

Strengthening country office capacity to support **Sexual and reproductive health in the new aid environment**

Report of a technical consultation meeting: wrap-up assessment
of the 2008–2011 UNFPA–WHO collaborative project

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Summary

Following the conclusion of the “Strengthening country office capacity to support sexual and reproductive health in the new aid environment” project, a series of four country case-studies were undertaken in Malawi, Lao People’s Democratic Republic, Senegal and Tajikistan in early 2011. These provided an opportunity to explore more broadly the changes that have occurred in the 5 years since implementation of the project, and to reflect on the changing roles of United Nations Population Fund (UNFPA) and World Health Organization (WHO) country offices, in what continues to evolve as a complex and dynamic context for sexual and reproductive health (SRH). This report provides a summary of key findings, with actions for further collaboration in SRH.

The case-studies marked an increasingly complex aid environment, with new stakeholders and partnerships for development, and a number of mechanisms seeking to coordinate donor contributions in sectoral and national planning processes. In addition to the sector-wide approaches and poverty-reduction strategy papers that were the focus of country office engagement in 2005, there is an increasing emphasis on reporting and strategizing in order to achieve the Millennium Development Goals (MDGs), in particular MDGs 4, 5A and 5B. While this has raised awareness of issues around maternal and newborn health, other aspects of SRH have been marginalized, in terms of both country priorities and donor support. The increasing importance of the aid effectiveness agenda has been reflected in the development of structures for donor coordination, and greater acknowledgement of country leadership and mutual accountability in these collaborations. Secure, predictable funding for SRH remains a problem, and much of the funding for activities are still donor dependant. Multisector approaches to SRH programmes remain largely underdeveloped.

Yet the shift towards health-systems strengthening and its support through the International Health Partnership (IHP+) and other related initiatives offer a framework within which SRH may be more broadly addressed.

The support offered to ministries of health by the UNFPA and WHO country offices has been marked by greater collaboration and a stronger functional focus. This has been achieved through harmonization of activities in the United Nations Development Assistance Framework, and by practical engagement of technical working groups and similar structures for SRH.

For SRH, the increasing momentum towards the 2015 MDG deadline provides a necessary opportunity for reflection, planning and repositioning. The focus now needs to be beyond 2015, taking the opportunity of that watershed to reframe the positioning of SRH in the evolving health and development landscapes. With the trend towards increasing coordination, alignment and harmonization (currently profiled by the Fourth High Level Forum on Aid Effectiveness, 29 November to 1 December 2011, in Busan, Republic of Korea), emphasis on community-level multisector approaches, and renewed focus on health systems, SRH needs to be positioned within this context.

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The report draws on findings from four country case-studies prepared by the following WHO and UNFPA staff members:

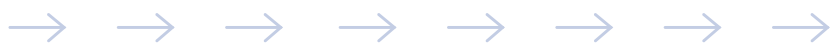
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The case-study reports are available upon request from either UNFPA or the WHO Department of Reproductive Health and Research. The report benefited from suggestions and input from all those present at the meeting. The contributions of Abdul Bun Hatib N’Jie (WHO representative, retired), Viviana Mangiaterra (WHO headquarters), Juliana Lunguzi (UNFPA Malawi Country Office) and Ini Huijts (WHO headquarters) as discussants, and input to the discussion from Gifty Addico (UNFPA Sub-Regional Office, Johannesburg, South Africa), were much appreciated.

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Abbreviations and acronyms

CCA	common country assessment
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
H4+	United Nations Health Four plus (WHO, UNFPA, UNICEF, World Bank, and UNAIDS)
ICPD	International Conference on Population and Development
IHP+	International Health Partnership and Related Initiatives
MDG	Millennium Development Goal
MMR	maternal mortality ratio
MNCH	maternal, newborn and child health
MOH	ministry of health
OECD	Organisation for Economic Co-operation and Development
PRSP	poverty-reduction strategy paper
SRH	sexual and reproductive health
SWAp	sector-wide approach
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Background

The conclusion of the “Strengthening country office capacity to support sexual and reproductive health in the new aid environment” project completes the trajectory of a substantial collaborative interest between the United Nations Population Fund (UNFPA) and the World Health Organization (WHO) around the positioning of sexual and reproductive health (SRH) in higher-level planning processes.

The first high-level consultation between UNFPA and WHO in 2002 called for collaboration in health-sector-wide approaches (SWAps), and adequate investment in reproductive health. In 2004, the second high-level consultation recognized the progress made, and identified a need for complementary efforts from both agencies to mainstream SRH in national and international planning processes. It was recognized that greater engagement in SWAps and poverty-reduction strategy papers (PRSPs) required the provision of high-quality, independent policy and technical advice that comprehensively addressed sectoral development. As a first step towards structuring an active joint programme of work, a “needs assessment” was carried out to determine the capacity-building requirements of UNFPA and WHO country offices for effective negotiation of the changing aid architecture in support of SRH. During 2005–2006, a number of exploratory activities were conducted, including four country case-studies in Mongolia, Nicaragua, Senegal and Yemen, to identify cross-cutting issues and key lessons that are relevant to these processes.

The findings of these baseline studies (1) confirmed the early stage of engagement of UNFPA and WHO staff in these processes, and described a prevalent lack of connection between the policy and planning level and programme strategy and operations. SRH advisers were seen to need capacity-building on how to locate SRH within broader ministry of health

(MOH), government-wide, and macroeconomic contexts. UNFPA and WHO country office staff, in particular, indicated their need for additional training in these areas, in order to support national MOH staff in their engagement in PRSPs, SWAp processes and monitoring MDGs.

From April 2008 to April 2011, with the support of grants from the Ford Foundation and the United Nations Foundation (UNF) /United Nations Fund for International Partnerships (UNFIP), WHO and UNFPA developed and delivered a training programme for their staff entitled “Strengthening capacity of UNFPA and WHO to advocate for the integration of sexual and reproductive health issues into national development planning processes”. This project aimed to build capacity within UNFPA and WHO country offices to support SRH in national development and health-sector planning and budgeting processes, and in partnership with civil society organizations. It coincided with other capacity-building initiatives in both organizations and focused on the “new” aid environment, but differed from them in its specific programme focus, and its emphasis on the positioning of SRH in this context. The training programme was delivered through four regional workshops to 110 staff from UNFPA and WHO country offices in 27 countries. In a few selected countries, follow-on grants were provided to support activities that were jointly conducted by UNFPA and WHO country offices targeting specific actions to advance SRH.

The external evaluation of the work shops, and the action plans that followed them, clearly demonstrated that the quality of training materials and delivery was highly valued by UNFPA and WHO staff in country offices. Post hoc evaluations suggest that the contents of the course have been made available through technical support to MOHs, and to other development agencies and donors.

As part of a 3-year collaborative project's wrap-up assessment, this study seeks to map out the changes in the aid environment experienced since the first case-studies were undertaken, the perceptions of UNFPA and WHO country office staff of their understanding of these changes, and their capacity to negotiate the complexities of this dynamic environment to support MOHs. This assessment used four case-studies, in Malawi,

Lao People's Democratic Republic, Senegal and Tajikistan, to explore more broadly the changes that have occurred in the 5 years since the previous case-studies, and to reflect on the changing roles of UNFPA and WHO country offices in what continues to evolve as a complex and dynamic context for SRH.

The case-studies

The assessment used a case-study methodology to examine changes in the positioning of SRH in higher-level planning processes in some least-developed countries, and in the international development environment supporting reform within the health sector. The analysis explored the extent to which the project “Strengthening capacity of UNFPA and WHO to advocate for the integration of sexual and reproductive health issues into national development and sectoral planning processes” has contributed to effectively responding to these changes. From the findings, we have sought to identify key directions for future technical assistance and guidance for WHO and UNFPA colleagues working at country level on this complex set of issues.

The four case-studies were selected from diverse geographic regions with contrasting political and sectoral structures. All are currently engaged in health-sector reform, and represent differing stages of progress towards a SWAp. The UNFPA and WHO country offices in each of the countries selected had participated in the project’s training course, and two of the four countries had received follow-on grants. The case-study of Senegal provided a point of continuity with the previous case-studies, and offered the longest experience with SWAps among the sites selected; Malawi gave insights into the challenge of strong central policy development and donor coordination in the context of decentralization; the Lao People’s Democratic Republic shows the early promise of the aid effectiveness agenda in a health system that has been fragmented and under-resourced; and Tajikistan, bridging both Eastern Europe and Central Asia, points to the unique issues of governance within the health sector as it emerges from post-Soviet central control.

The case-studies were undertaken from January to March 2011, by teams of four to five UNFPA and WHO staff with expertise in aid effectiveness and SRH; team members came from headquarters, regional and country offices of both agencies. The fieldwork was coordinated with UNFPA and WHO country offices, and UNFPA and WHO regional offices participated in planning the case-studies.

The research was undertaken using a common methodology, set of research questions and analytic framework for reporting. Prior to the fieldwork, a policy and situational analysis was undertaken by each team, based on the work of locally recruited consultants who assembled relevant policy documents, programme and project reports and plans, academic articles, and associated “grey” literature. During the site visits, interviews were conducted with key staff of WHO and UNFPA country offices, MOH and other government officials (e.g. finance), and representatives of nongovernmental agencies and donor agencies active in the health-sector reform process or in SRH. Brief field visits were conducted to include a “reality check”. Although the current development focus rests primarily on MDG5, the country case-study assessment used a broader definition of SRH that is consistent with the global reproductive health strategy, and the International Conference on Population and Development (ICPD) *Programme of action*, 1994 (3)¹.

Draft case-studies were presented and the results discussed during a WHO and UNFPA technical consultation meeting, held in Glion, Switzerland, 21–23 March 2011, which identified cross-cutting issues, progress made and lessons learnt. Annex 1 details the list of participants. The specific objectives of the consultation meeting were to identify cross-cutting themes from the four case-study reports; to explore actions that can be taken in the immediate, medium and long term to enhance the value placed on SRH within national development processes; and to provide guidance on strategic directions for future capacity-building activities.

Feedback from reviewers and technical staff has been incorporated into the final drafts, which are available upon request from UNFPA and the WHO Department of Reproductive Health and Research.

¹ The five key elements of reproductive health are defined in the World Health Assembly resolution 57.12, 22 May 2004, and are consistent with the 1994 ICPD *Programme of action* (3): improving antenatal, perinatal, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health.

Synthesis of findings

The case-studies bear witness to a period of dynamic and continuing change since the 2005 assessment:

- the importance of MDGs as a focus for global development has intensified as 2015 approaches;
- the significance of the *Paris Declaration on Aid Effectiveness* (2005) (4) has been amplified in subsequent communiqués, and the strength of its principles on reshaping aid efficiency has grown;
- new collectivities such as the International Health Partnership (IHP+) and the H4+ are supporting these changes;
- the focus of development assistance has shifted to recognize the importance of strengthening health systems;
- the increased flow of resources into the sector from global health partnerships and large philanthropic donors has had a significant effect on national sectoral planning and budgeting processes.

At the country level, the priority issues in 2005 were SWAps and PRSPs. In this review, it has become clear that multiple global initiatives now require attention; there are increasing numbers of stakeholders (national and international), with complex interactions; and there are greater demands in terms of transaction costs. Increased awareness of this evolving context in WHO and UNFPA country offices has led to enhanced collaboration in supporting government engagement with these developments.

The new aid environment and global change

Five years after the original baseline country case-studies were conducted, the “new aid environment” is arguably no longer “new” – although it is marked by continuing change. In 2005, with economic perspectives and the common focus on poverty increasingly framing international development, UNFPA and WHO country offices had been

challenged by the need to advocate for SRH in planning processes at sectoral and national level, rather than only at a programmatic level. The potential of SWAps for SRH had been recognized: UNFPA had clear guidelines for engagement and support; WHO were exploring theirs. One third of the way towards their target date of 2015, the first rounds of reporting on progress towards the MDGs were beginning to shape national planning processes. PRSPs were a mandatory precursor for World Bank relief for heavily indebted poor countries: SRH programmes offered clear strategies for targeting both poverty and MDG4 and MDG5. Potential synergies were increasingly evident, with calls for all countries to develop “MDG-based PRSPs” (5).

Since 2005, the international development perspectives have broadened, with new funding sources, partnerships and configurations of stakeholders. Global public-health initiatives such as the Global Alliance for Vaccines and Immunisation (GAVI) and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) have matured their operations and increasingly become significant sources of revenue for national health budgets in many low-income countries. Additional, new resources are being accessed from the private sector and corporate philanthropy, broadening the partnerships in health interventions and challenging public-sector models of governance. The Organisation for Economic Co-operation and Development (OECD) had secured agreement on the *Paris Declaration on Aid Effectiveness* in 2005, followed by the *Accra Agenda for Action* in 2008 (4) and the 2011 4th High Level Forum on Aid Effectiveness in Busan, Republic of Korea – each marking a new emphasis on country leadership, policy alignment and harmonization of donor processes, and a focus on managing for results and mutual accountability.

Between 2005 and 2010, WHO and UNFPA staff have had to engage in this increasingly complex and evolving development milieu. Early anxieties

around the ownership of PRSPs (6) have dissipated as they have become integrated into national planning processes and are now a common feature of the development landscape – even the term “PRSP” is used less frequently, with other, locally contextualized names now being more favoured. However, challenges to strengthening linkages across sectors in support of SRH still remain. At sectoral level, the creation of the IHP+ has provided a mechanism for operationalizing the *Paris Declaration on Aid Effectiveness* and the *Accra Agenda for Action* at country level (7); and the recent development of the Health Systems Funding Platform offers the promise of harmonized funding for health-systems development through its links to the joint assessment of national strategies (8).

Sexual and reproductive health and sectoral and national planning agendas

This greater diversity, and a health landscape that is increasingly crowded in terms of actors and issues, have increased the challenge of maintaining the profile of SRH in sectoral and national planning processes, while at the same time the growing number of coordination mechanisms provides many entry points to address this challenge. Each case-study reflects differing aspects of this dynamic, forged by their varying development histories and structures.

For Senegal, whose SWAp provided a promising locus for donor coordination in health in 2005 (see Box 1), the situation is increasingly complex: having been a priority in every development plan to date, SRH as an integrated concept does not appear in either the current *Document de Politique Économique et Sociale 2011–2015* (Economic and Social Policy Document 2011–2015; Senegal’s third poverty-reduction strategy paper) or the *Plan National de Développement Sanitaire 2009–2018* (National Health Development Plan 2009–2018). Health as a whole appears to have lost its prominence in the current *Politique Nationale d’Aide Extérieure au Sénégal* (National Policy for External Aid in Senegal). Whether this is a sign of a broader shift towards favouring “productive-sector” investments, or is a result of weakened leadership in the health sector (attributable to multiple changes of senior staff) is unclear. In either case, the absence of health (in general) and SRH (in particular) in current national plans – after having been formerly featured – draws attention to the uncertain “staying power” of any issue in national political arenas.

Box 1

Repackaging donor coordination in Senegal

Since the 2005 country case-study of Senegal, confidence has waned in the SWAp as a mechanism for effective coordination of donor support for the health sector. With frequent changes of the minister of health and senior staff impacting on the continuity of administration and policy directions, donors and MOH planners are looking to discussions around a proposed compact through IHP+ to provide a new focus for coordination. For SRH, this risks some of the progress in prioritization at the national level, with donors increasingly focusing on MDG4 and 5, and the comprehensive ICPD *Programme of Action* (3) appears as less central to the current 10-year health plan and national documents such as the *Document de la Politique Économique et Sociale* (9) than in previous versions.

For Malawi (see Box 2), governance structures ensure that SRH is well integrated into planning processes for health and poverty reduction. Under the Malawi Growth and Development Strategy (the equivalent of its Poverty Reduction Strategy), the SWAp secretariat (within the MOH Planning Directorate) acts as the secretariat of the Health Sector Working Group, monitoring the implementation of strategies. One of the eight technical working groups that advise the SWAp secretariat is concerned with sexual and

reproductive health and rights, and maintains SRH as a key component of the Joint Programme of Work and the Essential Health Package. Strong donor support contributes to this positioning, but brings with it the risks attendant with donor dependency – unpredictable financing, vulnerability around procurement of supplies, competition with changing donor priorities, and withdrawal of state financing. The human-resource crisis in the health sector continues to contribute to poor maternal and neonatal health outcomes.

Box 2

Translating policy strength into effective health systems in Malawi

Despite a well-articulated policy framework and effective use of the SWAp structure to coordinate donor activities through technical working groups, there are difficulties in achieving translation of SRH policy into decentralised operations at district level. While progress with maternal and neonatal mortality rates is encouraging, they remain unacceptably high, and with life expectancy at birth only 54 years for females and 52 years for males, and HIV prevalence at 12% in young pregnant women, the challenges are great. District health offices experience many challenges in balancing the requirements of both the MOH and the Ministry of Local Government. The mix of competing demands, such as separate planning guidelines, and tension in negotiating different sets of political pressures in prioritizing health needs, is time consuming – particularly in the context of constrained budgets, limited management capacity, and migration of health professionals. But the government's willingness to expand access to SRH services through service-level agreements with nongovernmental organizations, and donor commitment through the SWAp, promise an increasing presence for SRH at the district level.

The Lao People's Democratic Republic National Growth and Poverty Eradication Strategy (the equivalent of its Poverty Reduction Strategy) marks population issues, including SRH and human immunodeficiency virus (HIV), as national priorities, while acknowledging limited success in previous reproductive health initiatives. The current draft for 2011–2015 is targeted towards achieving the MDGs, and priority directions are less explicit in terms of reproductive health (see Box 3). The MDG 5A target is ambitious, given the progress in the previous phase, and in current drafts the MDG 5B target – universal access to reproductive health – does not feature. Securing specific budget allocations for SRH has been difficult, with domestic financial support committed largely to recurrent costs, particularly salaries, and development partners largely responsible for addressing the gaps to protect priority programmes from slippage due to budget shortfalls or shifting priorities. Nevertheless, development of the Health Sector Coordination Mechanism, a concrete step towards a SWAp, offers a locus for advocating SRH, and recent collaborations around maternal and newborn child health (MNCH) are promising in terms of donor alignment around an emerging national programme.

Tajikistan's National Comprehensive Health Strategy 2010–2020 (see Box 4) aims to reform its inherited Soviet health system – with its hospital bias, bloated infrastructure and vertical programmes – and to reduce fragmentation of services and

Box 3**Harmonizing the maternal and newborn child health package in Lao People's Democratic Republic**

While reviews of aid effectiveness in Lao People's Democratic Republic in 2008 and 2009 showed little progress, one positive, concrete example has been the harmonization of key donors around the implementation of the maternal and newborn child health package (MNCH). Where previously donor partners worked on programmes from maternal and child health in parallel, development funding from Luxembourg has enabled a subgroup of partners, the three United Nations (UN) agencies (WHO, UNFPA and UNICEF), to explore a more coordinated approach aligned to the national strategy and framework for MNCH (2010–2015), with plans to introduce a single plan and financial report across all agencies. The template for this report, submitted to the MOH, has the potential to influence other donors implementing district-level projects. The MOH acknowledges that this is a “big challenge” – though a highly desirable outcome.

better coordinate development partners. The strategy is strongly aligned towards the MDGs, and identifies components of maternal and child health, adolescent health, HIV and sexually transmitted diseases. SRH is not yet established as a priority by either the government or the relatively limited number of development partners; however, there is strong recognition of maternal and child health in the Poverty Reduction Strategy 2010–2012 and the National Comprehensive Health Strategy 2010–2020. Both strategies are consistent with current global aid effectiveness priorities and present opportunities for the UN and Government

to deepen engagement with the principles and practice of aid effectiveness, and the drive towards achieving the MDGs.

The MDG5 focus and sexual and reproductive health

The global focus on the MDGs, and on MDG 5A and 5B in particular, presents both opportunities and challenges in terms of advancing a comprehensive SRH agenda. With the MDGs adopted as the basic metric for most approaches to development and poverty reduction, the key targets enjoy government recognition in both national and

Box 4**Managing the transition: sexual and reproductive health in Tajikistan**

SRH policy finds itself at the nexus of a series of transitions in Tajikistan: from centralized Soviet economy to liberal democracy; from acute humanitarian assistance to longer-term development aid; and from hospital-based, government-controlled health services to a more comprehensive and pluralistic health sector. Poorly covered in national planning documents, support for SRH remains largely donor driven, with a failure to gain government recognition apart from issues related to maternal mortality. However, with MDG5 strongly supported within the Poverty Reduction Strategy and the National Development Strategy (2007–2015), the recent National Comprehensive Health Strategy (2010–2020) extends this to include maternal and child health, adolescent health, sexually transmitted infections and HIV prevention – although it does not elaborate further on broader aspects of reproductive health. Current explorations around the development of a SWAp, and a higher profile for the aid-effectiveness agenda, offer WHO and UNFPA the opportunity to promote collaboration around SRH, within a broader agenda for health-systems development and UN reform.

sectoral planning processes. The underlying concepts are readily accessible: decision-makers understand what it is to prevent maternal and neonatal deaths; to reduce death and disability for children; and to reduce death and disability from AIDS, tuberculosis and malaria. *The World health report 2005: Make every mother and child count* (9) marked the importance of responding to this burden of maternal and neonatal mortality, and mapped out strategies to achieve change. Maternal and child health finds itself strongly positioned in sectoral, national and global health agendas, and central to broader development discourse.

In 2005, the baseline country studies pointed to a lack of connection between advocacy for reduction of maternal mortality in national-level planning and the necessary linkage to effective programmatic responses through resource allocation, capacity-building and human-resource development. The 2011 case-studies suggest that this problem persists: despite a closing of the gap between policy and programmes, the limited progress with improving health outcomes has shown the importance of strengthening health systems – particularly for maternal and newborn health. For example, in Malawi and Lao People’s Democratic Republic, progress is being made against the MDG 5A targets, though at levels below their planned trajectories. In Malawi, the maternal mortality ratio (MMR) fell from 1120 per 100 000 live births in 2000 to 806 per 100 000 live births in 2006; in Lao People’s Democratic Republic, it fell from 790 per 100 000 live births in 2000 to 580 per 100 000 live births in 2008. However, problems with limited quality of maternal mortality data in Senegal and Tajikistan make interpretation of recent trends unreliable, and both countries reported incomplete data against MDG 5B.

Nevertheless, the renewed interest in maternal and child health has not unequivocally improved the profile of SRH; if anything, it has reinforced historical distortions within SRH, marginalizing attention to family planning, and often neglecting

the rights agenda and prevention of unsafe abortion. In terms of maintenance of a dedicated SRH governance structure, Malawi appears to be an exception. Its retention of a technical working group focusing on SRH, within an active SWAp structure, has ensured an ongoing prioritization of SRH in the Malawi Growth and Development Strategy II. For Lao People’s Democratic Republic, the focus of donor coordination around the MNCH package has reduced previous duplication and overlap, but other SRH concerns have remained underfunded. In Senegal, SRH has lost ground in both development and health planning, and in Tajikistan, the 2010 creation of a Maternal and Child Health Council marks a commitment to those issues, but SRH more broadly has not been addressed. Strong development assistance support for SRH has maintained the programme, but it has also contributed to conditions that allow the government of Tajikistan to shift domestic funding towards other programmes and rely increasingly on partner organizations such as UNFPA to support SRH (particularly commodity security).

Alignment and harmonization of sexual and reproductive health

The 6 years since the *Paris Declaration on Aid Effectiveness* (4) have marked a significant change in awareness of the importance of coordination of resources for health and development – though reviews of progress at the *Accra Agenda for Action* in 2008 (4) suggested that there was a need for a greater shift towards alignment with government policies and national systems (such as monitoring and procurement) than had already occurred. The case-studies have shown how increasing mechanisms for coordination have themselves presented challenges for governments, with a range of coordination structures at national, sectoral and subsectoral levels leading to high transaction costs for country office staff and government officials.

In each of the countries where the case-studies were conducted, coordination has been managed in different ways: the Government of

Malawi's recognition of the SWAp secretariat as their Health Sector Working Group secretariat eliminates duplication at this level; the Sexual and Reproductive Health and Rights Technical Working Group secures a key position for SRH in policy and planning. For Senegal, earlier confidence in the SWAp has been eroded, and donors with a commitment to alignment around SRH interests are now looking to the proposed IHP+ compact as a locus for coordinating development assistance. In the interim, development partners have not demonstrated a commitment to government policy directions, as high rates of turnover for ministers of health and their senior administration have disrupted policy directions.

Lao People's Democratic Republic committed early to the principles of aid effectiveness, when government and 22 local partners together agreed the *Vientiane Declaration on Aid Effectiveness (10)*. Reviews of progress in the country point to greater need for predictable development assistance and better synchronization with national planning and budgetary frameworks. The Sector Working Group provides coordination of donor activities, including those for SRH, and provides a preliminary sectoral structure as the country progresses towards a SWAp. However, the persisting dependence on stand-alone project formats for health aid, and the practice of partner organizations administering the projects through independent project-implementation units and maintaining different staff conditions and allowances continue to undermine attempts to harmonize at the level of implementation..

Other themes to emerge from the case-studies are the number of global initiatives that are being reoriented as local processes: PRSPs are increasingly local national poverty strategies, linked to national plans; countries are marking the local significance of the *Paris Declaration on Aid Effectiveness (4)* through their own country declarations or memoranda of understanding; and MDG indicators have provided a unifying framework for the development of local information systems.

For local planners engaged in these processes, the ready availability of SRH policy guidance has been valuable, though, as Malawi shows, strong policy requires operational capacity, particularly in a decentralized system. The case-study attributed the recent failure in Malawi to secure Round 10 GFATM funding to poor absorptive and dispersal capacity of funding, and weak accountability mechanisms from the previous rounds, marking the need for central policy strength and progress on good governance to be complemented by building competence at district level.

Each of the case-studies reported on how increased donor support for health has made it difficult for MOHs to successfully argue for additional domestic sources of revenue for the sector – each site experienced this dilemma to varying degrees. The findings of the case-study in Malawi show increases in development assistance to the health sector occurring at the same time as government-wide budget allocations to health were reduced or shifted to other line ministries. While there are other constraining factors on increasing domestic resources for health in addition to infusions of overseas development assistance to the sector (such as considerations of efficiencies and absorptive capacity), the case-studies found these were little discussed during the fieldwork.

UNFPA and WHO: changing patterns of collaboration

The case-studies suggest that there have been significant evolutions within UN agencies and their mechanisms for collaboration, which mirror the profound changes in the aid environment at global and local levels. While the legacy of working in a "project mode" as opposed to functioning through a programme-based approach continues to be present in both agencies, and progress has been uneven on UN Country Team (UNCT) administrative and financial reforms, the case-studies noted some important changes in patterns of collaboration. Earlier concerns around the United Nations Development Assistance

Framework (UNDAF) and its links to planning cycles within individual agencies, which were voiced in the 2005 case-studies, appear to have been reconciled by 2011. While some discrepancies continue, there is less focus on working through the numerous technical difficulties of different operational procedures across agencies, and greater recognition of the need to continue to focus on the principles and higher-level policy coherence, while maintaining harmonization in terms of programme implementation. Earlier uncertainty around engagement with SWAPs, and participation in pooling mechanisms, is no longer an issue. Feedback from both WHO and UNFPA offices suggested a greater confidence in engaging in the diverse mechanisms for coordination at sectoral and national level. In some cases, such as Lao People's Democratic Republic, the enhanced relationships between UNFPA and WHO were

traced back to the combined training programme provided by the joint UNFPA/WHO project. In Senegal, synergies between UNFPA and WHO maintained the profile of SRH within a fragmented policy framework. The co-location of UNFPA and WHO offices in Tajikistan promotes communication. More importantly, the mechanisms of coordination between UN agencies are reported as being focused not on demonstrating collaboration per se, but on achieving outcomes. This functional collaboration has been facilitated through the increasing use of technical working groups – in both Malawi and Lao People's Democratic Republic – providing a structure for collaboration between the UN agencies, government and other development partners.

The way forward: suggested future actions

Analysis of the case-studies by the technical consultation meeting has provided a number of conclusions that highlight the way forward in this complex evolving environment. For SRH, the increasing momentum towards the 2015 MDG deadline (e.g. the UN Secretary-General's Global strategy for women's and children's health (11)) provides a necessary opportunity for reflection, planning and repositioning. The intervening years will bring urgency in addressing issues of maternal and newborn mortality that constitute a crucial agenda within SRH. There is a need to progress strategies to address both MDG5A, with its focus on maternal mortality, and MDG5B, with its call for universal access to reproductive health, articulating more clearly the linkages between them and their capacity to impact synergistically in achieving both sets of targets.

While sectoral and national planning processes may provide ready accommodation for maternal and child health components, SRH advisers may need to deconstruct the SRH agenda, tracking the commitment to individual components as they are incorporated into the policy agenda and translated into other initiatives: family planning and contraception; adolescent sexual health programmes; gender and sexuality issues; sexually transmitted diseases; and prevention of unsafe abortion. Support to national government efforts to develop multisector engagement around SRH will continue to be needed, particularly as trends towards decentralized planning and financial management procedures move forward. This creates opportunities for country office capacity to expand into new areas, and to gain new skills in working with the UN OneHealth costing tool (12), abbreviated expenditure tracking methodologies, and monitoring and evaluation frameworks, among others.

The paucity of comprehensive SRH information for reliably measuring progress is a concern, and a focus on health-information systems, reliable indicators and improved data collection and analysis is necessary to confidently map progress. For WHO and UNFPA offices, the translation of available data into advocacy for SRH in local, sectoral, national and global forums is a critical contribution.

Country offices are recognizing the opportunities that the MDG5 focus brings, and seeking to map out the remaining elements of SRH into the matrix of planning processes. Family planning can be located within the evidence-based strategies for reducing maternal mortality. The maternal and newborn focus provides linkage to prevention of mother-to-child transmission of HIV. Further synergies with HIV offer opportunities to incorporate issues of risk behaviours and sexually transmitted diseases. Recent emphases on youth and adolescent health, such as in Tajikistan, provide opportunities to broaden the agenda further to include the important issue of gender equality.

It is clear that the focus now needs to be beyond 2015, taking the opportunity of that watershed to reframe the positioning of SRH in the evolving health and development landscapes. There is a clear trend towards increasing coordination, and towards alignment and harmonization; global attention to these factors will continue, and demands the positioning of SRH within this context. Health-systems approaches are achieving recognition, with the realization that the advances made through targeted vertical approaches can only be sustained in the context of stronger comprehensive health systems.

SRH, with its dependence on the integration of sectoral and intersectoral strategies; personal behaviour change and population interventions; primary health care; and higher-level referral, is well positioned to be located securely within the commitment to strengthening health systems.

The broadening of engagement for WHO and UNFPA country staff brings with it the need for a wider set of skills, knowledge and interest. These staff need to be able to strengthen links between development planning and health planning, health-financing systems, public finance management, and sex, and link these to commitments for the MDGs. They need to be able to offer SRH strategies and ensure that SRH indicators are integrated into information systems for sector-wide evaluations, performance-based financing mechanisms and routine programme monitoring – and that the data are reliably collected and analysed. From evaluation of the “Strengthening country office capacity to support sexual and reproductive health in the new aid environment” project, we are aware that training teams does translate into continued in-country cooperation, and that synergies do result from this opportunity for collaboration. We are also aware that training teams provides more sustainable change than does development of the capacity of individuals – though this itself has worth. The wrap-up assessment has received consistent feedback that engagement beyond WHO and UNFPA, to include other UN agencies, and extend contact to both government and civil society, is effective in securing a continuing place for SRH in an aid environment that is constantly changing.

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