information

Khartoum State comprises seven localities, three of which are predominantly urban: Bahri, Omdurman and Khartoum. The remaining four (Sharq Alneel, Jabal Awlia, Karary and Umbada) are predominantly rural. Primary health services are offered within localities. Funding for them comes from the State Ministry of Health through its regular budget (82 percent), with the remaining funds coming from the State Ministry of Finance. The SMoH allocates funds to localities on the basis of a number of criteria, including income level, wealth generated by the locality, and population. While at face value the criteria seem adequate, the way in which the different elements are combined and weighted does not render a fair result. From its budget analysis, PDV found that in 2007 this formula led to the following *per capita* expenditures (in Sudanese pounds, SDG) for primary health in the seven localities:



Source: Khartoum State Ministry of Health Financial Report, 2007.

Most people in Sharq Alneel locality are poor, with a majority suffering extreme poverty. The population cannot afford private health care, and so must rely on government services. Despite this and despite the fact that residents in the urban centers of Khartoum State (Bahary, Omdurman and Khartoum) are wealthier than those in rural areas, significantly less was spent *per capita* on health care for people in the rural areas of the State. The results for other years were similar.

Lower *per capita* spending might be justifiable if the localities receiving less money already had higher quality services. However, the data PDV uncovered on health personnel alone indicated the contrary: Sharq Alneel, for example, had only one doctor for every 26,000 people, while in Khartoum locality, the ratio was 1: 8,400. Such disparities would call for a substantial effort to be made to increase spending in underserved areas, until a similar level of service provision has been achieved in all areas.

PDV's recommendations

While a government crackdown on civil society prevented PDV from bringing extensive public attention to its findings, it did share with government ministries and agencies, legislators and civil society colleagues the following recommendations:

- The SMoH should seek to ensure that its spending improves health care services in rural areas, and equalizes access to quality health care among different localities.
- Overall, funds available for health care services within Khartoum State are too low. The federal government, with its ability to bring in much larger revenue than state governments, should significantly increase its spending on health care, and direct a substantial share of that increase to states in the form of conditional grants earmarked for primary health care services.

All governments use formulas to help them determine how much to disburse or devolve to lower levels of government. While these formulas may be based on sound criteria (such as population, poverty levels, etc.), they may nonetheless prove, in practice, to result in an unsatisfactory sharing of resources, because they fail to take into account important specificities that differ from area to area. In order to ensure compliance with the obligations of non-discrimination, government should regularly assess whether the formulas it uses actually enhance equality among different geographical regions.

Questions you might ask

yourself or your government about ensuring that allocations and expenditures on ESC rights-related areas do not discriminate on the basis of geography.

Does the government develop or have access to current data disaggregated by geographical regions that can be used to assess people's access to enjoyment of their ESC rights? If so, what is that data? If not, why not?

Is such data used by the (national and/or sub-national) government in developing its budgets touching on ESC rights-related areas? If not, why not?

Are *per capita* allocations for services in such areas as health, education, work, water and so on similar across different areas of the country (or state)? If not, why not?

Are people in specific geographic regions particularly disadvantaged in accessing their ESC-related rights? If so, which areas of the country are those?

How does the (national and/or sub-national) government develop its budget to ensure that people in these areas will increasingly be on a par with other areas of the country in terms of their enjoyment of their ESC rights?

Are there any programs, besides universal programs, that target these particularly disadvantaged areas, so as to close gaps?

Has there been a process of decentralization in the country in recent years in the country? If so, what programs and services have been decentralized? How are these decentralized programs and services funded?

If sub-national authorities are responsible for providing at least some of the funding for the services, what has the national government done to ensure equity among different areas of the country, given different funding capacities of different sub-national authorities?

If national or sub-national government provides lower levels of government with block or conditional grants, what factors are included in the formula for allocations to different parts of the country or area? What difficulties has the government encountered in applying the formula (e.g., inadequate population data)? How has it sought to address these difficulties?

Who was/is involved in developing the formula? Overseeing its implementation? Have questions been raised within the government or by civil society as to the equity of the formula? If so, what has been the government's response to these questions?

Peace and Development Volunteers

Peace and Development Volunteers (PDV) is a local Sudanese NGO established in early 2003 aimed at promoting and advocating for human rights, conflict transformation, and a culture of peace. It fosters sustainable development for the betterment of humanity, focusing on children and other vulnerable groups.

PDV derives its uniqueness from highly professional and experienced cadres and committed and enthusiastic volunteers. It utilizes distinct approaches based on capacity-building and the empowerment of a range of stakeholder groups.

The Article 2 Project

This booklet is part of the *Article 2 & Governments' Budgets* handbook. The handbook has been developed by the Article 2 Project, a working group housed first at the Partnership Initiative of the International Budget Partnership (IBP), and then at the Global Movement for Budget Transparency, Accountability and Participation. The project aims to enhance understanding of the implications of article 2 of the ICESCR for how governments should develop their budgets, raise revenue and undertake expenditures. The project encourages the use by civil society and governments of the legal provisions of article 2 to monitor and analyze governments' budgets. Download the complete handbook at: **www.internationalbudget.org/publications/ESCRArticle2.**

The case study in this booklet is derived from Buthaina Elnaiem, "Our Constitution, Our Health: Budgeting for the Right to Health", Peace and Development Volunteers, 2009.

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