From Transforming Power to Counting Numbers: The evolution of sexual and reproductive health and rights in development; and where we want to go from here

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The Power of Numbers: A Critical Review of MDG Targets for Human Development and Human Rights

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Preface

This paper is one of a series of papers in a research project, *The Power of Numbers: A Critical Review of MDG Targets for Human Development and Human Rights (the "Project")*[†]. Motivated by a concern with the consequences of the Millennium Development Goals (MDGs) beyond the achievement of the 2015 targets, the Project seeks to explore their broader policy and programmatic implications. It focuses particularly on the reductionism inherent in the way in which these global goals were set and came to be used, as well as the potential for distorting priorities and marginalizing, or even displacing, important human development and human rights concerns inherent in such global goal-setting exercises. A total of 11 studies are included, each analyzing the normative and empirical consequences of a particular MDG goal/target, and considering what other targets and indicators might have been more appropriate. The Project aims to identify criteria for selecting indicators for setting targets that would be more consistent with Human Development and Human Rights priorities, amenable to monitoring impacts on inequality, accountability and consistency with human rights standards.

Although this paper is currently accessible as a free standing working paper, it should be read in conjunction with the synthesis and background papers of the Power of Numbers Project. These papers provide necessary information about the scope of the Power of Numbers Project, the historical framing of international agreements leading up to the MDGs, and the human rights and human development frameworks referenced in the paper. These working papers are expected to be compiled as a special issue of the *Journal of Human Development and Capabilities*.

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Abstract

The only goal related to sexual and reproductive health and rights (SRHR) in the Millennium Development Goals (MDGs) was MDG 5, which called for improvement in maternal health and set a target of a 75 percent reduction in maternal mortality ratios (MMRs) from 1990 levels by 2015. Another target, MDG 5B, relating to universal access to reproductive health was added belatedly, in the face of substantial political opposition. In this article, we begin by providing some context for the selection of the targets and indicators chosen to measure "improvement in maternal health" and also consider why the broad vision of SRHR set out at international conferences in the 1990s was reduced to maternal health in the MDGs. Next, we examine what progress has been made with respect to MDG 5, focusing in particular on the human rights principles of equality and non-discrimination, participation and transparency, and accountability. We then turn to what has happened as a result of the choices made with respect to the targets and indicators focusing on maternal health, as well as the aspects of SRHR that were left off the MDG agenda. By examining research, funding, and programming we consider the intended and unintended consequences of the choice of MDG 5 as a goal, together with its targets and indicators, for the SRHR agenda. Finally, we consider various scenarios for including SRHR in goals that have been proposed moving forward, and discuss criteria for selecting targets and indicators from the perspective of human rights.

Introduction

Sexual and reproductive health and rights (SRHR) were comprehensively defined in the Programme of Action of the International Conference on Population and Development (ICPD or Cairo) in 1994, and reiterated and further developed in many subsequent international consensus documents. However, the only goal related to SRHR in the MDGs was MDG 5, which called for

improvement in maternal health and set a target of a 75 percent reduction in maternal mortality ratios (MMRs) from 1990 levels by 2015 (United Nations, 2000a). In 2005, another target, MDG 5B, relating to universal access to reproductive health was added, in the face of substantial political opposition, and indicators for measuring Target 5B were introduced in 2007.

In this article, we begin by providing some context for the selection of the targets and indicators chosen to measure "improvement in maternal health" and also consider why the broad vision of SRHR set out at international conferences in the 1990s was reduced to maternal health in the MDGs in 2001. Next, we examine what progress has been made with respect to MDG 5, focusing in particular on the human rights principles of equality and non-discrimination, participation and transparency, and accountability. We then turn to what has happened as a result of these choices with respect to maternal health, as well as the aspects of SRHR that were left off the MDG agenda. By examining research, funding, and programming, we consider the intended and unintended consequences of the choice of MDG 5 as a goal, together with its targets and indicators, for the SRHR agenda. Finally, we consider various scenarios for including SRHR in goals that have been proposed moving forward. We argue that the post-2015 development framework should be based on principles of universality and transformation and achieved through a multi-sectoral response to SRHR specifically and development more broadly.

MDG 5: Historical evolution of an international agenda

MDG 5, and all of the MDGs, emerged from a specific historical and political context. In this section, we briefly reconstruct the narrative that led to the establishment of MDG 5 as a Goal, as well as the specific targets and indicators that were selected to measure progress. Beginning with the Safe Motherhood Initiative in 1987, we examine different approaches to addressing maternal health at the global level, stressing in particular the achievements of Cairo and Beijing, and the retrogression reflected in the final MDG agenda. We also explore the limitations posed by the principal indicator selected to measure MDG 5: the MMR.

The Safe Motherhood Initiative: Initial Hopes, Slow Progress

In 1987, the Safe Motherhood Initiative (SMI) was launched in Nairobi, calling for a "reduction of maternal mortality by 50% by the year 2000" (Starrs et al., 1987). As the first

global campaign created to raise awareness of the toll of maternal mortality, the SMI sought to capitalize both on the success of the Child Survival Initiative as well as the urgency of the approaching end of the "UN Decade for Women," in order to firmly establish maternal health on the global radar (Shiffman and Smith, 2006). The SMI faced a series of challenges from its inception. Disputes over intervention strategies, problems with measurement of MMRs, and the lack of a unifying framework and leadership all contributed to slow progress in tackling maternal mortality and morbidity (MMM) (Shiffman and Smith, 2006). In the mid-1990s, however, a combination of factors led to the possibility of real change. First, strategies aimed at predicting and preventing obstetric complications through antenatal care (ANC) and training of traditional birth attendants (TBAs) had proven ineffective and a global consensus emerged within the public health community on the importance of access to treatment. In 1997, the World Health Organization (WHO), United Nations Children's Fund (UNICEF), and United Nations Population Fund (UNFPA) jointly issued 'Guidelines for Assessing the Availability, Use, and Quality of Obstetric Services', which was a historic step, as previously there had been a lack of leadership and a fragmented, uncoordinated approach to maternal health across UN agencies (UNICEF, WHO, UNFPA, 1997).

1990s: UN Conferences, culminating in Cairo and Beijing

At the same time as the public health community was slowly arriving at a consensus on interventions, the advocacy community began making strides with respect to global commitments. The UN World Summit for Children in 1990 generated global pledges and financial resources for a set of goals aimed at child survival, protection, and development. These included a restatement of the SMI goal of halving maternal mortality by 2000, as well as four sectoral goals related to the health and nutrition of female children, pregnant and lactating women, access to information and services by couples to prevent and space pregnancies, universal access to education, and access by all pregnant women to prenatal care, skilled birth attendance (SBA), and referral facilities for obstetric emergencies and high-risk pregnancies were established (UN, 1990; UNICEF, 1990).

Three years later, in 1993, the World Conference on Human Rights in Vienna marked a renewed effort to strengthen and implement UN members' commitments to human rights and

replaced the Cold War division between Civil and Political Rights (CPR) and Economic Social and Cultural rights (ESCR) (United Nations, 1993). Vienna proved an important testing ground for the women's movement as they achieved agreement that women's rights - long neglected as "private" issues - were human rights (Bunch and Reilly, 1994; Sen et al., 2007).

At the International Conference on Population and Development (ICPD or Cairo) held in Cairo in 1994, the women's movement built on this experience and was able to achieve substantial inroads into conventional development approaches. The ICPD represented a historic paradigm shift where demographic imperatives ceded importance to reproductive rights (Cook et al., 2003; Reichenbach and Roseman, 2009; Sen et al., 2007; Yamin, forthcoming 2013a). For the first time, previously disparate issues ranging from gender-based violence to family planning to access to care were captured under the umbrella of "reproductive health" and safe motherhood was embedded within the broader context of reproductive health. The reduction of maternal morbidity and mortality, together with family planning and comprehensive reproductive health services, were set as goals, along with graduated country level targets based on baseline MMR levels (UN, 1995a; AbouZahr, 2003; Sen et al., 2007).

This broad understanding of reproductive health and rights was reaffirmed at the Fourth World Conference on Women in Beijing in 1995, which built upon the ICPD agenda by recognizing that the protection of women's sexual and reproductive rights is an essential condition for their equal and full participation within society (UN, 1995b). The Beijing agenda made it clear that implementation of this vision required societal changes, shifts in power and gender relations, as well as changes in health care delivery (Reichenbach and Roseman, 2009; Yamin and Falb, 2012; Yamin, forthcoming 2013a). The thirteen targets set in the Beijing Platform of Action were disaggregated, with individual targets for women and poverty, education, health, violence, power and decision-making, economy, and human rights (UN, 1995b).

Post-Cairo and Beijing; the International Development Goals (IDGs); and the Rocky Road to the MDGs

Immediately, there was a strong backlash against the ICPD agenda. As Marge Berer has noted, an "unholy alliance" between the Holy See, conservative Islamic countries, and Christian evangelicals formed to mobilize a response (Berer, 2001). At the same time, other events led to conservative forces gaining the upper hand in global politics surrounding women's health, including a re-alignment in the G77 and the rise of the reactionary Christian Right in the United States leading up to the election of George W. Bush (Crossette, 2005; Hulme, 2009b; Yamin and Falb, 2012). Additionally, the change in leadership at UNFPA, whereby one of the great champions of the ICPD agenda, Nafis Sadik, was replaced with a more political appointee, further contributed to retrogression on the progressive agendas of ICPD and Beijing.

By the time of the ICPD+5 review in 1999, there was strong dissension over provisions relating to SRHR. In the end, the best that advocates could achieve was a simple reaffirmation of the language from the original ICPD. Additionally, at ICPD+5, tense negotiations within the feminist movement around gender justice and economic justice came to the fore, which in some cases pitted North against South. The ICPD documents treated reproductive and sexual rights as personal rights, but it was clear, at least to some, that these rights needed to be grounded in a broader campaign for global economic justice, as structural adjustment, aid, and trade policies, among others, in order to make it impossible for poor women in the global South to achieve such rights in a meaningful way.

In addition to these external and internal political conflicts, at the turn of the millennium it was clear that there were still other barriers to integrating the ICPD agenda into mainstream development practice. Despite the shift in language to "reproductive health" it proved challenging to "bring Cairo and Beijing home," due, among other things, to a lack of operational guidance. Though progress was made in certain areas, such as establishing legal frameworks that criminalized violence against women, achieving the broad goals of the ICPD and Beijing agendas required more than re-packaging the same programs with different names; it required, among other things, devising new indicators and approaches to programming that transcended sectoral divides (WHO, 2004; Berer, 2012; Yamin and Falb, 2012).

While SRHR was being contested at the global level, the mainstream development community was concerning itself with waning foreign aid levels. In 1996, in an effort to garner

increased international aid, the OECD's Development Assistance Committee (DAC) launched a document entitled 'Shaping the 21st Century' (DAC, 1996; Hulme, 2009a). The document listed seven global International Development Goals (IDGs) selected and adapted from the recent flurry of UN conferences, but did not include a plan of action. The focus of the IDGs was on reducing global poverty, but the purpose was more narrowly focused on increased foreign aid and monitoring effective spending. Reproductive health was on the agenda as "access through the primary health-care system to reproductive health services for all individuals of appropriate ages as soon as possible and no later than the year 2015", but broader connections to gender equality were absent (DAC, 1996). The IDGs were accepted by OECD member states, but, as they included no plan of action, they had little impact on global development at the time. The MDGs, however, draw heavily from the themes of the IDGs.

The Millennium Declaration and the creation of the MDGs

In 2000, the UN General Assembly adopted the Millennium Declaration (the Declaration), which was framed by the UN Secretary-General's report 'We the Peoples: The Role of the United Nations in the 21st Century' (United Nations, 2000b). The Millennium Declaration was an ambitious document, suffused with language of human dignity and equality. However, conservative opposition to the ICPD agenda, as outlined above, resulted in the notable absence of SRHR (United Nations, 2000c; Crossette, 2005; Hulme, 2009b; Yamin and Falb, 2012).

After the Millennium Declaration was approved, specific targets and indicators were established to implement the broad aspirations set out in the Declaration. The resulting MDGs were derived primarily from the IDGs. There were only two significant deviations from the IDGs: first, MDG Goal 8 was added to develop a "global partnership for development" and second, the IDG reproductive health goal disappeared entirely (DAC 1996; United Nations, 2000a; Hulme, 2009a).

Once the broader concepts of SRHR were absent from the Millennium Declaration and women's health was narrowed to maternal health, it was inevitable that the MDGs would also limit SRHR to the specific issue of maternal health. As others have written, the MDGs were

created by "message entrepreneurs", not diplomats, thus thematic inclusion in the MDGs was entirely dependent upon having been mentioned in the Declaration (Fukuda-Parr and Hulme, 2009). The broad agendas from Cairo and Beijing that presented a holistic vision of women's health, rights, and empowerment were further reduced to a single global health target in MDG 5. A reduction of maternal mortality ratios by three-quarters was set and designated as a policy priority (United Nations, 2000c). Gender equality also fared poorly in the MDGs, reflected only as a feeble target on gender parity in education, with additional indicators relating to political representation and female participation in the non-agricultural employment sector in MDG 3.

The target set for MDG 5 drew from the original ICPD target of "a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015" (UN, 1995a). Unlike Cairo and Beijing, however, differential targets that accounted for country specific starting points, development levels, and resource availability were not established in the MDG framework. Moreover, targets were framed in terms of absolute reductions rather than rates of change, which has resulted in major consequences for the assessment and evaluation of progress of the MDGs.

Assessing Progress on MDG 5

In this section, we assess the data regarding what has been achieved on MDG 5, noting the limitations of the principal indicator chosen to measure progress, the MMR, and the belated addition of a second target relating to access to reproductive health services, including family planning. We also assess developments with respect to MDG 5 in light of key elements of a human rights-based approach to development, including equality and non-discrimination, participation and transparency, and accountability.

The Limitations of the Target and Indicator; Belated Addition of MDG 5B

At the mid-point of the MDG action plan in 2007, global estimates of the burden of maternal mortality suggested that very little progress had been made since 1990 (Hill et al., 2007). Subsequently, leading up to the MDG summit in 2010, a flurry of global estimation exercises were undertaken, which showed that more progress had been made than was previously thought (Hogan et al., 2010; WHO et al., 2010).

A study by Hogan, et al. published in 2010 from the Institute of Health Metrics and Evaluation (IHME), which was funded by the Bill & Melinda Gates Foundation (Gates), estimated that in 2008 there were 342,900 global maternal deaths, a reduction from 526,300 in 1980 (Hogan et al., 2010). In the same year, the UN and World Bank published a 2008 global estimate of 358,000, a 34 percent reduction from 1990 levels (WHO et al., 2010). A study, also from the IHME and funded by Gates, estimated that global maternal mortality levels had declined to 273,500 (Lozano et al., 2011). In 2012, the UN again revised its estimate of maternal mortality, to 287,000 global maternal deaths in 2010, a 47 percent decline from 1990 levels (WHO et al., 2012).[3]

While the UN reports that all developing countries have achieved a decline in maternal mortality levels, 20 of the 25 countries with the highest remaining MMRs that are least likely to "achieve" the MDG target are in sub-Saharan Africa (WHO et al., 2012). This trend is unsurprising as these countries generally had some of the poorest starting points and required significant investments in health systems, as well as advancements beyond the health system, on factors such as infrastructure development and female education, in order to make progress on MDG 5. Nevertheless, the lack of progress has come to be used to "name and shame" governments that are not "on track."

The conversion of the MDGs, which were intended as global goals, into national planning targets was particularly detrimental in the case of MDG 5 because MMRs are such inappropriate measures for assessing progress on what strategies and interventions are effective or not. The lack of quality data in many countries with the highest burdens of maternal mortality means that these estimation exercises had to rely heavily on statistical modeling to produce their results. Due to poor data quality and availability, most estimates have large confidence intervals resulting in less precise estimates and overlapping confidence intervals between estimates and over time yield inconclusive results and complicate the interpretation of changing trends. A case-study of Afghanistan, as detailed by Yamin and Falb, illustrates this point: Hogan et al., estimated that in 1980 Afghanistan had 1,640 maternal deaths per 100,000 live births (CI: 632-3,527), in 1990, 1261 maternal deaths per 100,000 live births (CI: 491-1703), in 2000, 1957 maternal deaths per 100,000 live births (CI: 729-4356), and finally in 2008, 1,575 maternal deaths per 100,000 live births (CI: 594-3,396) (Hogan et al., 2010). The rise and fall of maternal

deaths in Afghanistan could be a real trend, but improved ascertainment and classification of maternal deaths may also have influenced the MMR estimates (Hogan et al., 2010). As Yamin and Falb argue, although these findings ultimately seem to suggest a declining trend in maternal mortality over time, the confidence intervals of these four estimates overlap so substantially that it is impossible to draw conclusions about whether and to what extent the levels of maternal mortality have declined in Afghanistan over the past few decades (Hogan et al., 2010; Yamin and Falb, 2012).

The limitations of MMRs, including the fact that they do not account for fertility levels, were recognized when they were selected as the measurement tool for MDG 5 (UNDP, 2003). It was not until 2005, as a result of strong lobbying by UNFPA and others, when target 5B was added and the underlying indicators for Target 5B were not established until 2007. Target 5B called for achieving by 2015, "universal access to reproductive health" and four health service coverage indicators (contraceptive prevalence rate, adolescent birth rate, antenatal coverage, and unmet need for family planning) were added to the official list of MDGs (United Nations General Assembly, 2007; Hulme, 2009a). MDG 5B was adopted against the strong political opposition of the Bush White House, among others, and it is widely acknowledged to be the MDG that is most lagging in terms of progress. Indeed, Target 5B has only been achieved, or is expected to be achieved, in East Asia (UN, 2012).

Equity and Non-discrimination

The MDGs have been criticized for their focus on aggregate advances, without regard to equity, and in the case of MDG 5, the indicator itself may have exacerbated this focus (UNICEF, 2010; UNICEF, 2011; UN System Task Team, 2012). Data disaggregation is vital to detecting disparities within and across countries and identifying potential patterns of discrimination across populations, which is essential from both a human development and human rights perspective (United Nations Committee on Economic, Social and Cultural Rights, 2000). Disaggregation of MMRs exacerbates the issues discussed above on data interpretation because of small sample sizes and large confidence intervals (UNDP, 2003). Thus, for example, the optimistic narrative of India's declines in MMR are undermined upon attempting to look state by state or at income quintiles, despite the quality and availability of the MMR data itself.

If the selection of MMRs unintentionally masked the equity impacts of the MDGs, inequalities were nonetheless sufficiently evidenced in data collected on SBA. A comparative study published in 2012 of 12 maternal, newborn, and child health interventions in 54 countries demonstrated that skilled birth attendance was the MDG indicator that reflected the greatest inequity, subject to significant variations by wealth quintiles and geographical distribution. For the 54 countries captured in the study, average SBA coverage was 54 percent, but the average coverage in the poorest quintile was only 32 percent, compared with 84 percent in the wealthiest quintile (Barros, 2012). These numbers indicate a stark 52 percent difference between quintiles (Barros, 2012). Nigeria was among the 10 countries with the most inequitable coverage of interventions (Barros, 2012).

Participation and Transparency

The MDGs were not born of a participatory process. A major challenge has been establishing national ownership of these "one-size-fits-all" goals and targets, and translating them to the local level (Jahan, 2003). The target and indicators selected to measure progress on MDG 5, and in particular the MMRs with their heavy reliance on sophisticated statistical modeling, have not facilitated transparency and local oversight by the populations affected, as would be consistent with human rights principles. Ideally, the populations affected should be able to audit these data collection and measurement practices, in order to evaluate their local health centers and the policies and programs at both the district and national levels. For example, the availability of contraception options at health facilities, as well as stock-outs, can be observed by local communities and the information can be valuably compiled to pressure government action. Even when this is not possible, at a minimum, national health institutions should be engaged in the calculation of indicators and the methods of calculation should be made accessible to the wider public so that the methodologies are well understood and seen as legitimate by the affected populations (Yamin and Falb, 2012).

This, unfortunately, has not been the case with the assessment of progress on MDG 5. Carla AbouZahr noted in her review of two 2010 global estimations exercises on maternal mortality that neither the United Nations nor the Institute on Health Metrics and Evaluation involved institutions from developing countries (AbouZahr, 2011). This lack of engagement,

marginal local ownership, and insufficient local capacity-building on data collection and analysis brings few beneficial results to the countries themselves (AbouZahr, 2011; Yamin and Falb, 2012).

Accountability

As noted, the MDGs were never intended to be used as national planning targets (Vandemoortele, 2009; Fukuda-Parr and Greenstein). They were conceived of as global goals that would focus international attention on selected issues relating to poverty reduction and, in turn, would mobilize aid from the North to the South to address those issues. The reductions called for under the MDGs were based on global figures over the past twenty-five years and in any given national context, those percentages become almost entirely arbitrary. The MDGs, however, presented a framework that could be measured and monitored and they quickly began to be used by donors and national governments to set national planning targets, frequently displacing domestic processes that had previously been underway (Yamin and Falb, 2012). National governments have been rated based upon whether they are "on track", "making progress", or have demonstrated "insufficient progress" or "no progress" toward achieving the MDGs. These rankings have been used by the World Bank and other international organizations under the theory that they foster "accountability", but these labels are misleading as they fail to account for differential starting places. Further, the use of MMRs in the MDGs as a mechanism for rating performance was especially inapposite.

By the time of the MDG Review in 2010, there was widespread recognition that the vast majority of countries were not "on track" to achieve MDG 5. The UN Secretary-General pointed to "failures of accountability" - both from national governments as well as donors and other actors – as one of the leading causes (UN Secretary-General, 2010). At the culmination of the 2010 MDG Summit, the UN Secretary-General launched the Global Strategy for Women's and Children's Health (Global Strategy), which emphasized the need for greater accountability (UN Secretary-General, 2010).

As a result of the Global Strategy, a number of advocacy, technical assistance, and accountability initiatives have occurred at the international level, including the World Health

Organization's Commission on Information and Accountability for Women's and Children's Health (CoIA). In May 2011, the CoIA issued its report, 'Keeping Promises, Measuring Results', which set out a framework for accountability and called for the establishment of an independent Expert Review Group (ERG) (CoIA, 2011). The CoIA reports' emphasis on tracking funding streams was welcomed by the global community, however, the framework for accountability falls short of international human rights standards in that it fails to include the necessary dimension of remedies and instead refers to "action" (CoIA, 2011). The establishment of an ERG, however, was an important acknowledgement of the need for more global level accountability mechanisms, especially for donors, and served as recognition of the human rights community's efforts with respect to MDG 5 in particular (Yamin, forthcoming 2013b).

MDG 5 in Practice: Intended and Unintended Consequences

The MDGs have been the central reference point for global development efforts since they were established in 2001 (Aryeetey et al., 2012). In this section, we review some of the effects on research, funding, and programming, as well as on the normative discourse of development as it relates to SRHR in particular. Over the course of the last twelve years, we argue that there has been a refocusing of SRHR to maternal, newborn and child health (MNCH) and on women as instruments of reproduction. Further, an overarching focus on measurement of maternal mortality has displaced broader political discussions regarding the comprehensive set of actions and societal changes needed to achieve SRHR.

Research and Institutions: a focus on measurement; a move toward MNCH

The selection of the maternal mortality ratio as an MDG target and indicator has generated an unprecedented amount of research and increased efforts towards measuring MMRs. In addition to the complex global estimation exercises, which arrived at differing conclusions, there have been thousands of country-level estimation exercises of maternal mortality. In the absence of adequate vital registration, many high-burden countries rely heavily on less direct and less effective methods to monitor maternal mortality. For example, the 2007-2015 Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda reports using Health Management Information Systems (HMIS), DHS data, as well as other facility and

household surveys, to monitor maternal health in the country, but multiple shortcomings in the data are freely acknowledged. These include low rates of timely reporting, incorrect and incomplete recording, proper case definition, data management, source of information, and methods of estimation (Republic of Uganda, 2008).

With respect to programming, the MDGs are widely criticized for having adopted a vertical approach to health issues, rather than supporting a cross-sector, systems approach (Waage et al., 2010). It is certainly true that such siloization existed before, but the MDGs exacerbated the tendency toward fragmentation through their narrow focus on showing progress through a limited range of indicators. By 2005, there was a widespread sense that the dispersal of reproductive, maternal, newborn and child health efforts was counter-productive. One prominent effort to redress this fragmentation was the creation of the Partnership for Maternal, Newborn and Child Health (PMNCH) and the launch of the "continuum of care" approach (WHO, 2005a). The mission of the PMNCH was to draw together the research and practice communities.

The continuum of care model was disseminated widely at the international level and suggested in the UN Secretary-General's Global Strategy on Women's and Children's Health as a principal solution to address failures to achieving MDGs 4 and 5 (UN Secretary-General, 2010). However, the continuum of care approach reinforced the idea of women as mere instruments of reproduction. References to essential interventions failed to consider the broader sexual and reproductive health needs of women and underscored narrow technical medical interventions, rather than the broader interventions suggested in Cairo and found even in the WHO's earlier reproductive health strategy (WHO, 2007).

Funding: The Politics of Aid

After HIV/AIDS, the second largest category of development assistance for health (DAH) was maternal, newborn and child health (16%), which received $3.987 billion in 2009, a significant increase from $2.523 billion in 2000 (Ravishankar et al., 2009; IHME, 2011; Leach-Kemon et al., 2012). From 2003-2010 ODA to reproductive health activities, which includes prenatal and postnatal care, delivery, prevention and treatment of infertility, prevention and

management of consequences of abortion, safe motherhood activities, more than doubled, rising from $305 million to $863 million (McCoy et al., 2009; OECD, 2011b). Financial commitments steadily increased from 2003-2008, repositioning MNCH as a priority on the international development agenda, however, due at least in part to the global financial crisis, there was an 8 percent ($75 million) decrease in ODA funding for reproductive health from 2009-2010 (OECD, 2011b). Although funding for health sector support has increased significantly from $0.144 billion in 2000 to $1.234 billion in 2009, the increase in funding has not permeated narrow, vertical approaches to programming (IHME, 2011).

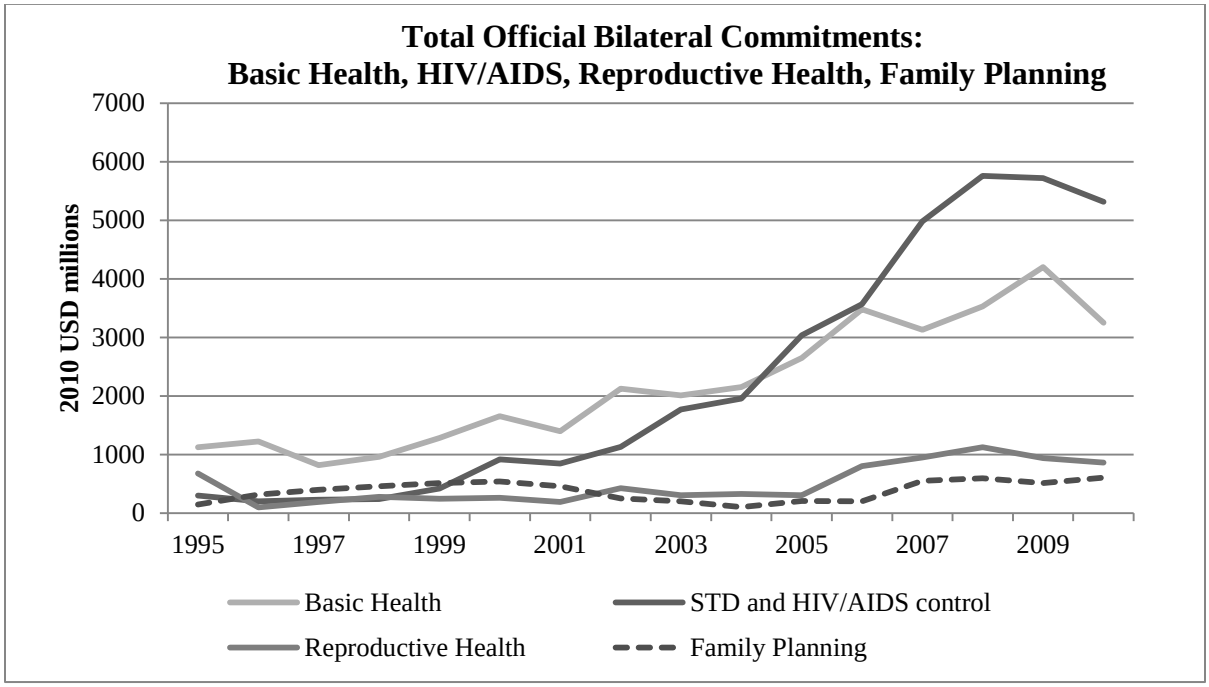

Figure 3. OECD-DAC, Overseas Development Assistance (ODA), Health

Certain aspects of MNCH have unquestionably received increased attention and funding during the MDGs. This, however, has not been the case for family planning. The United States government under the George W. Bush administration (2001-2009) explicitly adopted the Global Gag Rule, which precluded organizations receiving US funding support from even providing abortion counseling, significantly impacting the type of family planning information that these organizations were able to share. The Bush administration, after reinstating the Global Gag Rule, dealt a second blow to family planning by cutting support to the UNFPA over concerns

about the organization's role in China, which has adopted a one child policy that has in some cases led to coercive family planning practices such as forced abortion and sterilization (Saona, 2004). The absence of adequate funding for family planning for close to a decade in many of the poorest countries around the world, most of which are dependent upon donor support, was devastating in terms of its effects on women's SRHR. For example, a recent study looking at contraceptive prevalence 1990-2013 found that of the 26 countries with the lowest contraceptive prevalence in 1990 (lower than 10%), the absolute increase by 2010 was less than 10 percent for 16 countries, all of which were in Africa (Alkema et al., 2013). In terms of unmet need for family planning, the values estimated for middle and western Africa in 2010 were nearly identical to those in 1990 (Alkema et al., 2013).

There are, however, cycles in health, and sexual and reproductive health in particular, and family planning has begun to re-emerge strongly in the second half of 2012 in the lead-up discussions around sustainable development goals to succeed the MDGs. MDG 5B - universal access to reproductive health services - was one of the most underfunded and lagging of the targets and new research has been presented to demonstrate that not only could access to family planning eliminate up to one third of maternal deaths, but that it is also pivotal to sustainable development (Cohen, 2009; UNFPA, 2012; Alkema et al., 2013). For decades, private foundations have played an important role in the health sector, and in recent years the Gates Foundation has played an extraordinarily important role, mainly because of their ability to use funding to shape health policy and the broader global health discourse (Fox, 2006; McCroy et al., 2009). Given the Gates Foundation's specific agenda on women's health, which excludes abortion, and in light of the amount of money that the Gates Foundation paid in grants in 2006, $2.25 billion, which positioned Gates as the third largest international health donor, behind only the US and the UK, this has had important ramifications for SRHR (McCroy et al., 2009). In response to the historic shortfall in funding for family planning, as well as this newly resurgent urgency, a London Family Planning Summit was held in July of 2012. The Summit resulted, theoretically, in $2.6 billion in new aid commitments, including substantial commitments from the Gates Foundation (an additional $560 million by 2020, totaling $1 billion investment), the British Department for International Development ($800 million over 8 years), and UNFPA ($378 million over 8 years) (London Summit on Family Planning, 2012). Concerns have been

raised over whether this renewed interest in family planning is motivated more by population control than by concern over women's health and autonomy, particularly given the focus on large commitments for purchasing commodities and targeting women in sub-Saharan Africa (Gates Foundation, 2012; Ryerson, 2012).

Programming within the health sector: Narrow interventions

The four pillars of addressing MMM within the health sector, which require a focus on health systems strengthening, are widely recognized to be family planning, skilled birth attendance, emergency obstetric care (EmOC), and a functioning referral system (Freedman et al., 2007). Indeed, the main report from the Task Force of the Millennium Project on Child Health and Maternal Health, published in early 2005, underscored the importance of adopting a health systems approach and argued that SRHR were the missing element of the MDG framework (UN Millennium Project, 2005). The report fed into the 'Millennium plus 5' Summit and gave support to the establishment of Target 5B.

Nevertheless, the early adoption of MDG 5A, and the indicators chosen—MMRs and SBA—may have may have incentivized narrow technocratic agendas that focused largely on vertical interventions even within maternal health, and which did not integrate HIV/AIDS and reproductive health services effectively or emphasize strengthening health systems more broadly in many countries (United Nations General Assembly; 2006; Wilcher and Cates, 2009; Calvert and Ronsmans, 2013). The proportion of births attended by skilled health personnel was included as an indicator to MDG 5 to better monitor changes in maternal mortality over time, as MMRs were recognized as being unsuitable for that purpose. While SBA was in part chosen because it was easy to measure, focusing on SBA alone may likely have also had the unintended consequence of contributing to narrow approaches to maternal health. SBA focuses specifically on a subset of delivery care without improving or assessing the quality of the health system, or taking into consideration additional reproductive health needs (Austveg, 2011). If family planning (at least until 2012) was pushed to the periphery of the international agenda during the first decade of the MDGs, addressing the estimated 13-18 percent of maternal mortality due to unsafe abortions around the world was often explicitly excluded from the technocratic approach to maternal mortality (Barot, 2011; Yamin and Falb, 2012; Culwell et al., 2013).

Adopting broader health systems approaches to maternal health and SRH may have been further undermined by HIV/AIDS advocates and the restructuring and reprogramming around HIV/AIDS within UN agencies. In 2001, the Joint United Nations Programme on HIV/AIDS (UNAIDS) issued the *Global Strategy Framework on HIV/AIDS* which took an epidemiological, rather than social, economic, and health systems approach to the prevention and management of HIV (Berer, 2004; Germain et al., 2009). The document made no reference to strengthening health systems or integrating HIV/AIDS prevention, treatment, and counseling services with SRH services as was indicated in ICPD (Berer, 2004; Germain et al., 2009). The MDGs may have exacerbated the divide between HIV and SRH both by the adoption of a narrow vision of SRH only as maternal health and of HIV as only an infectious disease, ignoring its roots in human sexual behavior, and by separating HIV and SRH under different Goals (Germain et al., 2009).

SRHR: Out of the Spotlight, out of the Discussion

There were many issues highlighted at Cairo and Beijing that transcended health sector interventions - such as gender-based violence and sexual identity expression - that were left off of the MDG agenda and thus pushed to the periphery of global discourse. Gender-based violence (GBV) was marginalized further when negotiations on preventive sexuality education and language about marital rape were won by the opposition and removed from a resolution on violence against women at the Human Rights Council (Repoliticizing SRHR Group, 2011). Mobilization in the lesbian, gay, bisexual, transgender, and intersex (LGBTI) community to promote rights related to sexual orientation and gender identity (SOGI) has been sidelined by the conflation of SOGI rights and the broader sexual rights agenda that many people assume refers to gay marriage. The refusal to include sexual rights in any form in the global agenda has continued to disadvantage the LGBTI community.

Ironically, as SRHR rights were excluded from the MDG agenda, in recent years, LGBTI rights have re-surfaced in the context of aid conditionality. For example, in Uganda, where legislation imposing extreme criminal sanctions, including execution in certain instances, on homosexual activity has arisen, the US and UK governments have threatened to withhold development aid for the MDGs (Clinton, 2011; Cameron, 2011). At the local level, these battles

over SRHR are disconnected from the broader development discourse occurring at the country-level, except that they are now positioned in public dialogue as preventing financing for achieving the MDGs.

Looking Forward: SRHR in the Post-2015 Development Agenda

With the deadline for the MDGs approaching in 2015, and the follow-up to the Rio+20 Conference calling for a set of Sustainable Development Goals (SDGs) to succeed the MDGs, it seems inevitable that the post-2015 development framework will once again adopt the structure of goals, targets, and indicators. Criteria for targets and indicators need to be well thought out beyond simplicity and measurability, if such an approach is not going to be inherently reductionist. Development, from both a human rights and human development perspective, is a process which is aimed at changing relations and structures that deny certain people choices over their lives, and entrench poverty. Here we argue that given the behavior and knowledge effects documented with respect to MDG 5 and the MDGs more broadly, the next global goal-setting exercise should, at a minimum, be done through a staged and coordinated process, which affords participation of multiple stakeholders, and should take into account the gaps and experience of the MDGs and previous UN conferences. With respect to MDG 5 in particular, it is crucial to recognize that maternal health is only one dimension of SRHR, and that SRHR is ineluctably linked with many of the other goals.

Embedding SRHR across Goals

It is absolutely essential that SRHR be embedded across goals and that its connections to both gender and economic justice be contemplated in the future development framework. SRHR is relevant to many of the potential goals being considered for the Post-2015 Development Agenda, not just health. SRHR is related closely to population dynamics and sustainable growth. It is also inextricably linked to employment (and women's unremunerated work), education, nutrition and food security, democratic governance, and access to water and sanitation. Finally, it is fundamentally tied to both poverty and inequality, especially gender inequality (United Nations Committee on the Elimination of Discrimination against Women 1997; United Nations Committee on the Elimination of Discrimination against Women, 1999; High Level Panel on

Human Rights Mainstreaming Statement by H. E. Mr. Minelik Alemu Getahum, 2013). Women, and LGBTI populations, experience patriarchy and gender inequality often through discriminatory laws and practices related to SRHR, as well as a lack of access to responsive and quality sexual and reproductive health services, including adequate information. Those experiences are always mediated through intersecting inequalities of race, ethnicity, class and caste, as well as issues such as disability.

The Need for Universal Goals

SRHR also illustrates the importance of a universal set of goals, as has been highlighted in the ICPD Beyond 2014 Key Recommendations for Action and by the targets outlined by the Civil Society Platform to Promote SRHR Beyond 2015 toward the realization of the goal for Universal Access to Sexual and Reproductive Health and Rights (High-Level Task Force for ICPD, 2013; Civil Society Platform to Promote SRHR Beyond 2015, 2013). Issues such as GBV affect countries of radically differing development levels. For example, in Tanzania one-third of girls experienced sexual violence by the age of 18, 2 in 5 women experienced physical violence from the age of 15 and most report violence by a husband, partner, or boyfriend, and marital rape is not criminalized (TDHS, 2010; UNICEF, 2011). But in the European Union, usually at the top of human development markers, as many as 1 in 5 women have experienced domestic violence, in Norway 1 out of 10 women over fifteen have been raped, and 12 member states of the EU do not criminalize marital rape either (UN Women, 2011; WHO, 2013).

Additionally, achieving universal access to quality, comprehensive, and integrated sexual and reproductive health information, education, and services - part of any overarching health goal - is also an issue that affects both wealthy and poor countries. This requires providing an essential package of sexual and reproductive health information and services, which will differ across countries of different demographic makeups and development levels, but must include certain key services and must pay particular attention to the needs of women and marginalized or stigmatized populations. This also requires removing barriers to access, along the four dimensions recognized by human rights law of physical accessibility, affordability, accessibility of information, and accessibility on the basis of non-discrimination, which is also an

issue that challenges high-income countries (United Nations Committee on Economic, Social and Cultural Rights, 2000).

Setting Differential Targets When Quantitative Indicators are Used; Using Human Rights and other Legitimate Processes

Target setting is inherently reductionist if it is not embedded in a broader narrative of development and inclusive of reasons for holding governments accountable for certain specified performance standards. However, as targets are likely to be used in the next development framework, one significant lesson to be drawn from the MDGs is the need for targets that are differentiated by development level. Creating graduated targets that account for development level, as had been done in UN Conferences previously, at least acknowledges that each country has improvements to make and does not inherently disadvantage the countries that are furthest away from achieving a specified goal.

The inappropriate use of MDG targets to "hold national governments accountable" –akin to "using a fork as a spoon"—raises questions about how much control over the process countries would have to have in order for targets to be used for national accountability standards to be meaningful in a human rights framework. The approach offered by the Human Rights Treaty-Monitoring Committees provides one example of the relationship between international norm-setting, and a subsequent process of national benchmarking through which it is possible and appropriate to hold governments accountable. For example, General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights (United Nations Committee on Economic, Social and Cultural Rights, 2000), calls for a four-stage process for States Parties to develop and apply indicators, in this case with respect to the health system:

1) Establish *indicators* to measure health system performance;

2) Set national *benchmarks* for targeted achievement or for incorporation in national health policies;

3) Implement a joint ESC Rights Committee/State Party *scoping* procedure whereby national health system benchmarks would be evaluated to ensure that they were neither too modest nor unrealistically ambitious; and

4) Implement an *assessment* sub-procedure whereby, five years after the establishment of benchmarks, the ESC Rights Committee would evaluate the relative achievement of national benchmarks through an examination of relevant indicators.

In this case, the establishment of a process of setting national benchmarks as well as procedures for evaluation would allow for contextually-appropriate starting points. These processes could also theoretically be tied into the international human rights monitoring system, which would embed targets into a broader narrative of what development and progress means, as well as providing at least some accountability. Nonetheless, it remains unclear how much individual tailoring of targets is politically feasible in an international development agenda, and how much of a substantive role existing human rights accountability mechanisms might be assigned.

What is certain though is that it is essential that the process for setting numerical targets balances participation of and input from national governments in setting their own targets, in order to promote local ownership, with rigorous standards of justification, including comparisons to countries of similar GNIs and demographic situations, so that target setting is sufficiently ambitious. It is only through a legitimate process, which includes an opportunity for civil society to scrutinize the criteria for target setting, that governments will be able to be held accountable in a meaningful way for progressive realization of the respective rights, including SRHR (United Nations Committee on Economic, Social and Cultural Rights, 2000; Daniels, 2008).

Indicators

In a human rights framework, some indicators will not and should not be quantitative. For example, a target that calls for "universal recognition of sexual and reproductive rights" would necessarily rely on indicators related to legal and policy frameworks. The fact that these are not quantitative does not mean that they cannot be time-bound. For example, the ICPD +20

High Level Panel recommends: immediately "criminalizing sexual violence and ending impunity for perpetrators and eliminating early and forced marriage and female genital mutilation within a generation" (High-Level Task Force for ICPD, 2013). Legal changes to revise laws that allow perpetrators of gender-based violence to evade punishment if they marry the victim, or are the partners or husbands of the victims, and legal changes that eliminate sexual violence from post conflict amnesty provisions can be set with timelines and progress both on the enactment of legislation as well as on implementation can be measured.

As legal systems vary substantially, the ways in which SRHR are recognized would also need to allow for diverse mechanisms, ranging, for example, from constitutionalization to legislation, as well as rescission of inappropriate laws. Precisely because many issues in SRHR are so contentious and subject to ideological manipulation at national levels, international standards can usefully put pressure on national governments to conform domestic legislative frameworks to human rights norms, which is a key role that human rights law plays.

It is particularly essential that quantitative indicators be subject to meaningful disaggregation to demonstrate potential patterns of discrimination, be devised through transparent and accessible methodologies, and provide for robust, frequently measurable assessments of progress towards achieving the targets that can be used to evaluate specific administrations' actions. Unlike MMRs, indicators should be relevant to policy making and sensitive to policy interventions (Yamin and Falb, 2012; Yamin, 2010). This implies the need for process indicators, as well as outcome indicators. In human rights, indicators are used to measure compliance with international obligations and without such measures of conduct it is impossible to hold governments accountable for adopting "appropriate measures" on a non-discriminatory basis, as is required by human rights law.

While regular data collection and national compilation of data for the indicator is important to keep in mind, it is also essential to consider the creation of a post-2015 framework as an opportunity to enhance health and vital registration systems within countries, both of which are essential to SRHR data. Improving health management information systems (HMIS) in order to facilitate at least annual, collection of EmOC data, for example, would enhance the

accountability of governments, at least with respect to maternal health, and would facilitate real-time assessments of progress.

Conclusions

While maternal mortality is difficult to measure for statistical and practical reasons, attempting to measure the enjoyment of SRHR implicates a host of conceptual and normative complexities as well (Yamin and Falb, 2012). In selecting a few numerical indicators, and in highlighting one—the MMR—the MDGs process largely attempted to erase those complexities. In the course of the MDGs, the narrative of progress became driven by an extreme focus on measurement on that one numerical indicator. As a result, research and programming aimed at assessing narrow conceptions of progress ignored and even marginalized questions regarding the root causes of maternal mortality, let alone gender inequality and a broader vision of SRHR (Yamin and Falb, 2012; Yamin, forthcoming 2013b). The normative discourse, as well as research and programming, came to focus on women as instruments of reproduction, rather than as full human beings and subjects of a wide array of rights. Other areas of SRHR, which did not relate to reproductive health directly, fared even more poorly.

SRHR issues entail a wide array of CPR and ESCR rights and are inextricably linked to sustainable human development. The realization of SRHR empowers individuals to live lives of dignity and underpins the construction of social citizenship. Advancing SRHR is dependent upon the promotion of a global, not just national, social order that allows for greater economic justice as well as gender equality. In this context, the role of fully recognizing human rights, including, SRHR, is absolutely essential to the future development framework. The complexity of human relations and the social structures that advance or impede SRHR, and human rights more broadly, does not lend itself to measurement through a set of simple targets. Nevertheless, given that the setting of global goals, with attendant targets and indicators is being undertaken, and knowing what has happened with the MDGs, it would be unacceptable for the global community to do anything less than attempt to address the full spectrum of SRHR in the next global development agenda.

Notes

1. This article draws very heavily on a previous article: Yamin, A.E. and Falb, K.L. (2012) 'Counting What We Know: Knowing what to Count: Sexual and reproductive rights, maternal health, and the Millennium Development Goals', *Nordic Journal on Human Rights*, 30(3), pp. 350–371 and cite to the full working paper
2. The UN reports were funded through the WHO, the World Bank Netherlands Partnership Program, and USAID. UNICEF provided additional support for the 2012 report.

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