REPRODUCTIVE HEALTH matters

FEATURE

From Millennium Development Goals to post-2015 sustainable development: sexual and reproductive health and rights in an evolving aid environment

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Abstract: *Using research from country case studies, this paper offers insights into the range of institutional and structural changes in development assistance between 2005 and 2011, and their impact on the inclusion of a sexual and reproductive health and rights agenda in national planning environments. At a global level during this period, donors supported more integrative modalities of aid – sector wide approaches, poverty reduction strategy papers, direct budgetary support – with greater use of economic frameworks in decision-making. The Millennium Development Goals brought heightened attention to maternal mortality, but at the expense of a broader sexual and reproductive health and rights agenda. Advocacy at the national planning level was not well linked to programme implementation; health officials were disadvantaged in economic arguments, and lacked financial and budgetary controls to ensure a connection between advocacy and action. With increasing competency in higher level planning processes, health officials are now refocusing the post-2015 development goals. If sexual and reproductive health and rights is to claim engagement across all its multiple elements, advocates need to link them to the key themes of sustainable development: inequalities in gender, education, growth and population, but also to urbanisation, migration, women in employment and climate change.* © 2013 Reproductive Health Matters

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The year 2005 marked a significant point for United Nations (UN) engagement in sexual and reproductive health. The Millennium Development Goals (MDGs) had brought a focus on maternal and child health, reinforced by the World Health Report 2005: Make every mother and child count.[1] The potential of health systems interventions to improve maternal and neonatal mortality had been clearly demonstrated,[2,3] but there were already concerns over progress on reducing maternal mortality, particularly in sub-Saharan Africa.[4] That year the Partnership for Maternal, Newborn and Child Health was formed, focusing on the synergies between maternal, newborn and child health.[5] But this momentum was still limited to achieving MDG 5a: reducing the maternal mortality ratio by three-quarters between 1990 and 2015. From the perspective of sexual and reproductive health, this represents only one portion of the full spectrum of care outlined in the International Conference on Population and Development (ICPD), e.g. family planning, maternal and newborn health, addressing the public health problem of unsafe abortion, controlling sexually transmitted infections, combating harmful practices and promoting sexual health.[6] It would take a further two years before a special resolution of the UN General Assembly would mark the belated addition of MDG 5b: to achieve, by 2015, universal access to reproductive health,[7] reflecting the highly politicised

response to sexual and reproductive health, and the continuing resistance to promoting family planning.

By 2005, it was already clear that the global commitment to a comprehensive sexual and reproductive health agenda remained tenuous: with the consensus around the MDGs, major bilateral, multilateral and philanthropic donors now focused resources on HIV/AIDS and other communicable diseases, child health and a narrowly defined maternal health. The agenda for sexual and reproductive health was being played out in an increasingly complex global aid environment at the same time. This was already recognised by participants in high level consultations of the World Health Organization (WHO) and UN Population Fund (UNFPA) over the previous year, who shared concerns over country capacity to effectively represent sexual and reproductive health in the sectoral and national planning processes emerging from what was then referred to as the "new aid environment". Since the 1990s, trends in development had been increasingly integrative: the international agreement around poverty reduction as a primary development goal contributed to a primarily economic orientation for development, and the World Development Report 1993[8] reinforced this framing for health. Aid rhetoric now called for a shift from funding isolated projects to integrated programmes, or preferably, to direct budget support. At a sectoral level, development coordination gained prominence through sector-wide approaches (SWAps) in health, characterised by government-led sector reform packages and donor collaboration through pooled resources. Integrated Poverty Reduction Strategy Papers (PRSPs) were intended to achieve coordination in pro-poor policy at national level. UN country officers now found their professional training, with its strong technical and programme orientation, of limited use in advising health ministries on these new structures and approaches.[9] These concerns led to a programme of exploratory research, and the introduction of country-level capacity building for advocacy in national planning processes. The findings from this research and the subsequent evaluations of capacity building programmes targeting 27 WHO and UNFPA country offices in four regions[10,11] have provided the core data for the comparative analysis reported in this paper.

That same year, 2005, the ideas underpinning changes in the aid environment had been expressed in the declaration of the Paris Principles for Aid Effectiveness,[12] calling for greater emphasis on country leadership, policy alignment and harmonisation of donor processes, and a focus on managing for results and mutual accountability. These principles crystallised a desire among donors for approaches to development assistance that emphasised a shift in control towards local in-country stakeholders, with more predictable longer term financing and better synchronisation between government policy and budgetary and administrative processes. These trends contained the potential for more comprehensive approaches to sexual and reproductive health and rights, as well as other health issues. They provided options for developing policy across all the relevant sectors, defining a financial package that included both government and external funding, and building the necessary national infrastructure of health facilities and programmes that would underpin necessary service delivery.

The urgency of the drive for better coordination at the global as well as local level was a response to the rapidly escalating demands of what was becoming a global development revolution.[13,14] Coordination – expressed as alignment with local policy or harmonisation of donor processes – was being written into a range of development mechanisms. The commitment to reducing poverty had been translated into the health sector goals through MDGs 4, 5 and 6, to be monitored and reported annually, and integrated into other national planning processes such as Poverty Reduction Strategy Papers (PRSPs).[15,16] The country UN Development Assistance Framework (UNDAF) process followed the lead of broader aid effectiveness initiatives, seeking to align UN activities with government policy and harmonize the work of different UN agencies. Sectoral approaches to development in health now had over a decade of experience of country-led planning, with donors committing to jointly funding and implementing sectoral reforms. The substantially increased funding for health experienced prior to 2005 was to continue, with a greater diversity of stakeholders and a multiplication of global health initiatives. In terms of both resources and influence, global public – private partnerships, civil society networks and private foundations now rivalled traditional multilateral agencies involved in health development such as WHO and UNICEF.[13,17]

This changing aid environment has been well documented at the global level.[9,13,14] Our research explored how these global changes have had an impact on sexual and reproductive health policy