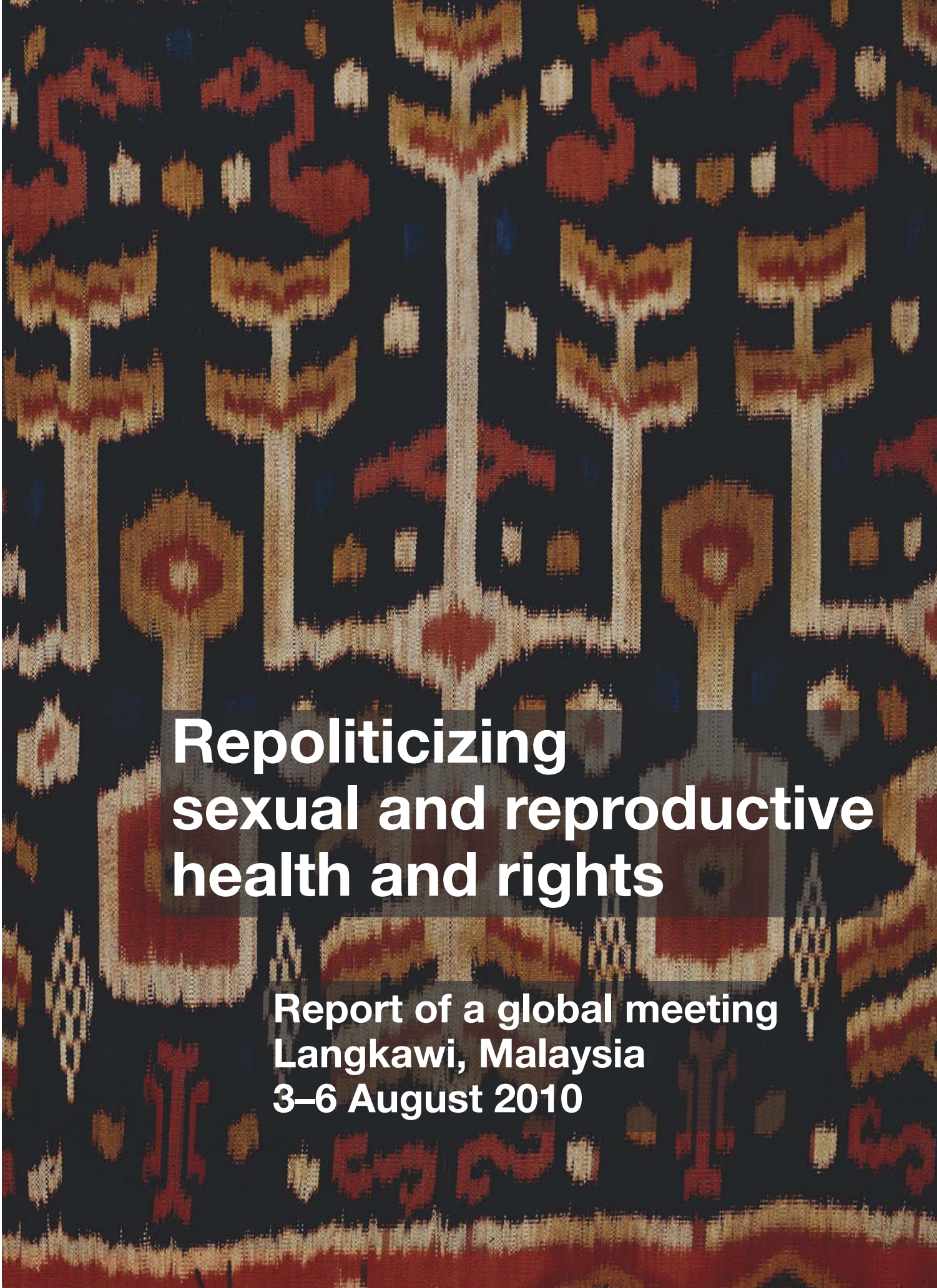

Repoliticizing sexual and reproductive health and rights

Report of a global meeting
Langkawi, Malaysia
3–6 August 2010

Repoliticizing sexual and reproductive health & rights: a global meeting

Langkawi, Malaysia

3–6 August 2010

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The Repoliticizing SRHR Group Statement of Purpose was signed by all the members of the group above and also by Rhonda Copelon, Sonia Correa, Amal Abd El Hadi, Rina Nissim and Gita Sen.

Janet Price was unable to attend the meeting but contributed a paper which was distributed during the meeting and is contained in Annex 2 to this report.

The full report can be found at:
<www.rhmjournal.org.uk> and **<www.arrow.org.my>**.

Print copies of the report can be ordered from:
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Front cover image: Ikat-dyed cotton cloth, Indonesia. Courtesy of the British Museum.
Designed and typeset by Boldface Typesetters. Printed by Witherby's Lithoflow.

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INTRODUCTION

Actors and processes

In June 2008, a group of long-time activists and researchers in the field of sexual and reproductive health and rights (SRHR) came together in London, UK for a brief (1.5 day) meeting organized by *Reproductive Health Matters* (RHM). The subject of the meeting was the state of the sexual and reproductive health and rights field/movement.

Participants[1] in this meeting discussed issues related to the following questions:

- How can we characterize the sexual and reproductive health and rights field today, and the shifting power and influence in it, including the UN agencies, World Bank, governments and public health systems, private (profit and non-profit) health sector, global health initiatives, 'corporate'/international NGOs, other NGOs and civil society and feminist groups?
- Is a collective advocates' voice needed in the SRHR field today, given the extent of mainstreaming of our issues and given the huge and growing number of people involved in the work nationally and internationally?
- If yes, in what priority areas is that voice required? If no, are there other reasons we wish to get together?
- Do we want to organize to make this happen? If yes, how and with whom?
- What kind of international conferences does the sexual and reproductive health and rights field need? What kind are we having?[2]

Participants expressed concerns about the fragmentation of SRHR work and the absence of an inclusive or collective analysis and critique of where the SRHR field was heading in relation to law and policy, health service delivery, research and education. Progressive donors are changing their agendas. In civil society, there are often 'gender people' and 'human rights people', but with little crossover. The connections are often not being made. There has been a lot of private investment in health and the consequences for SRHR need to be examined. There has been a backlash against some of the gains made in the 1990s and the agenda has been getting more conservative in response. The right-wing has been hijacking the notion of moral values and has been openly challenging human rights, especially in relation to sexuality and gender identity. People have been very concerned about sexual health but the issue has been limited to surviving sex, and in reproductive health, the issue has been limited to surviving reproduction. There is a mystical belief that children benefit from women's sacrifices. Fragmentation of the movement is following from the increasingly fragmented funding agenda. There are dozens of networks in the SRHR field: local, regional, international, issue-based – but they are not talking to each other. NGOs are being forced to

It requires services at community and primary care level, and referral for care at district and sometimes tertiary level care, and must be integrated

1 The meeting was attended by Amal Abd El Hadi, Pascale Allotey, Berit Austveg, Marge Berer, Jane Cottingham, Jocelyn DeJong, Thérèse Delvaux, Simone Diniz, Sharon Fonn, Asha George, Sofia Gruskin, Anissa Helie, Geetanjali Misra, Rina Nissim, Wanda Nowicka, Rosalind Petchesky, Saira Shameem and Charlotte Watts.

2 As background to the discussion, a paper was circulated to the participants, entitled "Are recent international conferences advancing sexual and reproductive health and rights?" This was written by Marge Berer initially and then co-authored by Saira Shameem and Pascale Allotey; it included written responses to it from Asha George, Jane Cottingham, Jocelyn DeJong, Thérèse Delvaux, Simone Diniz, Sharon Fonn, Sofia Gruskin, Anissa Helie, Pinar Ilkkaracan, Geetanjali Misra, Wanda Nowicka, and Rosalind P. Petchesky. See Annex 1.

focus on targets and outcomes that have to be quantified and counted; professionalism is beginning to mean knowing how to set targets, and a 'project' mentality is taking over. In WHO, SRHR has increasingly been separated into many different departments and the ICPD notion of a comprehensive approach to SRHR is being fragmented within it.

The several dozen priority issues identified in the first day's discussion that were considered catalytic and in need of analysis and exploration were grouped and eventually evolved into specific themes. Teams were formed consisting of everyone at the June 2008 meeting plus others who were invited to join. It was agreed that each team would draft a paper on their chosen theme. The initiative was named "Repoliticizing Sexual and Reproductive Health and Rights" and was conceived as a joint initiative of all participating organizations. Marge Berer, the editor of *Reproductive Health Matters*, was to be the convener.

A further one-day meeting of the group was held in Hanoi, Vietnam in April 2009, alongside a meeting of SRHR grantees of the Ford Foundation and an IASSCS conference on sexuality. The meeting reviewed the status of the papers that we agreed should be written. The content and purpose of the papers were discussed in depth, and author teams met for several hours to draft outlines for each paper, which were presented to the whole group for further ideas.

The Hanoi meeting also discussed the idea of a conference or workshop-type meeting as one means of starting to repoliticize sexual and reproductive health and rights. It was agreed to hold an international workshop/meeting in 2010 and the Asian Pacific Resource and Research Centre for Women (ARROW) volunteered to host it in Malaysia. The purpose of the meeting would be to invite a broader but targeted group of people including policymakers, academics, activists, funders, civil society and international organizations, with a view to engaging a broader audience in the need to repoliticize SRHR and developing a strategy on how to move forward with the SRHR repoliticization process, with the papers as a trigger.

It was also agreed in Hanoi to write a short statement of what was meant by the need to repoliticize SRHR. Following the Hanoi meeting, in July 2009, Rosalind Petchesky drafted the text for this and several members of the group contributed to the editing of it. ARROW, led by Saira Shameem, its Executive Director, made it into a leaflet for distribution. It was first made public by Marge and Saira at a meeting organized by the Norwegian Agency for Development Cooperation (NORAD) in Oslo in November 2009. This statement, which follows on the next page, evolved through discussions between members of the organizing group, and articulates the framework guiding the meeting that took place in Langkawi, Malaysia during 3–6 August 2010.

The meeting in Langkawi was organized through the combined efforts of ARROW and RHM. ARROW did all the fundraising for the meeting and the ARROW staff managed all the practical aspects of the meeting, including organizing the hotel and venue, and handling all the correspondence with participants. It also took responsibility for the documentation of meeting proceedings and their production. RHM coordinated the preparation of the agenda, including presenters and respondents, and its final form; set a timetable for and followed-up with authors; and coordinated the decisions on who to invite out of the list of 90-100 people who were proposed by the group members. Many members of the group contributed considerable time and energy towards preparatory tasks for the meeting, and during the meeting, played an active role in documenting and consolidating the meeting's proceedings.

STATEMENT OF PURPOSE

Repoliticizing SRHR
A transformative framework: beyond ICPD/MDGs

Over the past 18 months, our group has discussed shared concerns about what we perceive to be the fragmentation in and weakening and depoliticization of our field, in spite of the considerable gains that have been made in some countries, where political will and an active civil society have worked together on common goals. We have observed a discouraging trend of larger and larger amounts of money being granted to governments, large NGOs and mega-conferences run primarily from the global North. Funding to governments has also not paid sufficient attention to research, policy and programming efforts, building from the ground up in countries, leading to little if any apparent social change. The failure to improve service delivery beyond commodity-driven outreach services in order to link empowerment at the individual level within families and communities to timely and affordable access to curative care services, especially in the most resource-poor countries, is a prime example of this.

A framework based squarely on an economic and social justice perspective underpins our vision…

In 2015, the Programme of Action of the International Conference on Population and Development (ICPD, 1994) will be two decades old, without having reached fruition, and the Millennium Development Goals (MDGs, 2000) related to health will remain unfulfilled. We believe there is a need to develop a forward-looking vision, drawing on but moving beyond both the ICPD Programme of Action and the limited interpretation and implementation to date of the health MDGs, to a transformative approach, taking into account 21st century realities. In order to achieve the goal of SRHR for all, four basic criteria must be recognized:

Macro-economic influences on health

New thinking about sexual and reproductive health and rights must address the current economic crisis, the role of global capitalism, development aid and loans, and the long-standing inequities in wealth and resource distribution which are not being reduced and which have worsened considerably with the economic crisis. Inequities in access to health care due to the increasing privatization and commodification of health services and health insurance, the introduction of internal markets into health care delivery, and decades-old policies of charging user fees in the public health system on top of out-of-pocket costs, have undermined the myriad commitments made by governments and other institutions of power to achieving health for all, including sexual and reproductive health (SRH). These policies, supported by powerful forces globally, must be replaced.

Universal access to health care through a health systems approach

Sexual and reproductive health services include maternal health and preventing maternal mortality and morbidity; prevention and treatment of sexually transmitted infections, HIV and AIDS; family planning and safe, legal abortion; prevention and treatment of reproductive cancers; infertility prevention and treatment; and comprehensive sexuality and relationships education for youth. A framework based squarely on an economic and social justice perspective underpins our vision of how to make these services a reality for all. Vital to this framework is a health systems approach. In this, we join with others who have proposed revitalizing the primary health care approach of the 1970s Alma Ata framework for new generations and today's world, in which sexual and reproductive health care are a central part of primary care.

Current health systems strengthening efforts are giving insufficient attention to sexual and reproductive health and rights…

There is a pressing need – in nearly all countries, including the global North – for health sector reforms, the basis of which should be the right to the highest attainable standard of health, and ensuring the accessibility, availability, acceptability and quality of services. Reforms have proceeded in some settings, but often haltingly and unevenly, and health systems everywhere are plagued by huge gaps in funding for infrastructure and resources, services, staffing, training, skills development, management, and review and monitoring. Systemic discrimination based on class and age, and minority ethnicity, sexual identity and culture exacerbate lack of access to and quality of care.

Current health systems strengthening efforts are giving insufficient attention to sexual and reproductive health and rights and to human rights concerns as regards health more generally – such as ensuring attention to marginalized groups as integral to health systems as a whole. Essential services are targets of attack by right-wing forces, sometimes using religion as a pretext, which must be rejected.

Fundamental human rights principles

The sobering realities of war, violence, exclusion and discrimination underscore, more than anything else, the fact that a health systems approach must be inextricably linked to the promotion and protection of human rights, as regards access to health care. Recent efforts to gain such recognition on the part of civil society activists, engaged at the national level, are making important headway in some constituencies. For example, the criminalization of sodomy and of "carnal intercourse against the order of nature" were rejected in the Delhi High Court in July 2009 and can no longer be applied to consensual sexual activity among adults. And the UN Human Rights Council in June 2009 recognized that preventing maternal mortality and morbidity is about human rights, including the right to life and health, as well as a development issue. In putting human rights principles at the centre of any framework, we are arguing for the entitlement of affected communities to participate in advocating for sexual and reproductive health and rights within broader health systems efforts, and for mechanisms to hold policymakers and service providers accountable to meeting their needs, based on these standards. We also argue that beyond their legal dimensions, human rights offer principles that can be used for effective programming.

Strategic coalitions among concerned civil society groups

To achieve the goal of sexual and reproductive health and rights for all, there is a need to build coalitions not only with everyone who works in the fields of sexual and reproductive health but also with a wide range of others – HIV/AIDS activists, people living with HIV and AIDS, public health and primary health care educators and practitioners, feminist groups, human rights defenders, youth coalitions and lesbian, gay, bisexual, transgender and intersex advocates – while acknowledging that there may be substantial differences in our underlying values, philosophies and goals. There has been a tendency in some of the partnerships developed globally to ignore such differences, and imbalances in power and access to resources, and to create illusions of harmony and unity. The effect is a status quo where those with power are not challenged, and those who seek to achieve change are not empowered to do so. Our process aims to open dialogue among allies from diverse movements concerned with promoting health-related rights in general and sexual and reproductive rights in particular, in order to build a strong, collaborative basis for action.

Aim and objectives

The aim of the meeting was to propose a transformative agenda for moving beyond ICPD and the MDGs to re-politicize the analysis of and work on sexual and reproductive health and rights. It is based on the recognition that, to inform advocacy, action and activism, a solid, well-informed, theoretically sound analysis and position are required.

The specific objectives were to:

- Develop a transformative agenda for moving beyond ICPD and the MDGs based in a health systems, social justice and human rights perspective on sexual and reproductive health and rights issues;
- Present a series of position papers on strategic issues which will inform that agenda – for critique, discussion and further development;
- Identify potential alliances with others working for social change in allied areas of health, education and development; and
- Explore potential actions to popularize this approach and move the sexual and reproductive health and rights agenda forward.

Participants and agenda

The meeting was attended by 43 participants from diverse constituencies: academics, activists, civil society representatives, donors and policymakers. They brought with them expertise in different dimensions of sexual and reproductive health: public health, health systems, health financing, human rights, sexual and reproductive health, sexual rights, reproductive rights and HIV/AIDS. Many participants represented more than one constituency and had expertise in more than one area. Annex 3 gives the list of participants.

The meeting agenda was organized around six themes:

- Macroeconomic influences on sexual and reproductive health;
- Sexual and reproductive health and rights in public health education;
- Medicines and technologies for sexual and reproductive health: the role of the pharmaceutical industry, essential medicines and regulation;
- A human rights approach;
- Donors and funding; and
- Perpetuating power.

The first evening opened with a presentation of the agenda and the objectives of the meeting. Participants introduced themselves and explained briefly the nature of their interest in developing a transformative agenda and its relevance in relation to their work in the field.

During the next two days, there were six plenary sessions, three per day. Papers were presented in the plenary sessions (20 minutes each) and there were 1–2 respondents for each paper (10 minutes per respondent). Both afternoons had breakout sessions on the topics of

the plenaries and three other key topics: international conferences, maternal health and mortality, and strategic alliances. The aims of these sessions were to:

- Thrash out a critical analysis of the subject at hand, informed by evidence, to the extent possible;
- Ensure that all human rights dimensions, macroeconomic influences on health, and a health systems approach to achieve universal access, as related to the topic, were addressed;
- Contribute to elaborating strategies based on coalitions among concerned civil society groups for addressing the problem(s), taking account of local, national, regional and international level actions; and
- Provide a basis for further elaboration of the papers for later publication and discuss topics for any additional papers.

On the last day, the rapporteurs' group presented a summary of key points from the previous days' sessions. The summary also highlighted a set of initiatives that had been identified as priorities across themes in the plenary and breakout discussions. These were discussed in greater detail in small groups, culminating in an agenda for action.

Key messages

1. The Millennium Development Goals (MDGs) have inadvertently and unintentionally contributed to a narrowing of the sexual and reproductive health and rights (SRHR) agenda. In the past few years, the SRHR agenda has been reduced primarily to a focus on maternal health. At the same time, maternal/women's health has been linked to newborn, infant, child and in some cases even to adolescent health, leading to a confused and confusing set of objectives and targets. The way in which this narrowing has taken place does not even serve the purpose of reducing maternal mortality, as this depends on provision of the full range of sexual and reproductive health services, a human rights framework, and taking into consideration the underlying social and economic determinants of health.

2. The Programme of Action of the 1994 International Conference on Population and Development, which is nowhere near being achieved, has dropped from sight as a result of the MDGs, even with the inclusion of target 5b on access to reproductive health. Commitment to the principles and philosophy of the Programme of Action needs to be renewed as we approach the 20 years for which the targets were set.

3. The sexual and reproductive health and rights agenda is a multifaceted agenda, and ranges from providing health services such as antenatal and delivery care, condoms, contraception and abortion; to screening and treatment for diseases such as sexually transmitted infections, reproductive and genital cancers in both men and women; to treatment of a range of health problems, e.g. complications of unsafe abortion, pregnancy and delivery, symptoms of menopause and menstrual disorders. It requires services at community and primary care level, and referral for care at district and sometimes tertiary level, and must be integrated into and given priority by national health services if MDG and other agreed targets are to be met. Reproductive and sexual health services are extremely sensitive to the socioeconomic context and influences in countries. Funding remains grossly inadequate, and it is no accident that countries are more behind even in the few areas covered by the MDGs than they are in any other area.

4. The conference recognised that due to so many more groups, organizations and networks taking up different aspects of SRHR, what was once a smaller and more united movement has become fragmented. Some groups and networks take up sexual health, others sexual rights, and still others reproductive health and/or reproductive rights, and in many cases only one tiny part or aspect of one of these, e.g. microbicides. Moreover, there is less activism around broad shared agendas that deal with sexual and reproductive health as a matter of social justice. In an era of global health initiatives, health services are becoming more verticalized in new ways, and are decreasingly under political/democratic control. With increased demand on the part of donors for immediate and quantifiable results and rapidly increasing privatization of health services, a focus on the balance between equity, equality and cost of health care is being lost and the social agenda of the need for sexual and reproductive health and rights, as well as the public health imperative, is fading and needs to be renewed by concerted action at global, regional and above all, national level.

THEME 1

Macroeconomic influences on health

The first thematic session opened with the presentation by T.K. Sundari Ravindran of a paper entitled "Reproductive health services in the 21st century: Is anyone short-changed?" which was co-authored by her and Sharon Fonn.

The main message of the paper was that privatization in health is a major deterrent to progress towards the ICPD agenda, and that SRHR advocates need to engage with privatization and other health system challenges in order to achieve universal access to health care services, including comprehensive sexual and reproductive health services.

Privatization as defined in the paper refers not to the existence of a private sector in health, which is a universal phenomenon. It refers to deliberate interventions through policies and funding support to expand private sector provision of health care services; to introduce or expand private financing of health care (e.g., out-of-pocket expenditure, private insurance) and other market mechanisms within public sector health services; and to the gradual withdrawal of the state from taking responsibility for universal access to health care services.

Privatization in health is a major deterrent to progress towards the ICPD agenda…

The written paper discussed major drivers and manifestations of privatization in health, and examples of privatization in financing and delivery of sexual and reproductive health services. It presented a case example of a country trying to achieve a balance between surviving in a global economy and protecting the right to health of its citizens.

There is a major chasm between ICPD aspirations and the reality on the ground. In 1994, the ICPD in Cairo and its aspirational Programme for Action called for universal access to comprehensive reproductive health services. There was little cognizance on the part of SRHR activists that just a year prior to ICPD, there had been a watershed event in global health. In 1993, the World Bank published its *World Development Report* on "Investing in health," and defined an alternative global agenda where decisions for investment and priority setting in health would be governed by cost-effectiveness and returns to investment in terms of averted disability-adjusted life years. During the 1990s, the World Bank and other international actors encouraged and guided the introduction of a series of health sector reforms in many developing countries that were facing a major resource crunch. These included reforms to increase private modes of financing; reforms in mechanisms for priority setting to limit the range of publicly financed services; and to restrict the role of the state to stewardship and regulator of the health sector.

At the end of the first decade of the 21st century, global health initiatives (GHIs) have become major players in setting the global health agenda. Known originally as "Global Public Private Partnerships," GHIs first seem to have emerged in the late 1990s. By 2009, more than 100 GHIs for 27 health concerns had been set up. However, most of the resources are controlled by only four GHIs: Global Fund to Fight AIDS, Tuberculosis and Malaria; Global Alliance for Vaccines and Immunization (GAVI); US President's Emergency Plan for AIDS Relief (PEPFAR); and the World Bank's Multi-country HIV/AIDS Program (MAP). GHIs are predominantly multi-stakeholder partnerships involving primarily UN agencies, international financial institutions (IFIs), bilateral donors, foundations, international NGOs and private for-profit entities.

Evaluations of the impact of GHIs on national health systems show that they have increased development assistance for health for the specific diseases and concerns addressed by GHIs operating in specific countries. However, they were also damaging those same health systems by reinforcing and strengthening vertical programs. In many countries, GHI funding was not in synchronicity with country health priorities. Health inequalities were increasing, with a widening gap in met needs between those with health problems addressed by large GHIs and those with other health problems and other preventive and promotive health needs.

It is important to note that sexual and reproductive health concerns other than HIV/AIDS are largely absent from GHIs. The question to ask ourselves is: "Would we progress towards the ICPD agenda if we had one more GHI addressing sexual and reproductive health problems? Or would it run counter to all the principles guiding the ICPD agenda, e.g., integrated and comprehensive SRH services, universal access and people-centered services?"

The presentation then gave examples of privatization in the delivery of sexual and reproductive health services, including contracting in and contracting out of clinical and non-clinical services, the creation and promotion of private provider networks, and more recent initiatives to make private provision of SRH services financially viable. One example of this was the establishment of a "Development Credit Authority," which offers partial credit guarantees to banks lending to private provider networks. Contracting activities were usually initiated by governments. However, USAID was the main actor motivating and financing the development of private provider networks and other initiatives to establish and stabilize a major private sector in health care in many developing countries. The "Development Credit Authority" was also funded by USAID.

What is the yardstick with which to assess the desirability of such privatization in SRH service delivery? The assessment needs to be done on a case-by-case basis, asking questions about every aspect of health care, such as the following, which were of most concern to sexual and reproductive health:

- Has the initiative increased access to SRH services? Whose access has increased? Which groups may have been left out or are unlikely to benefit?
- Has it increased the range of SRH services available? Which age/sex groups' unmet need will this satisfy? Whose needs may have been overlooked?
- Has it resulted in an improvement in the quality of technical and interpersonal services available?
- Who is the initiative/organization accountable to? To what extent do users or potential users have scope for influencing decision-making?

Privatization in service delivery through private provider networks can help to increase access to services where government is unable to provide SRH services for political reasons, or to reach specific groups with whom NGOs may have good rapport. Contracting-in clinical services or physicians helps to overcome the human resource crunch. Contracting non-clinical services to the private sector reduces the administrative burden on the public sector.

A review of case examples of privatization in SRH services also raises a number of concerns

Private provider networks target those with some ability to pay and not the poorest. They are therefore not a substitute for public provision of SRH services.

Governments' contracting non-clinical services to for-profit private providers has not always been beneficial. In many middle- and low-income countries, there are only a small number of contractors who can deliver the required scale of services and the lack of competition works in their favor. In addition, lack of experience on the part of governments in writing and managing contracts has also led to inefficiencies. Where private physicians are contracted by the public sector, unless properly regulated, this has resulted in an increase in health care costs, due to unnecessary prescriptions, tests and procedures. If providers are paid not on a fee-for-service basis but based on population served, there are delays in providing high-cost care even when this is essential.

Private provider networks target those with some ability to pay and not the poorest. They are therefore not a substitute for public provision of SRH services. The case examples reviewed indicate that they provide a narrow range of SRH services: e.g., only select contraceptive methods, usually only outpatient care, abortion services never included, and even delivery care the exception rather than the norm. Quality is often the biggest casualty in services provided through private provider networks. Evaluations have shown that there was a big difference between what doctors said they did and what they actually did. Information and counseling were rarely provided. Some models have unqualified providers providing services after a brief training and no back-up supervisory or referral support. There was complete neglect of infection prevention procedures even for invasive procedures such as IUD insertion, exposing patients to a high risk of RTIs and other infections.

SRH services may be considered as a special category of services that need to be publicly financed…

In terms of financing, SRH services may be considered as a special category of services that need to be publicly financed. There is a lot of evidence to show that increasing out-of-pocket payments for SRH services contributes significantly to unmet need for health care and untreated morbidity among women and low-income groups. As for private insurance as a financing option, any insurance requires risk pooling (rich subsidizes poor, healthy subsidizes sick). To make a profit from it, the scheme would need to be restricted to random and low probability events – this excludes, for example, pregnancy and contraception. Small-scale micro-insurance schemes will also find it economically unviable to cover routine SRH services. Universal access to SRH services will have to be financed by large-scale, publicly financed social insurance schemes and/or through tax revenue.

The deliberate promotion of private financing and provision of health services in general and of SRH services in particular, especially in the absence of a strong private sector regulatory mechanism, has many negative consequences for the health system. To begin with, it cuts into donor funding that may have been available to strengthen the public health system. This worsens the resource crunch in the public sector. Essential equipment and drugs become unavailable, demoralized professional staff leave the public sector for the private sector and vacancies remain unfilled. Contrary to claims, market creation efforts do not 'free up' resources that can be used for the poor. The reality is one of shrinking resources; when patient load falls, fewer resources are allocated to the public sector, resulting in its steady deterioration and decline.

The worst affected by the decline of the public sector are those from the most marginalized

sections of society and those who cannot pay for health care. They will have to resort to the more affordable 'informal' SRH care (if these are still available). Those who can afford to pay may be spending money on unnecessary procedures and drugs. Studies show that the private sector in health in many middle- and low-income countries may not be much better than the public sector (if at all), in terms of efficiency and quality of care.

The presentation ended by drawing attention to the experiment in Thailand to provide universal coverage for a comprehensive package of SRH services through public financing, and harnessing the private sector towards meeting national health goals. Other countries, such as Cambodia, were experimenting with Health Equity Funds to ensure access for low-income groups to a range of health services, including maternal health care and contraceptive services. Social Health Protection Schemes operational in many Latin American and Caribbean countries ensure coverage mainly for pregnancy-related services, though excluding abortion. These latter schemes have scope for being enhanced to cover a more comprehensive range of SRH services. SRHR activists and professionals need to advocate nationally and globally to promote universal coverage of health services, including a comprehensive SRH package.

"Distribution of health care infrastructure nationwide is the must for universal coverage for health. It was difficult for Thailand to encourage private health facilities to provide services in rural areas. Therefore, expansion of the public health facilities to cover the entire population is crucial to overcome physical barriers."
Thaworn Sakunphanit MD., MSc., National Project Director, Health Care Reform Project, National Health Security Office, Thailand

Response

The response by Sylvia Estrada-Claudio from the Philippines presented a transformative agenda for achieving universal access to sexual and reproductive health, taking into account the macroeconomic influences on health. This agenda included the following:

- Our demand should be for access to universal health care, of which comprehensive sexual and reproductive health care is an integral component. Universal health care as defined by us would include preventive and promotive health care in addition to curative and rehabilitative. "Health promotion" as we understand it deals with social determinants like sexuality and the environment, and offers the political space for broader unity with other sectors of the social movement.
- Resources invested for the success of single-disease vertical programs should be redirected towards strengthening all the building blocks of the health system.[3]
- Universal health care should be publicly financed through quantum increases in tax-based funding. There is enough money in the global economy and within the national economies of many middle- and low-income countries to afford this. For example, the US government's bail-out of the corporate sector in response to the economic crisis was around US$9.7 trillion, while the increased health spending per year needed in low-income countries to achieve the MDGs is a miniscule proportion of this: about US$10 billion.

3 The six health systems building blocks are: service delivery; health workforce; information; medical products, technology and vaccines; financing; and leadership and governance. See: World Health Organization. Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework. Geneva: WHO, 2007.

- National governments could raise money through increased taxation, borrowing and reallocations, and making increases in the proportion spent on health by local governments mandatory.
- The substantive additional investments in health should be channeled towards increasing health facilities in under-served areas; training and deploying a large number of multipurpose health workers to be able to serve the needs of the population; and increasing availability and a sustained supply of drugs and supplies.
- If universal health coverage were to be achieved, public-private partnerships between government and the for-profit private sector should give way to partnerships between the government and health NGOs committed to social justice and public accountability. In the latter, both parties share universal coverage as a common goal. These should be called "public-public" partnerships, because categorizing socially committed NGOs together with for-profit organizations motivated by profit-making is not quite right.

Discussion

Discussion centered mainly around privatization and GHIs, and on applying the human rights framework.

A question was raised as to what was "political" about privatization. Financing was a technical issue, not a political one. The speaker responded that politicization in sexual and reproductive health was usually understood as referring to religious and other fundamentalist and patriarchal opposition to women's sexual and reproductive rights. It was clarified that for the authors, who gives money, for what, and who gets left out, were also politics. The promotion of an ideology that believes that markets should regulate health care implied that no one had a right or entitlement to the opportunities and resources necessary for good health. Profit motives would govern which health services are made available, and only those with purchasing power would be able to access the health care and resources necessary to live a healthy life.

One participant commented on the need to view privatization across all building blocks of the health system and not only in financing and service delivery, for example the widespread privatization of medical and health provider education and its consequences for health also need to be understood.

Another comment was on how privatization of health care has led to an increase in the number of health institutions with religious affiliations, which then do not provide SRH services. This is also the case in many middle- and low-income countries where a number of public-private partnerships are promoted and funded by USAID; such institutions do not provide safe abortion services.

In central and eastern European countries, which had moved from public to private health care, there was 'savage privatization.' Services to be delivered were picked and chosen based on what was more profitable. It was very important to include a perspective from this region.

There was a debate on whether privatization was 'all negative' for sexual and reproductive health, and whether public was always desirable. One argument was that the private sector played an important role in many settings in making abortion services and condoms

available in contexts where the public sector would not do so for political reasons. Sex workers in India were being served only by the private sector. The response to this was that 'privatization' was not the same as the presence of a private sector. The authors were also not talking about the non-profit private sector that serves several under-served communities; rather, the critique was of the 'for-profit' private sector and of marketization of health care.

The women's movement needs to take a position with respect to privatization in health…

Another point of debate related to whether we would want a global health initiative for sexual and reproductive health. One view was that if immediately after ICPD we had launched a GHI that came with money, we would be much further ahead in achieving ICPD targets than we are now. GHIs should not be caricatured as a vertical approach only because some of the "better" GHIs are focusing on vertical programs along with a larger health systems approach. This was countered by the view that global health initiatives by definition focus on single or limited issues and ignore the many social determinants of the health problem being addressed. They are characterized by short-termism. Some of them have been forced to start addressing health systems issues, but mainly from a damage-control perspective, which is not the same as investing in health system strengthening in the first place.

It was suggested that the women's movement needed to take a position with respect to privatization in health. We needed to learn from HIV/AIDS activists who have managed to engage successfully with the private sector to further health goals. A concern raised by another participant was that because a section of the HIV/AIDS movement was totally aligned with GHIs, we might alienate ourselves from them if we took an anti-GHI position.

How useful was the human rights framework to critically assess reforms in financing, including privatization in health? A human rights lawyer and activist responded that the potential contribution of the human rights toolbox on its own was limited because all it legally required of governments was progressive realization of the right to health. Some governments were using the language of human rights to make a case in favor of privatization.

Budget monitoring was also brought up as an important tool for holding governments accountable for respecting, protecting and fulfilling people's right to health. Others added that we need to demand accountability not only of governments but also international and intergovernmental organizations and the corporate sector.

THEME 2

Sexual and reproductive health and rights in public health education

The urgency for a workforce that is sensitized to critical components of both the clinical and public health aspects of sexual and reproductive health and rights cannot be overstated…

This presentation by Simone Diniz of the paper co-authored with Jocelyn DeJong, Sharon Fonn, Pascale Allotey, Sofia Gruskin and Thérèse Delvaux, provided a critical analysis of the broader contextual factors that support or hinder education in SRHR. It adopted a case study approach, and analyzed case studies of three initiatives for capacity building on sexual and reproductive health and rights within public health institutions to identify key challenges.

The urgency for a workforce that is sensitized to critical components of both the clinical and public health aspects of sexual and reproductive health and rights cannot be overstated. We need health professionals with the best technical skills as well as an understanding of sexual and reproductive rights; we also need public health professionals with capacity for research, policy formulation, management and advocacy. Cairo and Beijing legitimized a sexual and reproductive health and rights perspective, broadening the focus from fertility rates and population growth and infant and maternal mortality. However, political and financial support for training in sexual and reproductive health have waxed and waned since then.

Four major contextual factors were identified as influencing the nature and content of training in sexual and reproductive health and rights. Some of these are common to all health issues. Others are specific to sexual and reproductive health, which generate strong opinions steeped in social values, ideology, religion and morality.

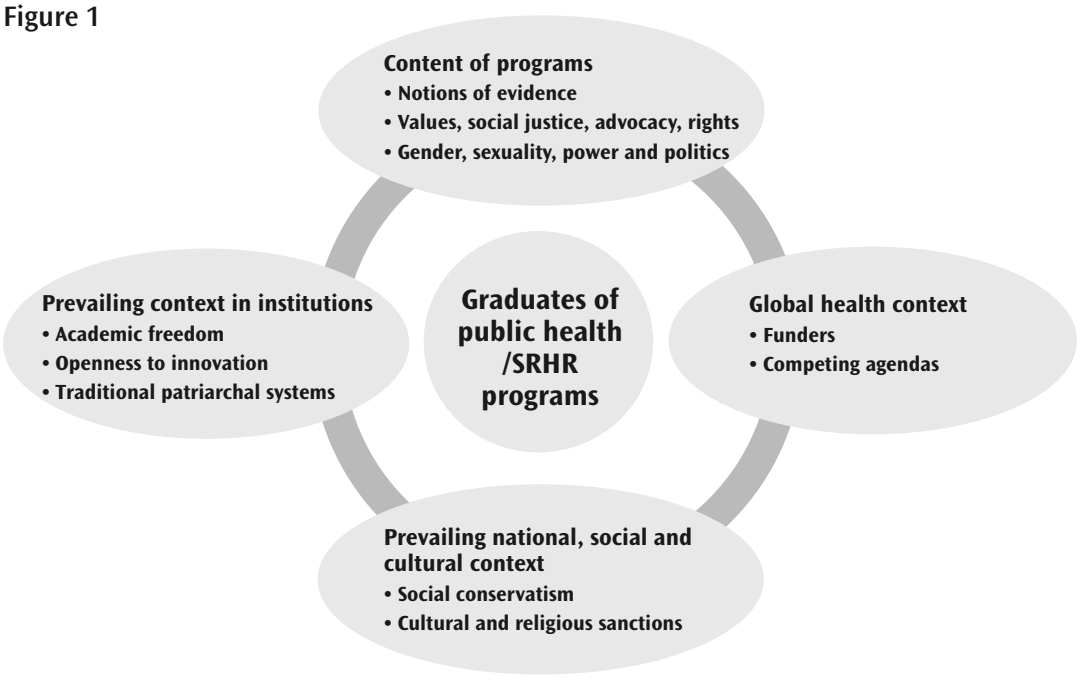
- *The global health context*: e.g., competing agendas, political and donor support for sexual and reproductive health, availability of funding
- *Prevailing national, social and cultural context*: e.g., political support, social conservatism, cultural and religious sanctions related to sexual and reproductive rights
- *Prevailing context in public health institutions*: e.g., extent of academic freedom, openness to innovation, predominance (or otherwise) of patriarchal norms and values
- *Principles governing content of programs*: notions of evidence; commitment to social justice, rights; willingness to address gender, sexuality, power and politics (Fig.1)

The Middle East

The first case study was of sexual and reproductive health education in the Middle East. Short courses have been offered once a year at the Social Research Center of the American University of Cairo since 1998, with a strong focus on social determinants of reproductive health in the region and a gender and rights perspective. The Ahfad University for Women in Sudan offered a two-week version of the WHO Course "Transforming Health Systems: Gender and Rights in Reproductive Health." The course was open to participants from the entire region.

In terms of University programs, there have been a number of initiatives to integrate reproductive health in the medical and nursing curricula in Yemen, Egypt and more recently, in the West Bank, with the impetus for reform coming from external agencies (e.g., World

Figure 1



Health Organization, Population Council and private foundations). Not much documentation on these efforts is available in the public domain. Only a small number of independent public health programs existed in the region. None of these offered independent programs on sexual and reproductive health, but incorporated reproductive health into the curricula to varying degrees. There were few social scientists on the faculty of these schools of public health, posing a challenge to teaching SRHR from a social context and social justice and rights perspectives.

A major contribution to research on sexual and reproductive health in this region is by the Reproductive Health Working Group. Established in 1988, this group has adopted an interdisciplinary approach, and made a sustained effort to include researchers working on reproductive health across the region. The group meets annually and members present their work to each other, and it serves as a forum for capacity-building and networking.

South Africa

The School of Public Health, University of the Witwatersrand, in Johannesburg, South Africa has a more than 20-year history of working in reproductive health. What is now known as the WHO Course on "Transforming Health Systems: Gender and Rights in Reproductive Health" had its beginnings in the Women's Health Project, part of the School of Public Health. The Women's Health Project brought together experts from around the world, including from WHO and the Harvard School of Public Health, to develop a course that would train health managers in a post-apartheid South Africa to work towards ICPD goals and offer gender- and rights-centered sexual and reproductive health services. By 1997, a three-week curriculum had been developed and field-tested in South Africa.

The success of the program was recognized by the WHO and from among competitive applicants, four regional training centers were selected to adapt and host the training. A 500-page step-by-step manual was published by WHO in 2001. Globally, over 1,300 partici-

pants directly participated in this course and thousands of participants have attended programs derived from that curriculum.

In the Witwatersrand School of Public Health, this course was offered for over 10 years. Now, parts of the course are incorporated into the teaching of Wits medical doctors, in the Masters of Public Health degree and the MSc in Epidemiology and Biostatistics. While sexual and reproductive health issues have been integrated and gender equity is evident as a theme, the focus of the MPH and MSc programs is that of health systems development. This is a reflection of the need to respond to the country's concerns with developing a functioning health system in post-apartheid South Africa; and with reshaping a system characterized by large and well-established vertical programs and by donor pressures to invest in these rather than in building general health care services from the bottom-up.

Brazil

Public health education programs in Brazil have their origins in the movement against the military dictatorship (1964–1984), one constituent of which was a strong movement for health rights (health party). As a result of the activism, health was defined in the 1988 Brazilian Constitution as "a right of every citizen and a duty of the State". A system of publicly financed universal health care (SUS) was created.

In the 1990s, there was a boom in gender studies, and SRH was included under "Gender and Health" in the 23 most prominent universities of Brazil. Besides gender theory, Gender and Health courses address a number of sexual and reproductive health and rights issues, including contraception, abortion, sexual diversities, masculinities and STIs/HIV.

Public Health training in Brazil is closely oriented to the public health system (SUS), including services provided as part of the PAISM (Comprehensive Women's Health Program), which was advocated by the women's health movement. However, training for service providers (doctors, nurses, etc.) may or may not include sexual and reproductive health and rights issues. Teaching reflects the limits of the political and legal context. For example, the use of the concept of gender in health varies – while in most places gender is used as an analytical concept, very few address power relations between women and men, women and health providers, institutions, and others. Teaching of maternal health is dissociated from sexual and reproductive health. Many of the most innovative instances of training and service provision are ignited by activism. Formal higher education follows it, often years later. Women's health, HIV/AIDS, violence against women, sexuality and sexual rights are all examples.

Trends

Sexual and reproductive health and rights training within public health education faces formidable challenges. Although the extent to which the content of SRH education can be politicized depends largely on the national and institutional context, some common trends are discernable across regions. Despite its roots in social justice, public health education in most countries is currently overwhelmingly technocratic. Recent advocacy has attempted to forge stronger links between traditional public health education and an approach driven by social justice, equity and human rights, but there is resistance to any move away from the technocratic approach. Erosion of academic freedom is a real threat in some countries and already occurring in others, and makes it difficult to address sexual and reproductive health

and rights issues in a meaningful way. Current global health debates strongly favor programmatic foci (maternal health, family planning, abortion services) as these are perhaps more resilient and are clearly preferred by funding agencies.

Given this context, while many public health training programs address SRHR in some form, most focus on biomedical and risk-centered approaches. Redirected political priorities, reduced donor funding for a comprehensive approach, fragmentation of the larger SRHR constituency into different interest groups have all affected progress in SRHR education. Overall, very limited progress has been made with respect to institutionalization for capacity building in reproductive health in a sustainable manner.

It is time to re-examine current approaches to SRHR education and to identify ways in which these may have to be changed. In order to do so, we need to have greater clarity on the competencies that we would like a person trained in SRHR to have, and the larger goals of SRHR education.

We need to have greater clarity on the competencies that we would like a person trained in SRHR to have, and the larger goals of SRHR education…

Responses

Two speakers responded to this presentation. The first speaker, Thérèse Delvaux, shared the experiences of the Institute of Tropical Medicine (ITM) in Belgium in including sexual and reproductive health and rights in its public health curriculum. In Belgium, gender and sexuality education and training are usually carried out by social science or demography departments at university level, and by the NGO sector. The Masters in Public Health (MPH) program in the Institute addressed medical/technical issues such as unsafe abortion, but there was less focus on gender and sexuality in the beginning. This was because there were few social scientists on the staff or in the course coordinating teams. To some extent, there was also lack of knowledge or misunderstanding of concepts or definitions related to gender, sexuality and SRHR among public health teachers. Gender was addressed, if at all, as an analytical concept within social determinants of health.

Over time, the situation has changed. There are now more social scientists on the staff and staff members have been involved in the initiation of a *Platform on Population and Development (2000)*. This is a collaboration between academics, demographers, NGOs and activists, which facilitates sharing experiences. This has contributed to the strengthening of SRHR education within the Masters in Public Health program, although sexuality is less addressed than it should be. They believe that multidisciplinary teams at academic level and/or collaboration with NGOs are needed for teaching SRHR.

There is substantial academic freedom for teachers. The political context is also favorable, with HIV and SRHR an integral part of the development cooperation policy. Therefore, safe abortion and family planning form a substantial part of the RH course (two of ten weeks). The course addresses political issues, including sexual rights and issues of men having sex with men. However, safe abortion and men having sex with men remain sensitive issues among some students. The speaker believed that teachers should stick to these and other sensitive issues in the course despite some resistance from a number of students. She also believed that a technically oriented course does not prevent the teacher from including activism and passion, and addressing social justice issues. Thérèse ended with a question similar to the previous presenter: How do we evaluate the impact of our courses on sexual

and reproductive health and rights? In other words, what learning objectives and competencies do we aim to achieve and what tangible changes on the ground would indicate to us that we have indeed done so?

The second respondent was Jo Wainer from Australia, a long-time activist for abortion rights. She is a social scientist on the medical faculty at Monash University, who introduced and successfully mainstreamed gender competencies in the undergraduate medical curriculum, together with colleague Ann-Marie Nobelius. It is important to intervene in medical schools because this is where most public health education takes place. Medical curricula the world over are elitist and students going through medical school imbibe the dominant culture. It is not surprising that they become resistant when we ask them to critique the prevailing ideology. Transforming the medical curriculum is not their need; it is ours.[4] This has to be borne in mind. We also need to address the deeply philosophical question – whether we can use the Master's tool (the medical curriculum) to dismantle the Master's hut – to start questioning the status quo that maintains inequitable gender and social power relations and underlies many sexual and reproductive health concerns.

One entry point that Jo had used with success was to tell students about the deadly impact of not including gender and SRHR in the curriculum. The students want to become the best doctors, and so when you tell them, "if you don't know this, then people are going to die as a consequence," bingo, you have them.

Jo spoke of the many levels of curricula: the official curriculum, the curriculum that the teacher decides on, what actually gets taught, and then the hidden curriculum: what happens between teachers and students, among students and among teachers. The hidden curriculum offers much scope for subversion. Much of the teaching on gender and SRHR needs to happen below the radar, privately between teacher and students. There are many women and men who are offering resistance to the dominant curriculum through their teaching and interactions with medical students. We need many more of these revolutionary men and women to teach to get transformative outcomes. According to Jo, sneaking our way into the current curriculum was the best way to transform the curriculum from within, one step at a time.

Discussion

How do we develop a core of health professionals who are able to teach and provide health and allied services from a social justice and rights perspective within countries and globally?

Discussion on this centered on two major areas: the where, when, how and what of integrating sexual and reproductive health and rights within public health education; and the macro forces influencing the extent to which it was possible to integrate 'politicized' SRHR content within public health education.

In terms of *where* in public health education SRHR education should be integrated, participants agreed that SRHR training is needed not only in the training of public health professionals, although two of the three presentations had talked about this. It is as

4 "They" refers to the medical establishment and "us" to feminists advocating for integrating gender in the medical curriculum.

important or more important to integrate it into the training of all providers responsible for various components of sexual and reproductive health services. This would include medical and nursing professionals, including specialists providing sexual and reproductive health services: not only obstetrician-gynecologists, but also urologists, who currently provide all specialist sexual and reproductive health care for men in many settings. Counselors, sex-educators and school teachers are another important category of personnel who need to be trained in sexual and reproductive health and rights, because they teach the younger generation. There are also a range of other community-level workers who act as change agents and it is very important that the message gets out to them.

In terms of *when* SRHR should be introduced, both pre-service training and in-service training are very important. In pre-service medical training, rather than introducing it as a part of public health in the last year of training, such themes should be introduced in the first and second years of training, because students are more open and not set in their ways.

What should be the content of the teaching? Discussion on this was not very elaborate, but there was agreement that it would address both the technical and political dimensions of sexual and reproductive health and rights, and be framed from a social justice and human rights perspective (both of these imply also a gender perspective). 'Political' dimensions of sexual and reproductive health include, for example, an understanding of social determinants of the many sexual and reproductive health needs and problems; of the economic and political factors and actors necessary for achieving universal access to comprehensive sexual and reproductive health services; as well as of forces and actors actively sabotaging or inadvertently derailing this.

There were many challenges to integrating sexual and reproductive health and rights as conceived here within public health education. One of the major factors is the privatization of public health and medical and nursing education, where schools are run with a profit orientation and students are trained to become "successful" individually, establishing profitable practices; the best case scenario within this setting is institutions where students are trained to be technically highly proficient but treat medicine and public health just as an academic discipline to excel in. Those trained in such institutions are not interested in the health needs of the local people, and do not see themselves as having a responsibility to serve society.

In the experience of some participants, bringing about changes within the medical and nursing curricula was far more difficult and challenging than changing the curriculum in a stand-alone independent Masters program in public health within a school of public health. Nursing councils in some countries are opposed to the inclusion of issues such as sexuality, sexual rights and abortion. In other countries, nursing education is becoming more aligned with and influenced by the medical curriculum. Subjects such as sociology, anthropology and ethics had disappeared from the nursing curriculum, and it was difficult to identify an appropriate point of entry for teaching about sexual and reproductive health and rights.

Resistance to including gender, sexuality and other 'political' content within public health teaching is experienced not only in low- and middle-income countries. There were also instances of world-renowned public health schools training policy makers from many low- and middle-income countries actively resisting the inclusion of such courses. Even if some

While we have a number of 'models' of curriculum, what we are in search of are models for change – how can we make change happen?

interested faculty members succeeded in getting permission to offer a course, these would not be institutionalized, so that when the individual faculty members left, the course disappeared with them.

On the other hand, there has been increasing support for teaching 'women's health' with a far less progressive content. It appears that a conflation of right-wing, centrist and 'well-meaning' forces have been succeeding in putting into the university curriculum courses that promote notions of 'women' that run ideologically contrary to what the women's movement has been trying to fight for for decades.

What may be the influence of global health initiatives on health professional education? One participant observed that GHIs brought with them an ethos of emergency response to a single health issue. The demand was therefore for health professionals who were highly specialized in a single issue and oriented to providing biomedical solutions for the same. This ran contrary to the kind of education and training in SRHR that we were outlining in this session. How likely are we to succeed against these forces?

Another hurdle to the authors' vision for SRHR education was the fragmentation of those involved in these issues across parallel movements and groups that appear to have little to do with each other: the women's movement, the HIV/AIDS movement, the human rights movement, reproductive health professionals, and others.

The discussion concluded with a set of proposals that constitute an agenda for immediate action.

- We need to map all efforts at SRHR education – for different categories of professionals, pre- and in-service, short courses and university programs, and others.
- This should be followed by identifying initiatives that we would consider to be 'successful' in achieving the goal we have identified.
- We then need an analysis of factors that have enabled some initiatives to succeed despite the many challenges that we have identified, and apply this to the design of new initiatives.

In other words, while we have a number of 'models' of curriculum, what we are in search of are for models for change – how can we make change happen?

THEME 3

The role of the pharmaceutical industry, essential medicines and regulation

The session started with a presentation by Marge Berer of the theme paper jointly written by Jane Cottingham and Marge Berer.

WHO's Reproductive Health Strategy outlines five overarching activities necessary for accelerated progress in SRH:

- Strengthening health systems capacity (including attention to financing, health workers, quality of service provision and barriers to use of services);
- Improving information for priority setting;
- Mobilizing political will;
- Creating supportive legislative and regulatory frameworks; and
- Strengthening of monitoring, evaluation and accountability.

Appropriate medicines and devices are mentioned only once, in the context of creating supportive legislative and regulatory frameworks: "to ensure that regulations and standards are in place so that necessary commodities (defined earlier as medicines, equipment and supplies), which meet international quality standards, are available on a consistent and equitable basis."

Obviously, further elaboration is required on how to ensure availability of necessary commodities for sexual and reproductive health care on a consistent and equitable basis, beyond the realm of regulations and standards.

The pharmaceutical industry plays a critical role in enabling (or not) universal access to health care services. There is gross inequity in access to appropriate, essential, quality medicines globally, ranging from over-medicalization to a severe lack of essential drugs. High prices, profit-making and other vested interests often drive developments rather than concern for public health.

The international pharmaceutical industry is influenced, *inter alia*, by: i) international trade agreements, ii) growth of a southern-based pharmaceutical industry competing with established northern companies, and iii) massive investment in technological solutions to epidemic levels of illness.

The list of essential SRH-related medicines and devices is a long one, and includes the following:

- Contraceptives and condoms
- Medical abortion pills and vacuum aspiration/surgical equipment
- Pregnancy: drugs for anemia, HIV, malaria, TB, magnesium sulfate, oxytocin, misoprostol, antibiotics, blood (products), disinfectants, anesthesia
- Treatment for bacterial/viral STIs, RTIs

The world can well afford to pay for commodities essential for SRH services.

- Vaccines against HPV
- Means for screening, diagnosis and treatment for reproductive cancers
- Means of infertility prevention and treatment
- HIV antiretrovirals and treatment for opportunistic infections.

Let us take the example of contraceptives to illustrate the issues related to SRH commodities. There is lack of interest in investment in contraceptives, reflected in international donor priorities. Seven to eight hundred million women/couples were using family planning globally, yet 137 million women were estimated to have unmet need for contraception (UNFPA 2008). Unless there is a renewed emphasis on contraceptive provision by governments and international agencies, expected growth in the need for contraception – as total fertility continues to fall and as (young) populations continue to grow – is not likely to be met. Comparable statements could be made about many of the drugs and devices listed.

Major investments are also needed for production of antiretrovirals. With policy shifts to making HIV testing universal, at least in high-prevalence countries, with a view to universal access to treatment for itself and to prevent further spread of infection, the already huge cost of providing HIV treatment is going to skyrocket as millions more people with HIV are identified. The effectiveness of highly active anti-retroviral treatment (HAART) for prevention of sexual transmission depends on the absence of sexually transmitted infections (STIs), which will complicate programs and increase costs further. Whether the Global Fund to Fight AIDS, TB and Malaria will be able to garner the additional resources needed for this is uncertain.

In contrast to the limited availability of these essential and life-saving commodities, availability of other commodities and services that are far less important has been increasing in response to demand from those with purchasing power. For example, hormone replacement therapy, with promises of eternal youth; viagra/female viagra, with promises of eternal sex; and cosmetic surgery, with promises of eternal beauty.

The world can well afford to pay for commodities essential for SRH services. The estimated total cost of financing the ICPD Program of Action is just under US$70 billion by 2015 (UN Commission for Population and Development 2009), and this includes the cost of commodities and a comprehensive array of sexual and reproductive health services. In contrast, the global market for a single health condition – cardiovascular diagnostics and therapy alone – was estimated to reach $192.4 billion through 2012 (Shahani 2007).

The case of human papillomavirus (HPV) vaccines offers some important lessons. As valuable as these vaccines are, their promotion is an example of aggressive marketing by pharmaceutical companies in isolation from a comprehensive approach to cervical cancer. The companies were initially not able to elicit sufficient interest from public health policymakers. Neither Merck nor GlaxoSmithKline, patent holders of these drugs, showed any apparent interest in making their products available at public sector prices in the developing world, greatly reducing the potential impact of the new vaccines on global incidence of cervical cancer. Comparative studies of HPV vaccines with various forms of screening, including HPV DNA testing, also potentially transformative, were not being done either. Vaccinating boys with the HPV vaccine was and is controversial, and only adolescent girls were being targeted for vaccination.

Comparatively no funding is available for a number of independent initiatives that have produced essential sexual and reproductive health commodities such as female condoms, medical abortion pills, microbicides and the new emergency contraceptive Ella.

A number of issues related to pharmaceutical products are currently the subject of heated debate globally. For example, the global drive to introduce generic drugs to reduce prices is strongly opposed by the pharmaceutical industry. Misinformation is being spread that lumps together generic drugs and counterfeit drugs and labels them as posing a threat to life and health. In developed countries, the cost of medicines is usually high, but is also usually reimbursed. Prescriptions are required and quality is controlled. In developing countries, there is huge scope for the manufacture and sale of cheaper (often unregistered) medicines. Medicines are sold across the counter even when prescriptions are required; the quality of medicines produced is not adequately controlled and can be very poor. An emerging phenomenon is the internet trade in drugs, which is subverting all regulatory mechanisms. Is it controllable?

The high cost of many medicines is largely due to the international patent system, codified by the Trade Related Intellectual Property Rights (TRIPS) Agreement. A number of countries – Brazil, South Africa and Thailand among them – have declared compulsory licenses (the legal right to exploit a patent which has been granted by a government, without the permission of the patent owner), particularly for antiretroviral treatment for HIV.

Another important issue relates to essential medicines, because the ownership and price of medicines and the programmatic infrastructure to deliver them are among the main barriers to access to health care. The WHO "Action Programme on Essential Drugs" (now Essential Medicines Programme) was set up in 1977, to assist countries in formulating national drug policies, selecting essential drugs, setting in place appropriate procurement mechanisms and a system of public sector pricing to ensure availability, affordability and rational use of medicines that are safe, effective and of good quality. This program is not always a high priority within WHO or in countries. The WHO produced a list of Essential Medicines for Reproductive Health in 2006 (at: <www.who.int/reproductivehealth/publications/general/a91388/en/index.html>).

Even as we identify these major challenges to access to essential SRH commodities, it is important to acknowledge the progress that has been made. We now have some essential SRH drugs available at public sector prices. Some large pharmaceutical companies are now creating programs that appear to be geared towards providing cheaper drugs to 'eligible' developing countries. There are examples of governments (e.g., New Zealand, United Kingdom), which manage drug spending within a public budget while improving access to subsidized medicines and achieve substantial bargaining power in negotiations with drug companies.

Access to essential medicines for SRH and HIV is subject to the same forms of scarcity and inequity as access to every other aspect of health care. The vast bulk of research and development, manufacture and distribution of drugs and devices supporting sexual and reproductive health remain in the hands of private, profit-making companies.

The following are some recommendations for ensuring universal access to essential medicines for sexual and reproductive health care:

The ownership and price of medicines and the programmatic infrastructure to deliver them are among the main barriers to access to health care.

- Support WHO's call for greater cooperation between governments, drug companies and other stakeholders to provide a mechanism for creating new medicines and products for treating diseases of poverty affecting developing countries, and make them affordable and accessible. (2008)
- Investment is needed further in helping countries to ensure adequate and regular supply at affordable costs of all medicines and devices, including those essential for sexual and reproductive health.
- Support production of and access to more generic drugs with rigorous quality control.
- Examine the feasibility of international controls on the prices of essential drugs, under the aegis of WHO.

Responses

The response by Kajal Bhardwaj entitled "Access to Medicines and Treatment – A Reality Check" gave a comprehensive picture of the issues that we needed to understand about universal access to medicine and devices. The presentation first took a closer look at the intellectual property system and access to medicines, and then stepped back for a look at an even more aggressive aspect of globalization.

Intellectual property rights (IPR)

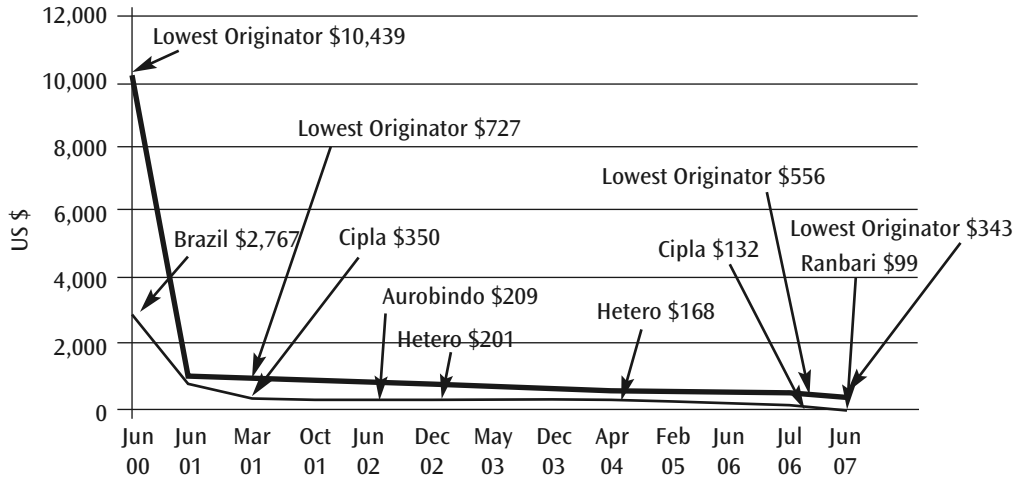
The World Trade Organization's Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) requires countries to grant 20-year patents *on medicines*. A monopoly on a drug for 20 years means that ordinarily there will be only one producer who will set the price, determine where the drug should be sold, in what quantities and so on. This system is justified on grounds of public policy. Patents, it is claimed, will promote and reward innovation while disclosing it and making it available to society.

But do they? Let us examine the case of the AIDS treatment crisis in order to understand whether patents facilitate access to medicines (Fig.1). In 2000, the best discount that originator companies were willing to offer for first line antiretroviral therapy was US$10,349. In 2000-01, Indian companies came in and offered the same drug at the substantially lower price of US$350. Figure 1 shows how the lower prices offered by multiple generic companies forced multinational pharmaceutical companies to slash their own prices; today the price is around US$80 per patient per year. This illustrates that with monopoly, big pharma can set prices at whatever levels they choose to, and the moment generic production starts, not only are generics available at lower prices, but big pharma are also compelled to reduce their prices.

Has TRIPS delivered on innovation? Developing countries had believed that if they signed TRIPS, they would benefit from innovations, especially drugs for neglected diseases. But this did not happen. For example, available treatments for sleeping sickness are ineffective or toxic. For Kala'azar, the most common treatment was developed in the 1930s. Commonly used tests for tuberculosis, which were developed in 1882, detect TB only in 45-60% of cases. AIDS treatments are often not adapted to resource poor countries, for example, for pediatric AIDS.

A recent WHO report observed, "There is no evidence that the implementation of the TRIPS agreement in developing countries will significantly boost R&D in pharmaceuticals on Type II and particularly Type III diseases. Insufficient market incentives are the decisive factor."

Figure 1



(WHO Commission on Intellectual Property, Innovation and Public Health, April 2006). The reason is that Asia, Africa and Australia together contribute only 7.7% of the market for pharmaceuticals and Latin America another 3.8%, while North America contributes 47.8% and the European Union 27.8% of the pharmaceutical market (World Pharmaceutical Market 2005).

The patent system was meant to be a social policy tool designed to stimulate innovation by giving the innovator a limited monopoly right in exchange for society enjoying the benefits of medical progress. However, innovation is meaningless if the majority of the people in need do not have access to it. True innovation needs to benefit the world population as a whole. It is unacceptable that innovation is reserved for the rich.

Of the drugs that are being developed, many are not new drugs at all. Of 1,035 new drugs approved by the US FDA in 1989-2000, 76% had no therapeutic benefit over existing drugs but were a means of 'ever-greening' the companies' monopoly through the issue of a new patent when the previous patent protection period of 20 years was about to expire. Of the 23% of new drugs that had therapeutic value, only 1% were for neglected diseases.

One of the countries where the growing battle on patents is taking place is India. Indian companies were able to supply safe, effective and affordable generic HIV drugs because of India's patent law. Before 2005, India recognized only process patent and not product patent, which means that they would produce the same product but through alternative processes. There was a strong industry producing generic drugs. In 2005, India had to comply with the TRIPS agreement. It had to start granting 20-year patents on medicines, threatening the supply of generics worldwide (HIV drugs, essential medicines, and others). As a result of vigorous public debate and pressure, the Indian Parliament used flexibilities in the TRIPS Agreement. It included key public health safeguards in the amendments, such as allowing patients groups to oppose the granting of patents; limiting the grant of patents for 'ever-greening'; compulsory licensing, and others. The law also allowed the continuation of generic production of medicines that started before 2005, even when the drugs were patented (first line ARVs included).

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Although the Indian law allows patient groups to oppose patents, this is a difficult, time- and money-consuming task. There are over 10,000 pharmaceutical patent applications and patient groups do not have the resources to keep track of them all. They are no match for the pharmaceutical industry's financial and legal muscle. All cases where civil society groups have been successful have been appealed all the way up to the Supreme Court. Pharmaceutical companies also sue governments when they try and use health safeguards and engage them in protracted legal battles. For example, the Indian government was sued by Novartis, the government of the Philippines by Pfizer, and the South African government by 39 pharmaceutical companies. The kind of pressure that is brought on governments that would like to do something different also needs to be understood.

There is also aggressive opposition by high-income countries to the production of generic drugs, and generics are being branded as counterfeit and spurious drugs, using the media. In India, the impact of the TRIPS regime is now being seen. Apart from highly priced patented medicines, India has seen the selling of several large generic companies to the highest multinational bidders within the last two years (2008–10). A number of generic producers have sold out to big pharma, jeopardizing the future of generics production and availability.

We have an ever-tightening trade system today, with Free Trade Agreements (FTAs) being increasingly negotiated. These FTAs require governments of the South to adopt even greater intellectual property standards than those required by TRIPS i.e. TRIPS-plus demands. The FTAs of the United States were signed 5-10 years ago and there is emerging analysis of the consequences for prices and availability of these TRIPS-plus measures. In Jordan, this led to up to a 600% increase in medicine prices. In Guatemala, there has been up to 845,600% price differences in the same therapeutic class. We now have FTAs that the European Union is signing with country after country, and others are following suit: Canada, Australia and Japan. How bad is this? The European Union is insisting on some of the most aggressive controls on intellectual property, which may lead to even higher levels of price increases. Government procurement of drugs will be seriously hampered. The impact of these trade agreements that decrease government revenues on their ability to invest in the health sector has also not been studied. We are in an unenviable situation.

The next response under this theme was by Jeff O'Malley, who focused on a few important issues related to patents and innovation. He referred to Kajal's point about anti-counterfeit legislation and Marge's reference to quality of drugs, and said that there are problems with quality and with counterfeiting. The latest move from big pharma is being framed in anti-counterfeit language but is in fact a Trojan horse for aggressive control of intellectual property rights. This is because in international law, 'counterfeit' refers to infringement of trademark, and not 'fake' medicines. This is a dangerous thing, because politically it is very difficult to argue against opposition to counterfeit drugs because everyone understands it as referring to spurious and fake drugs that can be dangerous to life and health. Anti-counterfeit laws are sailing through parliaments in country after country. These are mainly countries susceptible to US and EU pressures.

There is a proliferation of Anti-Counterfeiting Legislation in countries of the East African Community: Burundi, Kenya, Rwanda, Tanzania and Uganda. Only Kenya is a developing country; the rest are least developed countries, which do not even have to provide pharmaceutical patent protection until 2016 in the terms of the TRIPS agreement. They could and

should benefit from the TRIPS flexibilities for such countries. Instead, we see developing of 'anti-counterfeit' legislation, which could prevent them from utilizing TRIPS flexibilities. Tanzania passed the Subsidiary Merchandise Marks Act in 2008; Kenya's Anti-Counterfeiting Act also came into effect in the same year. Uganda has been discussing a Counterfeit Goods Bill since 2008. A draft Anti-Counterfeit Bill for all five East African Community countries is being discussed. The UN Special Rapporteur on the Right to Health has expressed concerns about the public health impact of the draft policy and bill in letters to the governments of all five countries.

One of the key objectives of the TRIPS agreement is to balance the rights of the inventor with those of the consumer. The inventor is given a monopoly of 20 years as a reward for developing a new product, after which generic products are free to enter the market and to reduce prices through competition. Compulsory licensing and such mechanisms are considered legitimate under TRIPs. The free trade agreements are in fact compelling vulnerable countries to give up these flexibilities under TRIPs.

Another issue Jeff elaborated on was declining innovation and increased patent protection, also in the European Union (EU). The number of new chemical entities that are brought to market by research-based pharmaceutical companies is seen as an accurate indicator of innovation. Over an 8-year period from 1996 to 2004, there has been a decline in the number of new chemical entities that are being brought to market – from 50 to 20. At the same time, we have seen a dramatic increase in the number of pharmaceutical patents that are being filed in both developed and developing country patent offices. In 2003, there were more than 312,000 patents filed worldwide. A report released by the European Commission in 2008 notes that the number of patent applications being filed in the EU doubled from 2000 to 2007. A closer examination of those patent applications shows that 87% are 'secondary' patents – i.e., patents that are not for the active substance itself, but various ancillary features, such as formulations, salt forms and methods of treatment. This is another form of 'ever-greening': artificial extension of market exclusivity through protection of secondary features, which has led in many instances to the exclusion of generic competition. This in turn restricts the availability of affordable medicines and constitutes an important obstacle for the realization of the right to health.

A constructive agenda to promote universal access to medicines and devices was outlined:

- Sub-standard medicines pose a serious threat to human life and health; their production and placement is criminal. It must be condemned and adequately addressed and should not be tolerated.
- Intellectual Property Rights enforcement is not an efficient approach to curtail production and trade with sub-standard medicines. IPRs are private rights that regulate use of protected objects. They are not suitable to ensure safety and efficacy of medicines and are likely to hamper access to more affordable generics.
- Developed countries should be mindful of the public health impact of TRIPS-plus provisions in the developing world and should avoid their encouragement.
- Developing and least developed WTO members should utilize TRIPS public health flexibilities provided in the TRIPS agreement and should avoid the implementation of TRIPS-plus measures such as bilateral Free Trade Agreements.

- National drug regulatory authorities should implement safety and efficacy measures for medicines.
- Countries should create a legal and policy environment that enables implementation of the MDGs, including Goals 4, 5 and 6.
- Countries should develop and implement policies that balance access to essential medicines and intellectual property rights protection, thereby facilitating the affordability of medicines and creating efficient market disincentives against the spread of substandard drugs.

Discussion

There were two main strands in the discussion, one related to the specific issues around SRH commodities and the other related to the larger issues around organizing for change.

The papers tended to focus on pharmaceuticals. One of the participants observed that the whole issues of devices and technologies for sexual and reproductive health care and their availability, use and misuse was another major area to examine. Drugs and devices to meet the sexual and reproductive health needs of men needed specific attention. The HPV vaccine for young boys was a need on which there was not enough discussion.

While the non-availability of essential SRH drugs was a major challenge, over-medicalization was of equal concern. For example, the emergence of categories such as "Gender Identity Disorder" in the revision of DSM5 (classification of mental health problems) was opening up markets for hormonal therapy at young ages. Drug companies have also medicalized problems of sexuality (e.g., sexual dysfunction) and turned them into a source of profit.

The new wave of promotion of hormone replacement therapy (HRT) for both women and men is another example of over-medicalization. There is a history of denial of side effects of HRT backed by evidence produced with pharmaceutical support, jeopardizing women's well-being. Testosterone withdrawal with estrogen supplementation for transgender people causes severe side effects, including depression, but that is rarely talked about.

Turning to the larger picture, a formidable challenge before sexual and reproductive health and rights activists is that the countries and organizations, which we have considered as our 'traditional' allies in terms of support to SRHR, become our fierce opponents when we talk about intellectual property rights. How do we position ourselves vis-a-vis such countries/organizations?

The first step was to acknowledge such differences and strategize accordingly. SRHR activists need to learn a different language and about a different world if we are serious about moving our agenda forward. We need to understand the world of international financing in health, of TRIPs and intellectual property rights. We need to take a stand that the very existence of WTO was a challenge to human rights, as was the treatment of health as a commodity to be traded.

More analytical work is needed to understand how sexual and reproductive health needs and services were specifically affected by the macro forces operative in the areas of medicines, devices and technology. These links have not clearly emerged from discussions under this theme.

THEME 4

A human rights approach

This presentation by Wanda Nowicka reviewed the current status of sexual and reproductive health and rights globally, with specific attention to the legal and human rights system. It also proposed some ideas on possible ways to move the SRHR agenda forward within these areas by, among others, repoliticizing these issues.[5]

The presentation first defined the term SRHR and especially sexual rights as used in the paper.

Sexual rights are defined very broadly as embracing all rights related to sexuality, and include reproductive rights as a component, because reproduction is only one of many aspects of sexuality. Sexual rights encompass sexual orientation and gender identity. They enable individuals to have full and positive enjoyment of their sexuality. They include all forms of prevention, such as sexuality education for adolescents, prevention of sexual violence and exploitation, but also reproductive choices for all, regardless of their sexual orientation and gender identity. However, because of limited time and space, this paper does not address sexual orientation and gender identity, and the focus will be rather on reproductive rights, especially on the right to abortion.

The paper does not analyze, although the issue certainly deserves thorough analysis, the phenomenon of vanishing SRHR, and especially abortion, from debates about maternal health, and maternal and infant mortality. It is particularly disappointing that many non-governmental organizations which should be in the forefront of standard setting and have huge resources to do so, choose to avoid SRHR in its entirety due to controversies such issues might give rise to.

During the 15 years since ICPD, there have been some important successes in sexual and reproductive rights at the national level. One of the recent successes is the abolition of the 'Sodomy' Law in India. The judgement transcended the LGBT issue with the implication of protection for all minorities and introduced for the first time in South Asia the idea of sexual citizenship.

Nepal's strict anti-abortion law was liberalized in 2004. In 2006, the Constitutional Court of Colombia overturned the restrictive ban on abortion, allowing voluntary terminations in cases of rape, fetal malformation, or when the life or health of the woman or fetus is in danger. Abortion law has also been liberalized, for example, in South Africa (1994), Ethiopia (2005) and Mexico City (2007). In Europe, abortion laws were liberalized in Switzerland (2002), Portugal (2007) and Spain (2010).

As far as international institutions are concerned, there has been significant progress in mainstreaming sexual and reproductive health and rights into standards of monitoring used by UN's Treaty Monitoring Bodies. The Human Rights Committee has adopted the ground-breaking General Comment on the equal right of men and women to the enjoyment of all

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5 The author acknowledged in her presentation her gratitude to Rhonda Copelon for her insightful comments and suggestions, which moved the paper in new directions.

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civil and political rights in 2000. According to this, governments have to report on women's reproductive health issues, including maternal mortality and unsafe abortions. The Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) has adopted, among others, a General Comment on women's health (1999). In the introduction, the Committee affirmed that access to health care, including reproductive health, is a basic right under CEDAW. The Committee on Economic, Social and Cultural Rights in 2000 adopted a General Comment on health, which addresses sexual and reproductive health throughout the document.

Progress has been possible at expert bodies, i.e., all the Treaty Monitoring Bodies and UN Special Rapporteurs. Human rights committees strongly address women's rights, including SRHR, in the monitoring processes of States' compliance with the conventions. They continue to issue powerful concluding observations on these issues. A number of committees, including CEDAW in its recommendations on Ecuador in 2008 and CESCR on Poland in 2009, issued strong recommendations on abortion. The Committee against Torture at its 42nd session (2009) in Geneva expressed its profound concern about Nicaragua's strict ban on abortion. The Committee described the criminalization of abortion under all circumstances in Nicaragua as a violation of human rights.

While these are the many successes in UN Human Rights' expert bodies, there have been more setbacks than progress in political bodies such as the UN Human Rights Council. This is a new human rights body, created in 2006 to replace the Human Rights Commission. On the positive side, this Council passed a resolution in June 2009 recognizing maternal mortality as a human rights issue. However, two highly controversial resolutions "Combating defamation of religions" (2007) and the resolution on traditional values ("Promoting human rights and fundamental freedoms through better understanding of traditional values of humankind") (2009) have also been passed by the Human Rights Council. These resolutions might particulary affect women's sexual and reproductive rights as traditional and religious values are often the language in which patriarchal mechansims of domination of women are couched.

Litigation in courts of law is one of the successful strategies employed by women's groups and NGOs at the national and international level. In Peru, KL, a 17-year old woman, was forced to continue her pregnancy in spite of a fatal fetal anomaly (anencephaly), to carry the pregnancy to term and to breastfeed the baby for several days until her inevitable death. This was despite the fact that Peruvian law allows for therapeutic abortion. Local NGOs, together with the New York Centre for Reproductive Rights, filed a complaint with the UN Human Rights Committee for the State's failure to protect KL from inhumane and degrading treatment. In 2005, the HRC issued a ruling establishing that denying access to legal abortion violated the woman's most basic human rights.

Another internationally well-known case is that of Alicja Tysiac, who challenged Poland in the European Court of Human Rights for denying her an abortion despite the pregnancy posing a serious threat to her health. In March 2007, the Court ruled that Poland had violated Tysiac's right to privacy and that the State had to pay her compensation. Following the Court's recommendation, the Polish government established the office of Ombudsperson for Patients' Rights and an appellate commission in which women can challenge doctors' decisions related to abortion.

As these examples show, litigation has significant potential for strengthening SRHR. However, the fact that such cases need to be brought by individuals poses major limitations on such strategies.

In the global arena, the Millennium Development Goals (MDGs) adopted in 2000, with their focus on the basic needs of the least developed countries, have actually relegated to a back seat a human rights perspective. Because the goals did not originally include any reference to sexual and reproductive health, many women's groups spent a number of years just to get the target of universal access to reproductive health into the MDGs and back onto the global agenda.

Turning now to the human rights of women in Europe, there have been some chilling setbacks to the advancement of human rights and especially SRHR, with the expansion of the EU in 2004. New members such as Malta and Poland have joined hands with Ireland to form an 'unholy alliance' to challenge the consensus that existed among EU countries on matters related to sexual and reproductive rights. There is no EU policy regarding SRHR, because of the EU's decision that questions of "moral significance", as well as those related to the protection of human life, would be regulated by EU member states at the national level. However, the EU makes significant investment in SRHR as part of its development aid. There is a real danger that the new 'unholy alliance' could negatively influence funding for SRHR programs internationally. Such attempts have already taken place in budget debates.

A major threat to reproductive rights in Europe appeared as a result of the anti-discrimination directive (Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation). If adopted, this may lead to the exclusion of reproductive rights from the new EU human rights law. The draft, as it is now, explicitly states that the Directive "does not apply to laws on reproductive rights."

Some positive developments at the Council of Europe offer hope. The Council is a regional body consisting of European countries, including those belonging to the erstwhile Soviet Union. The Council adopted in 2008 a resolution on safe and legal abortion in Europe:

> *"The (Parliamentary) Assembly affirms the right of all human beings, in particular women, to respect for their physical integrity and to freedom to control their own bodies. In this context, the ultimate decision on whether or not to have an abortion should be a matter for the woman concerned, who should have the means of exercising this right in an effective way. (…) 7. The Assembly invites the member states of the Council of Europe to: 7.1. decriminalize abortion within reasonable gestational limits, if they have not already done so; 7.2. guarantee women's effective exercise of their right of access to a safe and legal abortion; 7.3. allow women freedom of choice and offer the conditions for a free and enlightened choice without specifically promoting abortion."*

Unfortunately, the resolutions of the Council of Europe do not have a binding character. It is, however, certainly of moral significance as this is the first international institution to agree on a woman's right to decide.

A number of observations may be made on the basis of this review:

- The SRHR agenda has become gradually depoliticized, especially since 2000. Due to the extremely unfavorable political environment, NGOs working on SRHR issues chose strategically not to propose initiatives going beyond the Cairo, Beijing and other international agreements, on the assumption that it would be unrealistic to expect progressive change. Indeed, many believed that the more progressive the approach, the more backlash it could generate.
- For a number of years, women's movements have proactively made efforts to bring new actors to the SRHR table, including social movements – youth movements, human rights movements, LGBTQI, HIV/AIDS and sex workers. This outreach needs to be continued and strengthened by developing partnerships with trade unions, professional organizations (health providers, lawyers, media), educational institutions and others. Women's movements still appear to be very weak and marginalized when compared to other movements. The attempts to mainstream gender issues into other movements have had at best moderate successes; the issue of gender equity remains on the margins rather than being fully integrated, for example at the World Social Forums. Lessons need to be learnt on how to mutually support and more efficiently integrate our agendas with other movements, especially the stronger ones.
- Paradoxically, the global economic crisis might create a window of opportunity. The crisis made many people highly unsatisfied, abandoned and insecure. Among many problems such as unemployment and shrinking social security systems, access to health care is a big issue. In so many places, public health care is not functional and private health care is not affordable.
- The challenge remains, though, how to channel these feelings into positive energy which would push progressive development, and how within this framework to promote human rights, including SRHR. We certainly should focus more on economic rights as human rights and how they relate to SRHR. We know how the economic situation impacts on and often limits people's reproductive choices and influences decisions. Therefore, in movement building and repoliticizing its agenda, the global crisis and its impact on SRHR has potential to generate significant mobilization.

Responses

The first response to Wanda's presentation was by Hossam Bahgat. He spoke about a few more challenges in addition to the many that had already been outlined, and then made some proposals on what could be done for repoliticizing sexual and reproductive health and rights.

The first challenge relates to human rights as a normative framework. He believed that the normative human rights framework is restrictive. For example, the Right to Universal Access to Health Care does not exist per se under international human rights law. All we have is the right to the highest attainable standard of health within the maximum available resources available to the state. The state in turn is required only to progressively realize this goal.

The second challenge is that even this imperfect framework has been under constant attack and there has been a roll-back on many of the principles that have been established, not only in international human rights law, but also in international consensus documents such as from Cairo and Beijing. In the last session of the Human Right Council, during negotiation of a resolution on violence against women, there was opposition to any reference within

preventive measures to include sex education – not comprehensive sexuality education, but even sex education. There was a move not to mention marital rape – existing language on this was in fact removed. Even the agreed consensus language in paragraph 96 of the Beijing Programme for Action and in many resolutions after that, on sexual health and reproductive rights, is now considered objectionable and reference to reproductive rights is not supported.

Not only are we losing ground with respect to sexual and reproductive rights, but the normative framework of human rights is also shifting. In addition to the resolutions in the Human Rights Council that Wanda mentioned, the African Union Summit in Uganda in July 2010 adopted a resolution on recognizing diversity and cooperation and non-confrontation in the field of human rights. This does two things: first, it introduces the concept of diversity and cooperation as against universality (cultural relativism back in); second, it expresses concerns over 'controversial' new concepts, which in fact refers to sexual and reproductive rights. The picture is not very different in the Commission on the Status of Women, the Commission on Population and Development and the UN General Assembly.

The third challenge is that SRHR activists are largely absent from committees and meetings on governmental human rights mechanisms, or their presence is at best fragmented. Since 2004, with the transformation of the Human Rights Commission into the Human Rights Council, very few of them are to be seen at Council meetings. This has coincided with the rise in interest of the LGBT community in using the Council and intergovernmental spaces to promote their rights. Because of this, sexual and reproductive rights issues other than those related to sexual orientation and gender identity (SOGI) are not receiving attention. There are not enough of us there to resist the attack on Beijing language, on sexuality education and on reproductive rights. At the same time, there is an unhelpful conflation of the two agendas in people's minds. Many people who now hear 'sexual rights' think this refers to gay marriage. The demarcation between identity-based SOGI rights and the more inclusive and issue-based sexual rights agenda is no longer clear for many people. The attack on reproductive rights and the refusal to include sexual health in any form, in his view, is a direct consequence of this.

The way forward consists of ensuring the human rights project is not the province of human rights lawyers alone. We need to retain the human rights project as a transformative and liberating one and to reverse/challenge the undue attention given to international human rights law, the conventions and the interpretation of conventions.

If we do this, we SRHR activists will start seeing our human rights work as part of a larger movement for social justice. We will realize that as human rights advocates we need to take a critical position against our allies who support sexual and reproductive rights when they are against, for example, access to medicines, and such larger social goals. When guided by this larger mission, we as human rights advocates committed to sexual and reproductive health and rights will find it easier to take a position against military conflicts.

Secondly, there should be a shift back to national work. Such work is less represented now in the transnational movement than it ought to be. When we think of human rights we need to think not only of UN bodies and those working in national capitals but also recognize the human rights work being done at the grassroots and ensure that it is better represented in the global arena.

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With this perspective, this larger SRHR movement needs to be thinking about a cohesive strategy on how to respond to the backlash being experienced within UN human rights bodies. We need to think about how we would engage with UN mechanisms and other global spaces, to what end, and where we should be going next.

The second response was by Christina Zampas. She focused specifically on reproductive rights and made two major points.

The first point was that for every single success related to advancing reproductive rights legally, there has been a strong and coordinated response by the opposition. After the Mexico City abortion law reform, numerous Mexican states have proposed amendments to state constitutions that would recognize the right to life at conception. This was to limit the possibility of any liberalizing of abortion law in their respective states. In Portugal and Spain, there were constitutional challenges to liberalizing abortion laws brought by anti-choice groups arguing that the right to life provision of the constitution was against liberalizing abortion; however, neither of these succeeded. After the Council of Europe's resolution in 2008 calling for decriminalization of abortion and the removal of all de jure and de facto barriers to abortion, there has been a lot of activity at the Council of Europe against reproductive rights. Last year, a resolution commemorating ICPD+15 and supporting the Programme of Action could not be passed in the Council of Europe because of lack of support. In the UN, a number of opposition groups are getting consultative status and having an influence on the political process. They are setting the agenda and this includes ensuring that there is no progress on the ICPD agenda. In fact, they want to dismantle the ICPD Programme of Action, while sexual and reproductive rights activists are struggling just to hold on to what we have and are unable to advance the agenda any farther.

The second concern expressed by Christina was that many within the SRHR community have been reframing issues to make them more politically palatable. This has resulted in actions perpetuating stereotypes of motherhood, refocusing of issues away from human rights, and more towards health. In sexual and reproductive health and rights, the 'R' for rights has been removed. In a recent brochure for a conference, the UNFPA had a message saying, "No woman should die giving life." This sidelines completely the fact that many pregnant women die from the consequences of unsafe abortion. Abortion is not being included within maternal mortality in many forums. This is happening not just in the UN but within our own community. We hide many times behind safe issues. Persistent discrimination and inequality because of our reproductive capacity are not being challenged.

The move away from rights and towards what is called health is counter-productive. Given the limited scope of many currently utilized global indicators (which can seem to equate good health and survival and use mortality as the sole indicator), indicators could point to 'good' health even with the violation of many rights and the lack of fulfillment of other rights and health indicators recognized as necessary in other contexts. Poland used its low maternal mortality ratio to justify its restrictive abortion law. This is happening in other places. In Croatia, which has low sexually transmitted infection rates, the government response to the lack of comprehensive sexuality education (currently students are taught only about abstinence) is that Croatia does not need such a program. Even in what we see as successes in human rights bodies, we have to take note of the fact that none of these bodies has recognized the gender discrimination dimensions inherent in denying abortion.

Christina concluded her talk with the following recommendations:

- SRHR advocates have to articulate persistently that denial of services that only women need is discrimination and a violation of their fundamental human rights.
- SRHR advocates should empower all actors to participate in the process of holding states accountable by mainstreaming SRHR issues into the demands of other movements, by empowering individuals to take cases and endure the litigation process, and by using all available forums and means.

Discussion

The plenary discussion started with some clarifications from the floor. One participant wanted clarification on what Hossam had meant when he said that SOGI issues and other sexual rights issues had to be kept separate, because this contradicted the support for alliance building that had come up in other sessions. Hossam clarified that in his view SRHR included the right to choose sexual orientation and sexual partner, and went much beyond to include the right to services, autonomy over the body and so on. What he considered negative was that this larger agenda was being subsumed under the narrower SOGI agenda and that this was contributing to a loss of ground on sexual and reproductive rights that were not about SOGI.

There were two main strands of discussion that followed. One was about how we (SRHR activists) engaged with the UN Human Rights Mechanisms; the second was about reclaiming the larger human rights project.

One participant wondered whether there was any value to engaging with UN mechanisms. Given the regressive resolutions adopted by the Human Rights Council, should we not be boycotting it?

A long-time activist who had pioneered activism within UN's human rights mechanisms explained the reasons why there was a diminished presence of SRHR activists at the Human Rights Council, and a few others added to this. The mechanisms of accountability that were put up following Vienna, Cairo and Beijing were spaces that we SRHR activists think we put up and that therefore we should occupy. We are probably victims of our own success. When we work within the system, we internalize many of its values. The mechanisms tended to fragment the rights and it was difficult to have a comprehensive human rights framework. Now we need to ask questions regarding how we look at issues of equality and non-discrimination.

State-focused human rights are also a problem. Non-state actors like corporations, religious fundamentalist groups and others, equally violate rights but with limited accountability. Further, non-citizens, such as refugees and others, often slip off the UN agenda. We have not used the "due-diligence" framework, which holds the state responsible for protection from violation by non-state actors. This was also causing SRHR activists to question the relevance of UN advocacy.

A third factor is that UN advocacy is expensive and time-consuming. SRHR activists were suffering from fatigue because language worked on for years was being struck down suddenly. With the change from one six-week session that the Human Rights Commission

used to have, to three 2-week sessions under the Human Rights Council, it is difficult for those not based in Geneva to attend more than one of these. This has fragmented SRHR advocacy. It is tedious, no fun and no longer glamorous.

The central need of the project for repoliticizing was to bring back values such as social justice and human dignity as the guiding principles of human rights activism. Human rights is about making collective claims of justice and power. A large part of such human rights work was being carried out by those mobilizing people at the grassroots to claim their rights and entitlements. But they may not even think of their work as human rights work. It is for the SRHR movement to recognize and link up with such work and facilitate these voices to be heard. We also need to think through the links – how the work we do in international forums is of benefit to the grassroots.

One issue to bear in mind when framing sexual and reproductive rights as a social justice issue is that every woman, rich or poor, has sexual and reproductive rights. The right to services, for example, is not only for poor women but for all women.

Not letting the right to health be trapped within the limits of justiciability (the limits upon legal issues over which a court can exercise its judicial authority) would also be a part of the repoliticization project. These should be used more as normative principles to guide the movement. It is also time that we once again claimed abortion as a woman's right to choose and not cast it only as a women's health issue. On the role of litigation in advancing the rights agenda, one participant cautioned that we needed to be strategic about litigation, especially in the national arena, as there was a real danger that progressive international standards may be watered down in judgments handed down by national courts (unless a progressive judge was adjudicating).

THEME 5

Funding for sexual and reproductive rights and health

The theme paper on this subject was authored by Adrienne Germain and Alexandra Garita and was presented by Adrienne Germain. The presentation provided an overview of the funding situation and then posed some challenges for advocacy for greater resources for sexual and reproductive health. At the very outset, Adrienne drew attention to the fact that there was great diversity in the data available on who was funding whom and for what, and the figures presented were only to give a notion of the order of magnitude.

Overseas Development Assistance (ODA) for health had grown phenomenally from $2.9 billion in 1995 to $14.1 billion in 2007. However, this was still inadequate, and was fragmented (World Bank, 2010). The focus of funding has been on vertical programs, and there is general agreement that the largest share of funding for health as a whole was for HIV/AIDS. Funding for reproductive health had declined as a proportion, but not, as some have maintained, in absolute amount.

There are many sources of donor funding: bilateral, multilateral (UNFPA, UNICEF and World Bank), and more recently, special funding mechanisms such as the Global Fund to fight AIDS, TB and Malaria, UNITAID, GAVI and other global health initiatives. There are, as has already been said in the first session, more than 100 GHIs, which have now become significant donors for health. They translate into hundreds of projects at the country level, to be managed by the Ministry of Health.

In the past, private foundations such as Ford, MacArthur and Rockefeller were the source of modest but strategic funding for sexual and reproductive health. Enter the Gates Foundation with a whole different philosophy and with an interventionist approach to funding. They seek to influence the decision-making processes of their recipients. Between 1998 and 2009, the Gates Foundation has disbursed US$ 9 billion for health, an amount larger than overseas development aid given by some governments. Their funding has been focused on technology and R&D. The MacArthur Foundation currently has a focus on maternal mortality and adolescent sexual and reproductive health. In the Ford Foundation, SRHR per se is no longer a priority. The Hewlett and Packard foundations have an emphasis on family planning and population.

There is a re-emerging focus on health system strengthening. Ideally, this should be about harmonization of health sector investments across donors; meeting the most pressing needs of each country based on local epidemiology and demographics. They should prioritize comprehensive SRH.

Two health systems strengthening initiatives operational as of now are the International Health Partnership (IHP) and the US Global Health Initiative. Both emphasize harmonization of existing funding but there is no additional funding allocated. The World Bank is expected to increase its funding to $4.1 billion (a 40% increase over FY 09) for health system financing. The Global Fund for AIDS, TB and Malaria is experimenting with proposals based on National

Available funding for sexual and reproductive health falls way short of what is required.

Strategic Plans for health system strengthening that include not only AIDS, TB and malaria but also reproductive health and maternal and newborn health. The possibility of channeling overseas development aid for health systems strengthening through existing international channels, such as GAVI, is also currently being considered.

Estimated costs of reproductive and maternal-newborn health care range from US$15.2 billion to $23.7 billion annually (PAI, 2010). This includes family planning; maternal, newborn and child health; STI prevention; drugs; supplies and other materials, and personnel. It excludes safe abortion services and HIV/AIDS resource requirements of $19 billion – $35 billion annually.

Bilateral donor support for sexual and reproductive health is limited. While European donors (Denmark, Netherlands, Norway, Sweden and UK) have comprehensive SRHR policies, they have separate funding streams and staffing for HIV and reproductive health, and HIV receives much larger amounts of funding. The US Government never adopted SRHR, but the US Global Health Initiative supporting women and children's health would cover many aspects of reproductive health.

Available funding for sexual and reproductive health falls way short of what is required. For example, the UN Secretary General's Joint Plan of Action pledges $14 –24 billion in 49 countries, and the G8 Muskoka Initiative's pledge is for $7.3 – $8.3 billion.

There were numerous challenges to successful advocacy for universal access to comprehensive SRH services. We need to identify individuals within the donor community who drive funding decisions and work with them. SRHR advocates often do not pay enough attention to recipient governments who more often than not finance more than two-thirds of the health budget.

There was a need for consensus on many content issues: on whether or not SRHR included HIV (in Adrienne's view, it did); on whether we were on the same page in our support for horizontal approaches and against vertical interventions; and on whether we would use the language of human rights or appeal on a pro-poor, pro-women, pro-marginalized groups platform.

Another major challenge was that although we need much more money for health, new donor money was not likely. Our demand would therefore have to be for a bigger chunk for SRH from the health pie. The other focus should be on more strategic and efficient use of existing funding.

Last but not the least, there are numerous challenges related to building our movement. Donors are reluctant to fund political movements. There is also perceived and actual competition for limited resources among the several constituencies of sexual and reproductive health and rights. This has had adverse effects on alliance building and cooperative work. The emphasis on quantitative outcomes and results-based funding has meant that the value of advocacy work is questioned. In other words, we have to make do with fewer resources. But at the same time, there is a need for new blood, and for training and mobilizing to make this happen.

Responses

The first respondent to this theme paper was Marge Berer. Her presentation added more details to the previous day's discussion on global health initiatives and their implications and concluded with questions and issues before the SRHR community.

Some common characteristics of funding by GHIs include that although they claim to be 'country-driven,' often donor-driven agendas are still the reality. The grants are huge and organizations not large enough to handle substantial funding are forming 'partnerships' or 'consortia' to apply. Small grants have all but disappeared. Funding is results-based, and inputs have to be related to performance to establish value for money.

As already mentioned, the common programmatic features of GHI-funded programs are a focus on specific diseases and selected interventions, commodities or services, and the application of technical solutions (vaccines, microbicides, male circumcision, drugs) to solve health problems. They have increasingly complex and time-consuming monitoring and reporting requirements. They are causing substantial inequities in attention to different types of ill-health. Services and diseases, not to mention prevention, that are not funded are sometimes being left far behind.

There are more than a hundred GHIs, most of them having multiple partners, but some are bilateral. There are seven GHIs related to sexual and reproductive health, of which most are about contraceptive commodity security, one is on microbicides and two are on maternal-neonatal health. There are none that include other dimensions of sexual and reproductive health.

There has been a shift in the last 15 years in European funding for 'population assistance' from maternal health and family planning to HIV/AIDS between 1995 and 2007. Funding for STDs/HIV/AIDS had increased to 75% of total population assistance in 2007, from 9% in 1995. Basic RH services – probably maternal health care – received 17% of the funding in 2007 as compared to 33% in 1996. Comparable figures for family planning were 5% in 2007 as against 55% in 1995 (Euromapping 2009).

Marge raised a number of issues that needed to be debated to arrive at a consensus position. The first was about what kind of public-private mixes in national health systems would be compatible with our goals of universal access to sexual and reproductive health services, in financing, service delivery and other functions of the health system. How would we rate the different kinds of private actors (NGO and corporate) from this perspective? Donors are now determining the answers to these questions in many countries, by either influencing the government's policies or by actively funding and promoting the private and corporate sector in health.

We also needed a shared understanding on the meaning of 'health systems strengthening,' so that we are better able to evaluate the desirability of existing efforts ostensibly aimed at health system strengthening.

Another issue to discuss and agree on is how feasible would it be (what would it cost) to finance a health system that is equitable and also ensures equal access to a core set of services for all?

How do we need to organize to get the level of financing needed for universal access to SRH services?

The SRHR movement is currently in a weak position, and is not in a position to secure sufficient financing of sexual and reproductive health and rights. The sexual and reproductive health advocacy movement has not been effective as an advocate for 'universal access to SRH' in 21st century terms. All the same, it is important that we make no compromises on our agenda and continue to call for funding for the whole ICPD Programme of Action. The big question demanding an answer from all of us is, "How do we need to organize to get the level of financing needed for universal access to SRH services?"

The second speaker was Elmar Vinh-Thomas from the Global Fund to Fight AIDS, Malaria and TB. His opening remark was illustrative of the extent to which sexual and reproductive health had fallen off the international agenda. Elmar had recently been at a regional Asia-Pacific ministerial meeting on MDGs with 22 ministers of foreign affairs or trade discussing what needed to be done to be on target for achieving MDGs. Not once in the two days was any aspect of sexual and reproductive health mentioned. Most of the discussion was about innovative financing mechanisms for raising the necessary resources. The little talk there was on MDGs 5 and 6 centred on HIV/AIDS and maternal mortality. Sexual and reproductive health was simply not there.

Elmar talked mainly about opportunities within the Global Fund for advocating for sexual and reproductive health. The Global Fund for AIDS, TB and Malaria is eight years old, and has grown very fast to account for funding levels of US$3 billion/year. Of this, 55% goes to ministries of health; much of the rest goes to big civil society organizations,which rarely have a major focus on SRHR. A small amount of funding is received also by the private sector and faith-based organizations.

The Global Fund is committed to funding health systems strengthening. In principle, this is a good thing for the delivery of sexual and reproductive health services. However, in practice, health system strengthening refers to improving laboratory services, financial management, monitoring and evaluation and so on, much of which will not contribute to strengthening SRH specifically or directly.

There are some windows of opportunity. In principle, the Global Fund can fund sexual and reproductive health if this is included in the proposal. For example, there have been one or two funded proposals that included abortion services. There is potential for advocacy to influence Country Coordinating Mechanisms that submit proposals to the Global Fund to include sexual and reproductive health issues. The Global Fund is also able to fund a 'national strategy' for AIDS, TB or malaria. This is a double-edged sword, because while a progressive government could use this to advance sexual and reproductive health and receive funding for implementation, a conservative government could take us many steps back.

On the other hand, there are factors that limit the extent to which sexual and reproductive health can be prioritized within the Global Fund's funding restrictions. First, there is very little attention within the Global Fund to sexual and reproductive health and rights issues. The Fund has expertise on gender, sexual orientation and gender identity issues but not on sexual and reproductive health and rights per se. This influences the way in which Global Fund policies see the field of sexual and reproductive health, often reading it through a lens of women's health or HIV. Secondly, Country Coordinating Mechanisms in many countries submit risk-averse proposals that stick to 'proven' interventions to fight AIDS, TB and malaria and may not easily

allow for the inclusion of progressive sexual and reproductive health interventions.

On the other hand, a sizable number of members of the Global Fund board, which consists of both recipients and donors, is sensitive to matters of sexual and reproductive health. This is particularly the case for donor members, many of whom are outspoken on reproductive rights issues. Not all board members fall into this category and a sizable proportion tend more often than not to be conservative when it comes to sexual and reproductive health and rights.

So, while there are windows of opportunity, these are limited. It should also be remembered that the Global Fund's focus is on HIV, malaria and tuberculosis and this limits what it would be prepared to look at for funding.

The presentation referred briefly to the fact that private foundations based in the US and the UK have been increasing in number in the last few years. But very few of them fund internationally. Even private foundations such as Hewlett and Packard, who traditionally funded sexual and reproductive health and rights, have shifted away from this area now.

Discussion

With the exception of a comment on advocacy for SRH funding, discussion on this theme was less about funding per se and more about the health systems strengthening framework.

One participant shared her views on successful advocacy for funding. She said in the new call for proposals of the Global Fund for AIDS, TB and Malaria, the topics of sex work and migration are included. This was the result of protracted and sustained advocacy by sex workers. In India, sex workers have created a Global Consortium of Sex Workers that advocates for funds. Another illustration of successful advocacy for funding is by women's groups with the Dutch government. The groups highlighted the fact that there was very little funding for gender-related work within Dutch human rights funding and succeeded in establishing a separate fund for gender within human rights funding. Another point she made was that the capacity of grassroots organizations to advocate for funding needed to be raised, so that they are able to lobby for sustained funding.

There is an inherent contradiction in massive financial support for vertical programs through global health initiatives and attempts to strengthen health systems.

Concern was raised about the accountability of global health initiatives as new mechanisms for funding. While they often include bilateral or multilateral donors – which meant taxpayers' money – given the nature of the mechanism, taxpayers have little say in how the money is spent.

Another observation was about the inherent contradiction in massive financial support on the one hand for vertical programs through global health initiatives, and attempts to strengthen health systems on the other. Vertical programs are a part of the problem; they are contributing to the weakening of health systems.

Views varied on the scope for advancing the sexual and reproductive health agenda of funding for health systems strengthening. One observation was that there were two prominent health systems frameworks that were currently being used: the WHO building blocks framework and the World Bank's framework. An analysis of these from a human rights perspective showed that 'rights' do not really fit into them.

Another participant felt that there was indeed potential for promoting sexual and reproductive health through health systems strengthening initiatives, if one were able to influence some key actors – e.g., the International Health Partnership and the US Global Health Initiative – into adopting a transformative approach. The starting point for health systems strengthening is not "which parts of the health system need strengthening," which then leads to interventions such as improving management information systems and financial management. If we put people at the centre and make health outcomes the focus of the process, we would then start with examining who needs services and where, and what systems changes are needed to meet their needs. There will have to be a dialogue amongst all stakeholders, including users and non-users of services, to make some tough choices and decisions about how to allocate existing limited resources to best meet the health needs of all.

THEME 6

Perpetuating power

Berit Austveg presented the main paper under this theme, "Perpetuating power: Why maternal mortality continues to be high despite good intentions."

The ICPD in Cairo represented a paradigm shift that replaced the dominant population control approach with reproductive health and rights and sexual health within a human rights framework. The gains made during the past 15 years are mixed. Although the concept of reproductive health and rights and to some extent, sexual health, has taken root within bureaucracies, NGOs and in the political arena, the impact on sexual and reproductive health outcomes has been much less than anticipated.

One reason for lack of progress is the sidelining of sexual and reproductive health and rights issues following the adoption of the Millennium Declaration. The intimate link between maternal health and well-being to sexual and reproductive health and rights is well known and was one of the factors underlying the shift to the SRHR paradigm.

When the Millennium Development Goals were agreed on by governments, maternal mortality reduction was singled out as an MDG. Maternal mortality ratio (MMR) was made to be an indicator for the functioning of all components of reproductive health care and the underlying social determinants, but lower maternal mortality cannot be achieved without comprehensive services.

In practice, the focus on MMR led to exclusive attention to maternal health care, which again mutated into 'mothers' health. Mothers' health was to be protected because it was significantly associated with newborn health, and neonatal mortality rates have been the slowest to decline in most countries because they are dependent on maternal mortality and morbidity at delivery being reduced. Mothers' survival was also important for the health and well-being of older children, especially girls.

One important reason why such mutations and marginalization of women's needs happened is that abortion and adolescent sexuality are politically the most controversial. Family planning and treatment of STIs are also controversial, but perhaps to a lesser degree. It is interesting to note that despite its links to sexual behavior, funding for HIV/AIDS has not been controversial internationally, at least since the 1990s. After fierce discussions and sustained advocacy for several years, target 5b under MDG 5 – universal access to reproductive health by 2015 – was added by a special resolution in the UN General Assembly in 2005. Despite this, the narrow focus on mothers' health continues to get precedence.

Without the power to influence priority setting, financing and allocation of resources, it is not surprising that we are now at an impasse with respect to advancing SRH.

The focus on mothers' health, as we all know, has not succeeded in reducing MMR. The reduction in MMR globally is nowhere near the intended level, despite the extraordinary extent of political commitment evident in the inclusion of MMR as an MDG.

Not only has sexual and reproductive health been sidelined and maternal health singled out as a priority, maternal health itself has been detached from the comprehensiveness of reproductive health and framed solely in relation to motherhood. Maternal, newborn and child health has been made the priority, and the nurturing role of mothers is the focus. The

Partnership for Maternal, Newborn and Child Health (PMNCH), which was formed in 2005 with the merger of entities focused on maternal health and child health, represents this shift in scope and focus. The partnership includes WHO, UNICEF, UNFPA, the World Bank, governments, academic institutions and national and international NGOs. UNICEF has always had a troublesome view of family planning and abortion, and has contributed to keeping these issues out of the purview of maternal health. Even pregnancies in girls under 18 years of age are neglected by UNICEF. By framing maternal health within the 'mother and child' framework, maternal health has been cleansed from contentious abortions, even from family planning and from adolescent pregnancy and childbearing issues. PMNCH's website had the following slogan: "No mother should die unnecessarily from their newborn." You could tick a box if agreeing to the statement and would then get on a circulation list from the Partnership.

PMNCH calls 'continuum of care' a new paradigm, ensuring care from pregnancy through birth, newborn and child health. This indirectly suggests that all pregnancies lead to deliveries. In all fairness, the Partnership does deal with family planning and addresses abortion, and it does talk convincingly about women's health. All the same, the most prominent framing is about women as mothers, and the sidelining of other issues. Although PMNCH does not have formal power, it has enormous normative power and also considerable economic power.

The framing of maternal health and sexual and reproductive health have also been marked by economism, where political issues are underplayed and it is seen to be all about economics and managerial issues. The ICPD PoA is itself strangely silent about issues of power, and the handling of opposing forces and conflict are described as the need for balance, compromise and harmony between actors of equal power. But the depoliticization of sexual and reproductive health within the ICPD Programme of Action only means that the power differentials have gone 'under cover,' not that they have ceased to exist. The backtracking on sexual and reproductive health and the detachment of abortion and adolescent sexuality from maternal health are some of the consequences.

We have been more successful at the conceptual level and less so in the political and policy-making arena.

Depoliticization of sexual and reproductive health has gone hand-in-hand with a general increase in emphasis on benchmarking and measurable targets and goals as part of the "New Public Management". This contributed to the disappearance of abortion and family planning from MDG 5 initially. Since maternal mortality is difficult to measure, a proxy indicator was adopted in ICPD+5, viz. "the proportion of births attended by skilled attendants". This virtually sealed the fate of MDG 5, because only deliveries would now be included, not miscarriages or abortions.

In order for the lofty ideals of ICPD to be realized, myriad decisions have to be made at multiple levels and these have to be followed through to implementation. Power defines and creates concrete physical, economic, ecological and social realities. When rationality meets power, rationality loses and power prevails. This is what appears to have happened to the ICPD goals. Without the power to influence decisions related to priority setting, financing and allocation of resources, it is not surprising that we are at an impasse today with respect to advancing sexual and reproductive health. Naïve belief in logic and reason and disregard for the political strides that were necessary have hit many walks of life, but perhaps sexual and reproductive health has been hit the hardest. The way forward lies in a better

understanding of the different roles to be played by different actors, more meaningful communication between actors, and an appreciation of the political nature of the undertaking.

Responses

The first response was by Adriana Ortiz-Ortega. She began by highlighting that Berit's paper had bridged public health with issues of power dynamics. Berit had acknowledged the power dimensions underlying the separation between feminist notions of sexual and reproductive rights and the MDGs: "The influence of power has increasingly been ignored in the MDG agenda, with the effect that existing power structures, which create obstacles to change on the ground, are not being challenged."

Berit's paper was an invitation to analyze the complex power relations which had resulted in the subordination of sexual rights to reproductive rights and the separation of maternal health from the broader reproductive health framework. The challenge before us is to examine how this change was possible. We have been historically reconstructing what political and conceptual shifts have happened at different meetings (e.g., MDGs dropping any reference to reproductive health in 2000, and then reinstating it in 2005 as a sub-target). How did the different actors and interests come together to bring about policy-shifts? We need to understand this better.

We need to analyze the complex power relations which have resulted in the subordination of sexual rights to reproductive rights and the separation of maternal health from the broader reproductive health framework.

In order to begin the project of 'repoliticization,' we need to ask ourselves the following questions at the outset:

- Does depoliticization refer only to the limited meaning given to sexual and reproductive health and rights by the International Family Health Movement (those working on maternal and child health from a public health perspective alone)?
- Does depoliticization also include the ways in which the agenda is hijacked through the use of highly codified technical definitions of components of sexual and reproductive health?

If we also include the second of these in the definition of depoliticization, then building indicators becomes an important item on the repoliticization agenda. For example, if the maternal mortality ratio is a difficult indicator to measure and deliveries by skilled birth attendants distorts the goal, then what would be a suitable alternative?

It has been said at different points in this meeting that feminists (male and female) negotiated the ICPD agenda from a relatively fragile position. It also appears that we have been more successful at the conceptual level and less so in the political and policy-making arena. We have measured our successes mostly in terms of legal change, budget approval and the drafting of policies. But are these the best indicators? Do they really capture the extent of our success or lack of it? We need to understand the changing nature of power in the 21st century; understand what is happening that prevents us from getting to where we want to (i.e., whether policy and legal changes really imply a shift in power in our favor). It is hard to do this kind of analysis because the information we will need in order to do this is not easy to lay hands on. But we have to start moving in this direction.

Adriana emphasized the following as important for repoliticization:

- We need to continuously engage with identifying and re-identifying the different stakeholders and their discourses.
- Equally important is to analyze how many stakeholders managed to reshape the routes or derail progress by inserting new ideas.
- It is important to analyze not only right-wing discourses but to map resources, influence and the impact of ideas.
- Feminist critiques of power and empowerment need to be revisited to encompass varying contexts and experiences. For example, feminist discourses and action pioneered the expansion of the notion of power to include sexual differences and the false dichotomy between private and public spheres in matters related to gender, sexuality and reproduction. Yet we need to expand analysis of power relations and how they operate differentially in domestic and international scenarios. The feminist movement has invested 15 years in building capacity to influence decisions, and to participate hand in hand with government and agencies. What accounts for the present difficulty in preserving similar negotiating power? What are some lessons we can learn from this?

We need to review and reconsider our conceptualization and understanding of various aspects of the nature of challenges before us. For example, what do we understand by coalition-building? What accounts for the thriving of religious conservatism alongside market structures? Of fundamentalisms within democratic political structures?

In conclusion – it is very important to build alternative indicators that can give better accounts of how effective feminisms have been in setting, influencing, and transforming the agenda: influence at the level of conception, design of actions, follow-up, and others. Such indicators would help us understand better the levels and points at which we are able to have influence and points where we are unable to influence.

We would analyze our progress or lack of it at different levels: local, national and international, across different countries, through the use of indicators designed to aid such analysis. Such experiences must be shared virtually across countries and regions, and contribute to constructing strategies to move forward sexual and reproductive health and rights as conceived by feminists, located within a rights and social justice framework.

The second response was by Jeff O'Malley. He built on three ideas contained in Berit's paper:

- power dynamics amongst nation-states and their impact on SRHR;
- the relative failure of the SRHR movement to effectively pursue a mainstreaming or multisectoral agenda; and
- the influence of economism or managerialism for the SRHR agenda, specifically, the opportunities and risks posed by working within such a frame.

At the time of ICPD, there were also power dynamics amongst nation-states, between states that were talking about universality and states that upheld state sovereignty; states that believed in individual rights and state obligations and those that believed in cultural values and local variations. These differences have not only endured but have become stronger. SRHR is seen as a part of a liberal, universalist and secular agenda, and this has affected how the issues are interpreted.

There has been an increased emphasis on 'country ownership' within the UN and OECD countries and other international bodies. It is difficult to challenge country ownership – but country ownership could in some settings damage the SRHR agenda. Country ownership means national governments and not all stakeholders; and national governments may not prioritize SRHR for a number of political reasons.

The emergence of the G20 countries as a powerful group is another factor to bear in mind. They are a friendlier set of countries with regards the SRHR agenda and could influence global change.

The SRHR movement's failure to mainstream its agenda is at least in part due to the lack of attention paid in the ICPD Programme of Action to mechanisms and institutional structures to help address the social determinants of SRHR. Neither Ministries of Health at national level nor WHO and the UNFPA are equipped to address the social determinants of SRHR. In contrast, there have been effective responses to social determinants of AIDS. The existence of UNAIDS as the institutional arrangement to address AIDS globally has been one important reason for the difference.

The Global Fund for AIDS, TB and Malaria represents a success in terms of raising money, implementing changes and improving health outcomes. Its Country Coordinating Mechanism defines a country as more than its government or the Ministry of Health. For addressing the social determinants of SRHR, we need to work with multiple stakeholders including diverse line ministries and not only the Ministry of Health. We may have something to learn from such structures.

Does a managerial frame support progress in the SRHR agenda? On the one hand, complexity and managerialism do not go well together, and if we are looking for complex approaches and solutions, we may not go very far in terms of a transformative agenda. On the other hand, we can make progress through incremental changes within a managerial frame.

Discussion

One axis around which discussion revolved was the extent to which the Global Fund for AIDS, TB and Malaria may actually be used to advance the SRHR agenda. Conceptually, the Country Coordinating Mechanisms represent space for participation by various stakeholders. In practice, in most countries the more powerful players, such as representatives of the Ministry of Health, dominate the decisions. The proposals are often written by consultants hired by multilateral agencies, with little input from in-country actors interested in SRHR issues. There is money allocated for strengthening the CCM, which the CCM could use as it decides. This could be used, if the CCM so chose, to give voice to the voiceless. In practice, however, countries where such efforts were needed are also countries with very dominant governments that would not allow the space for this.

Another issue discussed was the uses and limitations of managerialism for the SRHR cause. One participant believed that we have the evidence on the economic costs of unsafe abortion or non-use of contraception and that we could put this to better use to advocate for our agenda. According to another participant, one of the risks of managerialism is that simplified and measurable outcomes are promoted; this meant, for example, a tendency to support commodity distribution (bed nets, condoms) rather than more complex interventions. This

Strategic alliances are the most important for us, to confront the perpetuation of power and also to build our own power, in order to gain the level of strength that we need to put our agenda back on the table.

is being emulated by some in the SRHR field, translating into distribution of safe delivery kits or STI safe-treatment kits, etc. Is this really the way to go? The emphasis on simple and measurable targets also leads to oversimplification of complex issues. One consequence of this is the stereotyping of all women in policies and laws, as vulnerable and unable to protect their own interests. This has played into the hands of the opposition: anti-abortion groups have also framed their agenda as protecting women from the harms of abortion.

A major challenge confronting the feminist SRHR movement was that those opposed to our goals and agenda were subverting our cause by distorting what we mean by sexual and reproductive health and rights. They have influenced language to an extent that most people understand sexual rights to mean only rights of gay people and reproductive rights as abortion. We need to reclaim our language. If we want to repoliticize, we have to start using accessible language that everyone understands.

Another challenge was to defend liberal secular spaces and the universality of human rights. We need to build alliances with others who see this as their project.

Adriana reiterated her concern about framing new and more comprehensive indicators, not as a technical exercise but as part of the repoliticization project. We need indicators that will help us assess where we are as a movement in progress towards the agenda we set ourselves. Some indicators are disappearing (e.g., safe abortion availability), and this is happening behind closed doors. We have ended up giving away the core of our agenda by not challenging this. We are using more guarded language: e.g., instead of talking about political action we talk about advocacy. We need to be the people who develop the platform for building discourses.

Jeff's comparison of the relative success of the AIDS community in advocating for their cause as compared to the failure of the SRHR community to do so provoked several responses.[6] One participant observed that the AIDS movement is a movement led by HIV-positive people directly affected and at risk of serious illness and death. The abortion movement was at one time also as passionate as this. Another reason was that the SRHR movement had become professionalized and many of its actors have a career in SRHR. This has changed the way the movement works. Others expressed discomfort with the strong distinctions being made between the SRHR community and the HIV community in the context of the meeting. There should be no real division between the two, and to talk about these as separate was counter-productive.

The discussion ended with the comment that strategic alliances are the most important for us, to confront the perpetuation of power and also to build our own power, in order to gain the level of strength that we need to be able to put our agenda back on the table again.

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6 There may be a considerable overlap between the SRHR community and the AIDS community, and one may question the representation of these as distinct and different. Here we merely report on what a participant said.

Highlights from thematic discussions

On day three of the meeting, Pascale Allotey summarized for participants the major points that emerged from thematic discussions in the plenary and in the breakout groups. We reproduce below the summary presentation she made, which anchored each theme around the following questions:

- What are the priority issues to be addressed?
- Who or what are the main drivers?
- Who are the key institutions and stakeholders to be influenced at national, regional and international level?
- How do we influence them?
- How do these issues relate to others identified?

The presentation first highlighted key points emerging from the thematic discussions in the breakout groups. It then drew on common issues running across themes. The presentation ended with a summary of eight major strategies for moving the SRHR agenda forward.

1. Geopolitics and macroeconomics

Priority issues

The challenge of commodification and (savage) privatization of health:

- Access and equity
- Compromises to quality
- Issues that fall between the gaps
- Effects on broader health systems
- Loss of accountability/abrogation of responsibility
- Is there justification for demonizing privatization/private sector?
- Clarity on whose agenda – neoliberal? Western/Northern?
- Are we using the right language?
  - Public/private/third sector/religious institutions
  - Sexual health/reproductive health/maternal health / SRHR
- Silo(ed) approaches

Drivers

- Global health funding architecture (GHIs)
- Religious institutions and restrictions on ideological/theological provisions
- Governments and other bodies (greater accountability)

Strategies

- Use of Human Rights Project, including for funding challenges
- Understand and explore use of the International Covenant on Economic, Social and Cultural Rights and

International Covenant on Civil and Political Rights to promote SRHR

- Outcomes need to go beyond health
- Promotion of universal access
- Focus on long-term indicators

2. Public health education

Priority issues

- Depoliticization and need for SRHR education at multiple levels of health and related/ associated sectors including broader population
- Increase in conservatism and decrease in academic freedoms; political and ideological forces determine both knowledge production and dissemination
- Lack of consistency in content, approach and language
- Lack of agreed core competencies of what is needed in training and education
- Competing needs/agenda of students, faculty, institutions, workforce and funders (including private educators)

Enablers and resisters

- Global health actors, including funders and NGOs
- Religious institutions
- Media
- Market, including students
- Professional bodies and academics
- Government/policy makers/institutions
- Broader determinants (capitalism, economics, gender dynamics)

Strategies

- Needs analysis/mapping of existing resources/optimal time to introduce SRHR issues
- Create ways to overcome resistance
- Focus on multi-disciplinary engagement
- Quality control but caution about 'guild mentality'

3. Pharmaceuticals

Priority issues

- Drugs and devices are a significant part of SRHR, significant unmet need but not considered serious players in pharmaceutical market
- There are still controversies in SRHR technologies, many of these resulting from imposed social, cultural and political values; there are however some products on essential medicines list
- Need to balance generics against quality control
- Clear link between macroeconomic influences, perpetuation of power and SRHR

- International agreements have failed to protect
  - Declining innovation against increased patent protection
  - 'Counterfeit' legislation that brands not only spurious drugs but also generics as counterfeit

Stakeholders

- International organizations (allies and opposition)
- Governments
  - Do they invest in drug R&D, what are regulatory frameworks like?
  - How do they bring the price down?
  - How much pressure are they under from big pharma via bilateral agreements? Need for extensive analysis
- Development community and social movements
- Individuals – costs to both individual and family

Strategies

- Understanding and questioning ideological bases for intellectual property rights
- Discussion needs to be in context of rights and the Alma Ata Declaration
- Getting the language right
- Education and collaboration across movements

4. International conferences

Priority issues

- Two main kinds of international conferences
  - Civil society
  - Formal inter-government/UN system
- Evolution in ethos
- Shrinking civil society space
- Tokenism in terms of representation and lack of transparency in terms of process
- SRHR and women's movement toothless tigers and ineffectual in this space

Proposal

- Strengthen communication between allies
- Call for accountability through 'conference watch'
- Return to UN processes – explore how that can be done strategically at ICPD+20/Beijing+20/MDG+??

Five-year strategy

- Develop a clear agenda
- Map actors and meetings for the purposes of advocacy
- Understand and prepare for opposition
- Build strategic partnerships

5. Human rights

Priority issues

- Challenge to universality and hijacking of humans rights agenda, e.g., resolution on defamation of religion
- Human rights arena (UN) is still imperfect and restrictive: violations by non-state actors do not get due attention; right to health is defined within the parameters of progressive realization
- 'Language' often wrongly appropriated or not effectively used
- UN Geneva process for HR is time consuming, resource draining – is the process of working through WHO/UN system really useful?
- Current political climate has had an effect on human rights discourse across the board, e.g., war on terror
- Indicators for health are not necessarily indicators for human rights – we need stronger alliances and development of more comprehensive indicators for what we value.

Stakeholders

- Governments
- UN bodies – need to map what is happening in Geneva/New York
- Multilaterals – need to understand /influence positions of alliances
- Donors
- Grassroots organizations
- Us – getting the story straight given conflicts, and compromises between realization of rights (privacy vs. violence)

Strategies

- Access to Human Rights Council
- Human rights as a social justice/democracy project – innovation for extending existing tools
- New ways of looking at old tools – indicator of the value of a life
- Explore experiences from complimentary/similar groups or alliances, e.g., HIV & AIDS groups, climate change lobby

6. Donors and funding

Priority issues

- Funding trends reflect in a real way the power bases and challenges of working in the complexities of SRHR
- Need to understand ethos of funding and be smart about our approaches – there is unlikely to be a shift from the model of results-based funding and management – and within that context, rights-based approaches are too hard
- Health systems funding is still harder to fund compared to vertical programs because results are not immediately tangible and quantifiable
- This creates problem as well for universal health care coverage
- There is cause for optimism with some initiatives
- Are we clear what we need money for?
- What do we do with funding from/at country program perspective?

- How do we want international architecture to evolve to deal with our issues?
- Do we have a consensus on SRHR issues and our emphases?
- How do we fund ourselves?

Stakeholders

- Donors need to be held accountable
- 'Providers' who access funding because resources are available

Strategies

- Donors/funding agencies are made up of people – personal approach critical

7. Maternal health and mortality

- The best overall framework is that of an overarching sexual health agenda, incorporating reproductive health, which again incorporates maternal (or for a better vocabulary: pregnancy-related) health
  - we do NOT compromise on including abortion
- Tension between old and young around the pleasure aspects of sex and reproduction, not only the dangers
- Danger of overuse of technology
- Strategic alliances provide a good way forward

8. Perpetuating power

- Realizing all aspects of SRHR is a significant, complex issue made even more complex by agendas that are motivated by limited resources, ideologies and supported by power structures
- It is expedient to simplify these issues and reduce complexities to simple 'transparent' indicators, but the process of simplifying has numerous consequences, e.g., stereotyping, fragmentation, unhelpful indicators
- With political will and general commitment, there are models that can overcome these complexities in order to address the issues that underlie maternal deaths, which is a core area of SRHR

9. Strategic alliances

- Need to be clear about purpose of alliance to understand what compromises might need to be made as a result of it
- Alliances to be built on ideology/issues
- Need to know/understand allies
- Shared goals? Long term and short term – would potential allies have a similar take on currently identified issues (youth, women's, anti-poverty, men, gay movement, sex workers, IDUs)?
- Who: women's movement, men's groups
- ICPD Programme of Action is still relevant and provides good framework for analyzing what needs to be done and with whom

Cross-cutting issues

Priority issues

- Mapping the issues for a better understanding of the landscape
- Would a Global Health Initiative in Sexual and Reproductive Health and Rights address our concerns?
- We need to have a longer term vision than most funders and 'powerful' stakeholders currently have
- Development of new indicators that measure what we value rather than value what we measure
- There are context-specific challenges that are important to note to prevent further fragmentation
- Alliances need to be across sectors in a real way if the ultimate objective is to address the underlying causes of poor SRHR
- Link between economic rights and SRHR
- Facilitation of participation in the Human Rights Council
- How do we deal with faith-based organizations

What we can do

Expand spaces for engagement

- Increasing representation of civil society/coalition work
- Enhancing the accountability of state and non-state actors, including GHIs, private foundations and donors in general

Research for influencing agendas

A new development agenda with social justice at its core

- Locating SRHR, universal access and the right to health within the global macroeconomic context of trade, TRIPS, FTAs, privatization, financing and others
- Critical clarity of the kind of progressive health systems strengthening required
- Defining 'Repoliticization of SRHR'
- Bringing the various potential allies' analyses of the attacks on rights, on shifts in capitalism, or re-reading of contemporary politics, e.g., environment
- SRHR as inclusive of men – condoms/contraception/fertility issues for men; reproductive cancers; male circumcision; SOGI; access to pharmaceuticals and technology; men's sexual health; gender framework informed by masculinity theory; health education and sexuality education
- Repoliticizing the conceptual frameworks of the politics of language, indicators, limitations of a rights framework, medicalization, an overarching sexual health and rights agenda?
- Deepening the ICPD framework

Alliance building

- Learning from the HIV movement; if we don't create alliances we will fail as issues are diverse and interconnected
- The importance of activism

Strategic interventions around SRHR education

- Tools, manuals, dissemination, mapping, strategic points of intervention

Influencing donors

- Working inside existing framework and outside
- Influencing directions of funding , agenda setting, expanded role of the Global Fund, women's funds, core funds for small NGOs
- New SRHR funding for MDGs 4, 5 & 6 – disbursed by the Global Fund for AIDS, TB and Malaria and SRHR?

International meetings

- Reinvigorating the International Women and Health Meeting
- ICPD+20 – Involvement of civil society as well as a parallel NGO session? Separate NGO meeting on SRHR?

Structures and communications – organise an international sexual and reproductive health and rights alliance

The way forward

Following Pascale's summary of the highlights of the proceedings of the meeting, participants were asked to vote for three of the eight strategies presented above that they thought were key. The five strategies that received the most votes were chosen for further action-oriented elaboration in small groups. The following is a summary of these discussions.

1. Expanding spaces for engagement

- **Meetings**: What type do we need to advance the agenda?
  - There are many meetings – we see similar people – are these the ones we need to see?
  - What do we want to influence (as the advocacy group)?
  - Advance the agenda at the local/ national level – much done at the international level but this does not reflect back at the national/ground level. Do we still want to engage at the international level? Shrinking spaces also.
  - But there is a connection between the international and national level work.
  - Actors have changed from past decades. Need to face new realities.
  - How can we create a new strategy for 2015 ++ – end of ICPD and MDGs – How do we strategically use the next 5 years?
  - We don't have adequate information – to see the implications of not having (another) ICPD, etc.
- **Need to have space for engaging in strategic international events** – groups to have specific agendas and how to engage on it.
- **Discussion about the ICPD agenda**: One view is that the ICPD agenda is not ending in five years and we should not be the people to say it is ending. The agenda has not been achieved and work must go on until it is achieved; otherwise, anti-ICPD/opposition will take advantage. While there was agreement on this in principle, others argued that the ICPD's Plan of Action was a 20-year, time-bound one. Our position has to be to advocate to extend it, and to do so with urgency. If not, the reality is that the ICPD Plan of Action will indeed come to an end in 2014.

2. New development agendas with social justice at their core

The group agreed on the following points from the summing-up presentation:

- Locating SRHR, universal access and the right to health within the global macroeconomic context, trade, TRIPS, FTAs, privatization, financing and critical clarity of the kind of progressive health systems strengthening required
- Defining 'Repoliticization of SRHR'
- Bringing the various potential allies' analyses of the attacks on rights, on shifts in capitalism, or re-reading of contemporary politics, e.g., environment.
- SRHR as inclusive of men – condoms/contraception/fertility issues for men; reproductive cancers; male circumcision; SOGI; access to pharmaceuticals and technology; men's sexual health; gender framework informed by masculinity theory; health education & sexuality education
- Repoliticizing the conceptual frameworks of the politics of language, indicators, limitations of rights framework, medicalization, an overarching sexual health and rights agenda?

- Deepening the ICPD framework

The group also added on issues of sexuality and SRHR in conflict situations.

Opportunities

- Post-MDG framework that will emerge in the next 5 years – How to pursue the rest of the agenda but recognizing that there may be tensions between progressive agendas and compromises that emerging paradigms may demand of us
- Social justice: primary principle; including human rights, equity – opportunity for issues of SRHR that will need rethinking of current frameworks
- Engagement with other 'principles' from a social justice perspective (managerialism, economism)
- Deepening ICPD – strategic but not necessarily tied to an event like ICPD+20; through whatever process
- MDG 3 + 4, 5, 6 – look at other MDGs as well, e.g., MDG 8 – has TRIPS
- How to shape coming the 5 years of MDGs and creating spaces for SRHR within that effort
- Recognize the three strategic content areas of working
- Allies working on a number of areas are crucial: climate debate, human security debate
- We need to have a theory of social change: how to get to this social justice point. Otherwise we may buy into conservative and regressive thinking on social change; think of international change alongside community level change

3. Influencing donors

- Different strategies (governments, foundations, bilaterals, multilaterals) – Global Fund
- Mapping: who is funding what? What opportunities do we have now? What evidence/research/data do we need? Who are the people?
- Stratification: In-country/regional/global
- Identify what we want donors to do? Fund 'us,' 'issues,' 'research'? Fund systems (health/development)?
- Create an SRHR 'donor-interest group'
- Advocate for accountability: create an SRHR Watchdog with civil society participation – like the Global Fund Observer
- Look into CCM membership in-country/technical working groups to influence global fund proposals on SRHR
- Capacity building at country-level around politics of financing and how to tap into money
- How do we synergize the efforts of our various movements? E.g., HIV, maternal health, human rights, SRHR
- How to influence bilateral funding? GHIs? What opportunities exist with the current US GHI? How do we shape these for SRHR?

4. Research

Research is needed for producing evidence that shows the relevance of SRHR, and to influence and motivate actions and policies that can move forward the Cairo and Beijing agenda. But it is not the evidence alone that is important, but how and by whom such evidence gathering happens. We envisage building inclusive intellectual leadership that is multi-country, multidisciplinary, multi-level and multi-sector, cooperative. We may not be able to get all the dimensions in place right away, but this is where we want to go.

One of the first tasks of such a group would be to carry out a review of evidence available on progress towards ICPD goals and in fact, to expose the meagerness of relevant evidence. We would like to use this as the basis for advocating for support for the ICPD agenda beyond 2015.

The review will help identify research gaps and will guide further research. In addition, the following were some research topics that the group identified as important:

- Identifying/mapping major actors setting the SRHR agenda and the ways in which they worked
- Assessing level of funding at country level for SRHR
- Association between laws and sexual and reproductive health
- Map and document political work in support of (or which has scope for furthering) SRHR happening at the grassroots and country levels

We needed to mainstream sexual and reproductive health and rights research within public health and human rights research, and also work with others to draw on useful frameworks and concepts.

One of the ways in which we could begin this process is by utilizing spaces available within existing health conferences. We may organize satellite sessions within conferences or have one-day sessions on the day before start of a major conference. A core group of us could get the ball rolling, share the idea with others and bring in more people.

5. International SRHR Alliance

- The SRHR agenda at national level
  - The ICPD Program of Action is not being implemented fast enough or at all at national level in many countries.
  - There is a backlash from the anti-abortion, anti-SRHR movement.
  - The narrowing of the agenda by the MDGs has been another source of unintended subversion of the SRHR agenda.
  - There is a lack of money for SRHR in countries and an ongoing lack of political will.
  - There is also an absence of a critical mass of support to influence the national agenda and bring about change.
- We need to regroup and work together across all the parts of the SRHR agenda. We have become fragmented ourselves at NGO level.
- We need to repoliticize ourselves and become activists again in a life and death cause, and not just professionals doing a job and developing a career.
- We propose to form an international SRHR alliance which covers sexual health, reproductive health, sexual rights and reproductive rights, with an organizational membership base that supports the principles we have outlined here, that also involves working with those in power both as regards law and policy, and health

services and programs, at national and international/intergovernmental level.

- The role of this alliance will be to:
  - Support action at national level as its primary goal.
  - Define an activist agenda with international, regional, and national relevance and specificity through a regular, representative, international conference.
  - Reinvigorate and link existing national groups and networks, and existing regional networks, and support the formation of regional and sub-regional networks where these do not already exist.
- The alliance will be inclusive, it will learn from successful strategies, it will build bridges, and it will be cross-cutting in its perspectives. It will not attempt to convince everyone to support one 'line' but will seek to define principles, develop a common platform and promote consensus positions.
- The alliance will examine existing structures in order to find an appropriate structure that will meet its aims, and it will use existing and new forms of communication and technology, including the internet and social networking, to communicate.
- Both those with experience, especially of movement building, and those who have the energy to make this proposal work, i.e., young people, will be needed to achieve this alliance and its aims.
- It will not be a global health initiative.
- This will be a huge task and it is not a task that can be carried out on a voluntary basis.
- Research is needed on possible structures and a small committee would need to be formed to develop this project, which would look into whether financial support would be forthcoming.

ANNEX 1

Are recent international conferences advancing sexual and reproductive health and rights?

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Conferences provide formal opportunities to interact on topics of import to the participants. They are a forum for communication between non-profit organizations, researchers, decision makers and donor agencies working to develop innovations, deliver services and/or engage in advocacy. Conferences have played an important role in public health efforts in galvanizing support, sharing critical information and determining policy direction.

In recent years, the culture of reproductive and sexual health conferences, including the international AIDS conferences, has evolved in line with corporatized global trends. Millions of dollars and tens of thousands of person-hours are spent on the organization and attendance of international conferences and consultations. The International AIDS conferences, for instance, are renowned for star-studded appearances[1] by Hollywood A list performers and elderly statesmen. Presenters reflect a who's who list of global public health compiled from large international NGOs, funding agencies, United Nations agencies, the media and entertainment fields, with some involvement of governments.

The last 18 months have seen at least two large international conferences in the UK alone, one on safe motherhood, the other on safe abortion. The conferences were expensive. Women Deliver in 2007 cost £430 for registration, including for presenters, and £980 for exhibitors. Other related conferences charged similar fees on top of the costs of travel and sojourn. The handful of scholarships provided did little to redress the balance of participation. Conspicuously absent were the voices and participation of many who would have been most able to contribute to discussions that affect their countries and learn from others from similar contexts. Others have noted with concern, as we do, the low profile given to presenters from the very countries whose issues the conferences purported to address.[2] Furthermore, 'participants' were often treated as passive recipients of information, with little opportunity to engage despite often long-standing expertise as active participants in their own countries.

While these recent conferences aim to have policy impact, their policy declarations are not UN agreements which activists, implementers and researchers can follow up on to ensure change. What therefore motivates these international meetings? As organizations, agencies and donors need to prove their activity, these conferences have become a tangible output, an end in and of itself. In November 2008 and January and February 2009, four separate international meetings took place in The Hague, London, Stockholm and Washington, DC to discuss global policy on maternal mortality. In three of the four instances, the majority of participants were based in or from the USA and Western Europe. In September 2009, UNFPA will sponsor an ICPD+15 NGO conference in Berlin, an important and needed policy forum following up on government commitments. The first organizing committee meeting consisted of eleven participants from North America

and Western Europe, with only five representatives from Africa, Asia and the Pacific, Latin America, Arab states and Eastern Europe (only one for each most affected region).

Conference organizers do not bear sole responsibility for this situation. The SRHR field, like other international health arenas, embodies creative tensions and contradictions that are delicately balanced in some places and fractured in others. Initially a coalition of activists, implementers, researchers and donors forged a political path to establish the field through UN Conferences and other forms of international mobilization.[3] Today, we are a large, disparate group, with different funding bases and class trajectories. The organizations involved draw motivation from agendas ranging from women's human rights and social change to corporate and business models for commodity distribution and service delivery.

The funding environment adds to the pressures. With more funding available to support technological innovation and scaling up service provision,[4] less attention is being paid to the national and regional platforms required to support broader public health efforts and sexual and reproductive rights and health. A greater focus is needed within health systems, that takes account of health as a complex social intervention that goes beyond program-specific, technical interventions[5] Many NGOs have adopted corporate practices to secure funding, power and influence; and a growing list of donors will no longer administer grants to small advocacy-oriented NGOs. Funding is handed to governments unaccountable to their populations, or to a few 'international' NGOs whose politics and policies (and central offices) are almost all controlled from the United States. The cultivation of egos and public health superstars rather than an engagement with and accountability to the political and social change required to transform the lives of poor people is therefore almost inevitable. Consequently, the question of genuine representation from grassroots organizations is complex.

So if participation is complex and the current power brokers in SRHR are an exclusive group, are conferences still relevant and worthy of investment? We would argue that they are, as long as they are a means to an end – they should be for dissemination, networking, advocacy, agenda and priority-setting, and above all, for planning and following up on transformative change at national and regional levels. Sexual and reproductive health and rights remain a priority, particularly among the poorest people and in the poorest parts of the developing world. Progress on reducing maternal mortality and unsafe abortion is disappointing, and we are far from achieving respect and protection for women's sexual and reproductive health and rights. Conferences can contribute to achieving these goals.

We would therefore propose a different kind of conference, one that aims to take work forward, and to motivate change to happen, and involves an organizational structure that facilitates such involvement. This kind of conference involves a globally representative, broad-based group of experts and stakeholders in the planning and execution, from beginning to end. It enables active participation. It maintains a commitment to providing space for women's health and rights NGOs to share their work and inspire each other towards the kind of change that will improve women's lives. Its purpose and outcomes belong to, and are the responsibility of, everyone involved in the field. It has no 'stars.' It has work to do. If there is one thing such a conference absolutely requires, it is that it is a collective undertaking with active input from participants, with the aim of analyzing and motivating concrete work at country level.

Such a conference makes sure that the people who are in a position to do something at country level, where the problems exist, are present and able to meet with others also engaged in that process. It facilitates attendance based on ability to bring about change, not ability to pay. It gives time to participatory dialogue, discussion, debate and analysis. It seeks answers, political perspectives and knowledge of what has been shown to work. It invites experts to identify current issues and possible solutions, and lead everyone down new paths of thinking.

This is undoubtedly a more difficult conference to organize, but it is possible and it has been done. Jonathan Mann's AIDS conference in Amsterdam in 1992, with at least 10,000 participants, managed it. It was characterized by panel sessions lasting 3–4 hours set up to enable questions and discussion from participants. It was a passionate event and it had a major impact on people's thinking. Frustrations with the NGO Dialogue with the UN MDG+5 review in 2005 led to six women's groups in south Asia setting up their own government–NGO platform for dialogue and advocacy, the Women's Health and Rights Advocacy Partnership (WHRAP) Regional Task Force on Sexual and Reproductive Health and Rights (www.whrap.org/). Their meetings engender lively debates, between advocates and policymakers.

Although we have focused on SRHR, these issues resonate with many conferences in global public health. In order to change, we need organizing committees whose members represent, between them, the field and relevant regions, who know and understand the issues inside out, and who share a commitment to being inclusive, transparent and accountable. Moreover, the financing and organization invested in realizing these conferences must also support existing national and regional preparatory and follow up processes for realizing social change. The SRHR field has struggled to sustain globally representative policy processes and at the same time is being starved of adequate funding. We and the women whose health and lives are at stake, whom we seek to represent, are paying for these failures in more ways than one.

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ANNEX 2

The 'politically 10%' group

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This short interjection, in response to the excellent plenary papers presented, addresses a group of women who make up 10% of the female population across the globe and who constitute one fifth of those living in severe poverty. As a group they face levels of sexual abuse and rape at up to 3 times the rate of other women, along with high levels of physical and emotional abuse. They rate highly on all the risk factors for HIV and other sexually transmitted infections.[1] Yet despite their consequent great need for sexual health care and support, the services offered to them consist predominantly of non-consensual interventions – 'coerced abortion, pressure to undergo tubal ligation and hysterectomy, unlawful sterilization, and systemic denial of appropriate health care and sexual screening'.[2]

There is a widespread and generalised assumption that, as a group, they are asexual, without desire and unable to initiate sexual relationships of their own choice. Consequently, their experience of sexual and reproductive health care is one of 'limited contraceptive choices, with a focus on menstrual control, and of poorly managed pregnancy and birth experiences. They rarely receive help with infertility and they repeatedly face incomprehension at and the denial of support in their choice to be a parent.[3]

This group has felt largely excluded from the women's health movement, which has tended not to see them as politically identified. This is despite beginning to organise amongst themselves, developing sophisticated analyses of the specific impacts of hetero-patriarchal society they face, analyses that have much to offer other feminists. Rather they have had to fight constantly against mainstream feminism's portrayal of them as a disparate array of victims and charity cases who place a burden of care upon other women and who are assumed to exist so far outside feminism's ideals of women as strong, self-determining and independent that that there continues to be no place for them within the international women's movement.[4]

This 'politically 10%' group are disabled women, women with disabilities[5] – whether visible or invisible, physical, intellectual, psycho-social or sensory. Despite the many years of mainstream feminist health and sexuality campaigning, 'this group of women feel very excluded, frustrated and misunderstood' from SRHR and campaigns.[6] The women's movement, including those involved in women's health has, by and large, failed to understand the politics of disability, the battle for disability rights and the importance of standing alongside disabled women in their struggle for disability, sexual and gender rights.

First and foremost, it is important to grasp that disability is a political not a medical or a charity issue. Disability is about prejudice and social exclusion, about discrimination and lack of access – to places, education, services, jobs, leisure and pleasure. It is about the denial of rights and the refusal to recognise those with differential embodiment as fully human. It concerns societal anxieties in acknowledging that those who are seen as 'different' in body or mind still experience desire, develop sexual identities, face crises of self image and confidence, chose relationships, want children (or not) and require information and education to support them just as non-disabled women do.[2,7] Non-disabled feminists need to address their own assumptions about difference and look more closely at the ways in which norms and practices of compulsory ablebodiedness influence their understanding of disability. The anxiety and vulnerability that many experience when confronted by unfamiliar anomalous embodiment is not unusual, but it must be analysed and challenged rather than simply pushed out of sight, ignored and dismissed as too uncomfortable to deal with, much as notions of compulsory heterosexuality had to be dealt with when lesbians came out to confront hetero-normative feminism.[8]

On a different strand, much as feminism has challenged the medicalization of women's lives, so disabled people challenge the medicalization – and negation – of their own lives. And as with the women's health movement, who

advocate sourcing information from those who have lived with and found alternative ways of managing conditions when making profound decisions about health, so disabled people advocate turning to those who live with impairments to gain a more adequate understanding of how life may be lived in that context.

Disability studies has a concept of the Temporarily Able Body (T-A-B) – in recognition of the fluidity and change that faces us as embodied subjects. We are all vulnerable to aging, illness, accident – events that can change our status from non-disabled to disabled at any moment. So access initiatives need to recognise they are ultimately for the many not the few. Small steps to inclusion, such as meeting where there are ramps and accessible bathrooms and or by providing a diversity of communication methods, with large font, clear language written and spoken/Signed contact touch a wide number of lives.

Yet through all this, feminist organizations must themselves reach out to women with disabilities before this group will confidently feel included within the broader SRHR conversation. Disabled women welcome advocates to work alongside them but 'Nothing about us without us' is the disability movement's slogan.[9] Women with disabilities do not require 'helpers' to tell them how their political struggles should be fought. And within the SRH field, disabled women's concerns are particularly acute as it is all too easy for the public to dismiss them as both reliant upon and defined as failures by the medical system. So women with disabilities need to fight to establish their right to their sexual identity and to the health care to which all sexually active individuals are entitled.

The UN Convention on Rights of Persons with Disabilities was passed in 2008[10] – and as the most recent UN Rights convention, should be high on your radar as you consider repoliticizing SRHR. This is particularly so as, during the passing of the Convention, disabled feminists struggled hard to try and prevent all mention of sexuality and sexual rights being deleted. They were only partially successful, in the face of attacks not simply by religious groups and state bodies but also by the official representatives of the disabled people's Movement.[11] The struggle to acknowledge the sexuality and SRHR of women with disabilities, to provide effective support, information and services is undermined from all sides, including from within mainstream disability politics, so the support and advocacy of non-disabled feminists can be of great value to this ongoing campaigning.

The plenary papers discuss many options for repoliticizing SRHR but almost, though not exclusively, from the perspective of the 90%, the non-disabled. Health services need to recognise that disabled people are not a tiny minority but 10% of the population, a significant group facing inequity, disadvantage and poverty who must be catered for. Basic planning in the health services can be adapted to offer services for most disabled people without major reorganisation, but the hardest part seems to be thinking about it in the first place.

A recent WHO/UNFPA guidance note on promoting sexual & reproductive health for people with disabilities,[1] contributed to by many disabled people's organisations, identifies four major challenges that the world imposes on persons with disabilities. And remember, it is these social limits, not people's individual impairments, that need to be addressed in policy & planning of health services. They are:

Firstly, *lack of awareness, knowledge, and understanding*. Amongst disabled people, limited knowledge about sexual health issues can have severe consequences. Just as an example, education about HIV/AIDS has neglected deaf people who sign – and because they are not specifically addressed, many have not seen themselves as at risk, resulting in higher levels of risk taking, and higher rates of HIV/AIDS. Liverpool VCT in Kenya has now set up a programme with counsellors who sign, aiming to remedy some of the gap.[12] Amongst health personnel at all levels, the knowledge and understanding required is not primarily medical. Rather it is the de-medicalization of attitudes to disabled people that is needed, and an understanding that disability and its politics of exclusion must be confronted and changed.

The second challenge is of *prejudice and stigma*. This links in to the education of health personnel mooted above, but also to the relation between health personnel and disabled people. Not just personnel on wards or in

communities, but those making policy and undertaking planning must all recognise the need to challenge discrimination against people with disabilities and must unpick the prejudicial views that limit expectations of sexual & reproductive rights for women with disabilities. Further health workers act as gatekeepers for disabled people regarding many non-medical issues linked to sexual and reproductive rights – to family housing, to benefits, to registration as disabled, to decisions to have a child, to use contraception – and the bureaucracy, lack of flexibility, failure of imagination and social and financial corruption that resides within these systems all exacerbate the struggles and difficulties in disabled people lives.

Thirdly are *physical and attitudinal barriers* to health services. Services are no good to disabled women if they cannot access them – and a ramp, a lower examination couch, for example, can be worth their weight in gold.[13] But beyond the many physical and communication initiatives required to provide quality services, major attitudinal barriers remain, particularly in SRH care. Women with intellectual disabilities and women with psychiatric diagnoses, in particular, are regarded, even by health staff who should know better, with fear and uncertainty, are deemed incapable of having a relationship and as dangerous to others including children they may desire. They are too frequently institutionalised against their will where they are vulnerable to forced contraception, unwanted sterilisation, abuse, violence, torture and rape. Their sexual choices, especially if non-hetero-normative, are deemed part of their 'illness' and both sexuality and disability become further pathologized.

And finally, *exclusion of persons with disabilities from decision-making*, especially regarding policy making brings us round again to the need to educate health personnel to institute mechanisms whereby disabled women's voices can be heard as authorities upon what, how, when & where services should be provided. Disabled women face many layers of oppression in negotiating their way through health services and their involvement as part of effective planning, policy and advisory committees is the best assurance that programmes will meet needs. But vitally, power and knowledge cannot be transformed simply by consulting one or two independent disabled women. Rather not only should views represent a diverse range of disabled voices, but power structures must be re-formed so that, in line with women's health ideology, disabled women's voices can be heard as authorities in all discussions relating to disability, their lives and sexual health service provision.

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ANNEX 3

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Repoliticizing Sexual and Reproductive Health and Rights:
A transformative framework for moving beyond ICPD and the MDGs
3–6 August 2010, Langkawi, Malaysia

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Repoliticizing sexual and reproductive health and rights

Report of a global meeting
Langkawi, Malaysia
3–6 August 2010

In June 2008, a group of activists and researchers in the field of sexual and reproductive health and rights met under the auspices of *Reproductive Health Matters* to discuss growing concerns about the fragmentation of work in the field and the absence of a collective critique of where it is heading. Health care provision is being privatised. There has been a backlash against many of the gains made since the 1990s, and the agenda is getting more conservative in response. Human rights are being challenged, especially in relation to sexuality and gender identity. Progressive donors have changed their agendas. Smaller NGOs, often the innovators, are being defunded. Attention to sexual health is being limited mainly to surviving sex, and attention to reproductive health is being narrowed to surviving pregnancy. There are dozens of networks in the field, but we do not have a common agenda. NGOs are being forced to focus on and quantify targets and outcomes. And sexual and reproductive health and rights is in danger of disappearing from governmental and inter-governmental agendas.

It was agreed to launch an initiative calling for repoliticizing sexual and reproductive health and rights. As a first step, we held an international meeting, convened by ARROW in August 2010, to outline a transformative agenda for moving beyond ICPD and the health MDGs. This publication is a report of that meeting. It contains summaries of the presentations and responses to them, the discussion and conclusions arising from them, and notes on the many ways the participants could see for moving forward.

REPRODUCTIVE HEALTH *matters*

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