8th International Dialogue on Population and Sustainable Development

Making Sexual and Reproductive Rights a Reality: What does it take?

Proceedings

October 5 – 6, 2010, Berlin, Germany

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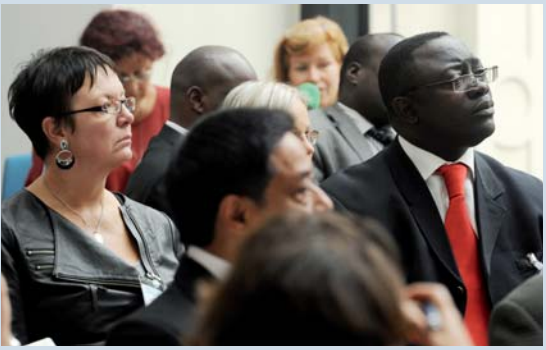

Working Groups on good practices from four countries

Editorial

Kofi Annan, the former Secretary General of the United Nations, once said: “It is my aspiration that health will finally be seen not as a blessing to be wished for, but as a human right to be fought for”. I share this aspiration. We must not accept the deaths of infants who die shortly after being born, or of mothers who do not survive pregnancy, as tragic strokes of fate.

Such occurrences violate the basic human rights to life and to physical and mental health. These are human rights that have been recognized for decades now by the majority of states. We must ensure that states discharge their duty, but we must also join together to provide support wherever they reach the limits of what they can do on their own. When I call for us to “join together”, I am referring not only to partner governments and donor countries, as they are called, but also expressly to civil society and private sector players as well.

The International Dialogue on Population and Sustainable Development, especially this year’s Dialogue, is sending out the right signal: government, the private sector and representatives of civil society organiza-

tions, both national and international, have come together in order to discuss the topic of the future, "population". I should like to express my thanks to all the organizers and sponsors for making this event possible. It is only by working together that we will be able to create the opportunities for personal initiative that are needed to "help people to help themselves". And only by working together will we be able to fight poverty on a sustainable basis and achieve the Millennium Development Goals (MDGs).

"Health and human rights" are priority areas of German development policy. How have our actions shown this? In 2010, BMZ launched a "Development Focus on Human Rights" campaign. A few weeks ago at the G8 summit in Canada and the MDG summit in New York, Germany's Chancellor Angela Merkel announced that we would provide another 400 million euros for the period up to 2015 to help improve two mother and child health. We will use these funds in particular for projects concerned with reproductive health and family planning. These are matters that are not only vital for the health of millions of people but also have an impact on conditions for development in general. Again, they are also a core human rights issue.

The participants in the 8th International Dialogue have worked together to come up with ways of linking two priority areas of our development policy with each other, namely health as a basic prerequisite for development and human rights as a precondition for a life lived in self-determination and dignity. Thank you for joining us in Berlin.

Dirk Niebel

Federal Minister for Economic Cooperation and Development (BMZ), Germany

Introduction

Joachim Schmitt,
Division for Health and Population Policy, Federal Ministry for Economic Cooperation and Development (BMZ), Germany

The promotion of human rights, including the right to health, is an important issue within the international development cooperation agenda. It also features high on the agenda of the German Federal Ministry for Economic Cooperation and Development, and has been declared a political priority by Germany's development minister, Dirk Niebel.

Human rights and health are interrelated. The underlying causes of morbidity and mortality in developing countries – malnutrition, inadequate access to clean drinking water, living and working conditions which are hazardous to health, lack of education and the exclusion of many poor and disadvantaged people from essential health services – arise from the failure to meet human rights commitments. Human-rights-based policies that empower women and address unmet needs for sexual and reproductive health services – whether in developed, developing or least developed countries – have an impact on population dynamics. While giving people, especially women, more control over their lives, this change in dynamic also has critical longer-term implications for the use of natural and scarce resources, for education and employment opportunities, for issues relating to migration and conflict, as well as for new emerging issues such as climate change. Therefore everything possible should be done to enable women to realize their human rights and to provide them with the means of achieving their desired family size.

Within the last few years, growing numbers of bi- and multilateral agencies as well as

civil society organizations – and some partner governments as well – have declared their interest or committed themselves to a human-rights-based approach to promoting sexual and reproductive health. There is also growing practical experience of promoting the right to health and/or a human-rights-based approach to sexual and reproductive health in the context of development cooperation programmes. Looking ahead, a clear focus on human rights may serve to enrich discussions around strategies going beyond the Cairo ICPD Programme of Action (in 2014) and the Millennium Development Goal target date of 2015.

The objective of this International Dialogue is three-fold:

- to provide a forum in which to present and discuss strategies and good practices for promoting a rights-based approach to sexual and reproductive health and population dynamics;

- to address current and potentially controversial issues around the right to health and a human-rights-based approach to sexual and reproductive health, including for example family planning, abortion, protection against discrimination on the basis of sexual orientation, or the financial viability and financial implications of the approach;

- to focus on defining (joint) ways ahead for further promoting a rights-based approach to sexual and reproductive health within donor, civil society organization, private sector and partner government strategies, development cooperation programmes and also various international development cooperation and human rights forums.

This year's International Dialogue focused on the expert level, with a limited number of participants from civil society organizations, the private sector and partner governments. The conclusions presented here will inform and guide future German development cooperation in this area. They will also feed into future International Dialogues to be developed and elaborated further.

Welcome Address

Klaus Brückner,
Director GTZ Office Berlin,
Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH,
Berlin, Germany

It is my particular pleasure and privilege to welcome you all most warmly on behalf of GTZ in Berlin to the 8th International Dialogue on Population and Sustainable Development. I am impressed about the great number of so many distinguished participants and panelists. I am sure that this will be a guarantee for lively and results-driven discussions with inputs from the world of politics and ministries, international and national governmental and nongovernmental organizations, civil society, universities and research institutes, the media, the private sector and churches.

The International Dialogue on Population and Sustainable Development, an annual, two-day conference taking place in Berlin, was first convened in 2002 by a consortium of German development cooperation organizations, private enterprises and their international partners like Unites Nations Population Fund (UNFPA), International Planned Parenthood Federation (IPPF) and World Health Organisation (WHO). The objective of this forum is to provide a platform to exchange strategies on population issues and sustainable development. Over the years the International Dialogue has grown into an important event and internationally recognized dialogue forum. Each conference is dedicated to a particular topic and reflects the broad range of issues under the comprehensive concept of reproductive health and population.

This year's thematic focus will be sexual and reproductive rights, an important issue on the international development cooperation agenda. By ratifying all the key human rights conventions, the Federal Republic of Germany is committed to collaborating actively

on implementing human rights. In line with this commitment, the German Federal Ministry for Economic Cooperation and Development (BMZ) adopted the first Development Policy Action Plan on Human Rights in 2004, and its continuation in March 2008. This plan requires all German governmental development agencies to apply a human rights-based approach (HRBA) across all sectors and levels of intervention. Unless we make progress on sexual and reproductive health rights, we will find it very hard to gain traction on wider development goals.

As long as more than 200 million women in the world have an unmet need for family planning, their chances of finishing their education, being in paid work, and breaking out of poverty are reduced. We cannot hope to reach the Millennium Development Goals (MDGs) if fifty per cent of the world's people are not afforded equal rights and opportunities. Addressing the needs of women has to be at the heart of the development agenda everywhere.

It is not by coincidence that the vast majority of the annual deaths related to pregnancy and childbirth complications could be prevented with low-cost, targeted interventions, policies and services, all of which have been known by the medical profession and health systems for decades. And it is not by coincidence that improving maternal health, Goal 5 of the Millennium Development Goals (MDGs) remains the least successful of the eight Goals. Accountability for actions taken or omitted is therefore indispensible to ensure that gaps in policy and practice are addressed and filled. To this end, and also in view of the September 2010 review summit of the MDGs, the support of health workers and health advocates, such as the participants to this dialogue, is absolutely crucial to set the tone of the discussion and the key elements of the international and national agendas on sexual and reproductive health.

Let us not forget that only in recent years has the subject of sexual and reproductive health been recognized as a human rights issue. Allow me to retrace that in June 2009, the Human Rights Council adopted by consensus Resolution 11/8 entitled, "Preventable maternal mortality and morbidity and human rights". This development was due, in no small part, to the efforts of civil society advocates. The application of a human rights approach helps us understand that maternal mortality and morbidity are not simply issues of public health but the consequence of lack of fulfillment of multiple rights. A rights-based approach assists States to understand and make visible the connections among poverty, discrimination, equality and health. It also outlines their obligations to promote, protect and fulfill all human rights, including the right to health.

Let this dialogue be a milestone in inspiring the action which helps us achieve these critically important goals which seek to transform the lives of women and their families and communities. And may this conference also reaffirm the critical role of policy makers and advocates in achieving universal access to reproductive health. I wish you success for the conference, creative thoughts and ideas, and plenty of opportunities for exchanging your experiences. ■

Welcome Address

Klaus Brill,
Vice President Corporate Commercial Relations, Bayer Schering Pharma AG, Berlin, Germany

A difficult question cannot be answered by two or three keynote speeches. This is why we developed this expert's meeting in this special format. Within the next two days, we will ask all of you to share your experiences in order to develop an action guide with specific recommendations for policy makers and advocates worldwide how to make reproductive health initiatives successful. An ambitious goal we have set. But I am convinced that our tools and experienced facilitators will make this possible. However, what we need most is your knowledge and your commitment.

Be sure that the next two days will be very demanding. We will learn from each other what made your best practices a success story in the past and how to apply those findings on future projects. Consecutive workshop formats will enable us to identify general success factors. It will be the challenging task for Franklin Apfel, Managing Director of World Health Communication Associates (WHCA) ltd., and Renate Bähr, Executive Director of the German Foundation for World Population (DSW), together with their colleagues to sum up our recommendations, and enable us to jointly produce an action guide to support political decision makers all over the world in their efforts to ensure that our initiatives make sexual and reproductive rights a reality.

As a research-based pharmaceutical company, Bayer Schering Pharma is well aware of its responsibility to contribute to the international efforts to improve the provision of health care services around the world. For this reason, we are supporting the United

Nations Millennium Development Goals (MDGs), which list improved health as one of its key objectives.

At Bayer Schering Pharma, we have developed a strategy for Social Health Care Programmes in line with our company's areas of expertise. We place a particular emphasis on combating neglected and tropical diseases. Moreover, we continue to support improved access to innovative medication which, for example, can treat clinical symptoms in oncological and haematological diseases and we are focusing especially on family planning and strengthening women's health.

Since 1961, Bayer Schering Pharma has cooperated with governmental and private organizations to provide high quality contraceptives to family planning programmes in over 130 countries. More than 2,7 billion cycle packs of oral contraceptives have been provided to reduce women's exposure to health risks of unwanted childbirth and unsafe abortions.

In 2008, we began supplying the US Agency for International Development, USAID, with contraceptives that will enable more than eight million women in developing countries to realize their right of choice. Our family planning efforts help to reduce the health risks associated with unintended pregnancy, and empower women and men to determine the size of their families.

Through awareness building activities at World Contraception Day each September 26th, and through our support of sexual education programmes in regions with high population growth and rates of sexually transmitted disease (STD) infection, we foster awareness for sexual health. Thus we distribute health information and services where they are needed most.

We cooperate with a number of NGOs, whose sexual education projects consider gender, age and cultural differences. A notable example of this is the "Youth2Youth" programme of the German Foundation of World Population (DSW). Focusing on "early adolescents" (younger than 15 years), this innovative education programme for Uganda encourages responsible behavior using a peer to peer approach adapted to the local situation. Teaching equipment and materials are provided by a "youth truck" that travels throughout Uganda to those schools and community centers where the trainings are held.

Let me briefly introduce you some numbers which may explain why it is so important to ensure such programmes

- Annually around 350,000 women die of childbirth complications. Every minute, one woman dies needlessly from complications of pregnancy and childbirth, and every minute 20 women suffer from illness and disability.
- Each year there are 76 million unwanted pregnancies. More than half a million women die from pregnancy and childbearing complications.
- According to estimates of the United Nations Population Fund, 200 million women worldwide want to use family planning methods, but lack access to information and services.

There can only be sustainable solutions if all groups in society work together. This is why we support targeted dialogues with actors in politics, industry and health at the local, national, and international levels, and we are committed to partnerships.

Since 2001, Bayer Schering Pharma organizes this event series "International Dialogue on Population and Development" in cooperation with the Federal Ministry for Economic Cooperation and Development and other partners. I am very interested to see what results this conference brings and I am sure we can all look forward to fruitful discussions and debates. ■

Keynote Speech

Thoraya Ahmed Obaid,
Executive Director, United Nations Population Fund (UNFPA), New York

Progress and Challenges: Sexual and Reproductive Health and Rights

I am honored to be able to be with you in the 8th International Dialogue on Population and Sustainable Development. It is my third time for me to address you and I am very pleased to realize many good friends in the auditorium. On the other hand I have to say it is very sad for me, since it will be the last time for me to be here. In December 2010, after ten years, I will retire as Executive Director of the United Nations Populations Fund (UNFPA) and I will go back home to Saudi Arabia and Egypt.

I would like to thank the German Government for the support to UNFPA throughout the years. I am very happy that Germany has a strong commitment to the whole area of sexual and reproductive health. I am grateful for Germany's support to developing countries in order to increase their ownership of the agenda and to ensure that we leverage national resources so that the ownership is really integrate into the physical sturctures of the budgets of the governments. I would like to thank the German Foundation for World Population (DSW) and particularly Executive Director, Renate Bähr, for all the good work that she does to promote population issues, including sexual and reproductive health and rights. You are doing a great job in moving this agenda forward.

I am particularly pleased that the focus this year is on making sexual and reproductive rights a reality. This is the second target under Millennium Development Goal 5. There is a lot of emphasis on target one – "reduce maternal mortality by three quarter ratio". This of course is good, because that is the basic human right: not to die when giving

birth. But we have to be careful not to bruise the profile of the target which is universal access of reproductive health by 2015.

When I look at my ten years as the Executive Director of UNFPA I first have to say that UNFPA is a wonderful organization made out of very devoted people, passionate people, and activist people. It is their passion keeping the organization going and the agenda moving.

Looking back the ten years also means to be confronted with a world, where women try hard to establish a better life. It was an agenda for women I was working for. But now, more and more I see it is an agenda for men. I think this makes a big difference. In September 2010 at the MDG Summit in New York, I could experience the Premier of China speaking about maternal health. This is a big development. This means that the maternal health has come up to the political level of world leaders. They talk about this issue without being shy, without feeling ashamed or uncomfortable. Now we have to wait for them saying not only "maternal health" but also saying "reproductive health". This is the challenge we have to move on to.

Also, during the past ten years with UNFPA, I have had the privilege of seeing first-hand some further progresses that is being made. I remember visiting a health clinic in Bangladesh, watching pregnant women waiting to get their check-ups and seeing new mothers learn how to care for the babies they had. I also visited a hospital that had been set up to repair the devastating childbirth injury of fistula. I am so happy that the issue of Fistula is not longer hidden. When I for the first time visited a hospital where fistula was treated – it was in Ethiopia – I have to confess, I was crying. And remembering now, I could cry again. I can tell you that in all my years, there are few things as rewarding as seeing women who were suffering from fistula, often ostracized by their families, being able to get surgery and have a second lease on life.

In St. Petersburg, I visited a health clinic and listened as young men and women spoke about their work as peer educators, reaching out to sex workers and drug users to prevent unwanted pregnancies and HIV infection. They were doing their part to support individuals who are often left behind, and they were so proud of the work they were doing. When I was cleaning up my desk beginning to pack I found a photo which was taken, when I visited Kosovo. You can see babies all lined on a long table. I remember they were wrapped on the same side, then turned to the same side and all fed, one after the other. It was amazing to see how the dealt with the babies but also with the mothers. When we went through the maternity ward there was a woman just having an abortion. The surgery room had glass windows so you could see women delivering babies. There was no privacy at all. Nowadays there is more awareness of privacy and the medical staff is more aware of baby centered treatment. Another issue we were able to work on in Central Asia and Eastern Europe: decrease the historically high abortion rates and enable women to have greater access to reproductive health

care, and increase the use of family planning to support their choices.

Another change I gratefully can realize: it is accepted now that women have special needs in crisis, whether it is natural disaster or war. This was not always so. Nobody thought that women could deliver babies when there is a flood or there is a war. I took us a long time to convince even our donors that women do have special needs in this case. I am happy that now we finally have an agreement with the World Food Programme (WFP), with the United Nations High Commissioner for Refugees (UNHCR) and with the Red Cross. As part of the logistics, when they deliver their own goods, they also deliver our reproductive health kits. Inside is a bar of soap, string, a plastic sheet and a razor blade. The purpose of this simple kit is to reduce maternal and newborn death, by promoting clean hands, clean surfaces and a clean umbilical cord.

There are many more examples I could choose from to demonstrate clearly that we have made progress since the International Conference on Population and Development 16 years ago in Cairo. The fact that ICPD was a lower level representation and that governments at of the Summit 2000 and 2005 declared their commitment to universal access to reproductive health by 2015 shows a development. Now at recent Summit governments reiterated their commitment but focusing on maternal health. We also saw during the past two decade, more and more solid policy and legal foundations, more and more countries putting laws in place, the human rights council last year agreeing on the landmark resolution on maternal mortality, the Security Council 1325 and the other resolutions on violence against women. The legal frameworks are there. Now the issue is to implement these legal frameworks.

There is another point that I believe is very important: In the Millennium Development Goals, all governments are asked to measure their progress, but we are weak on data systems. We are weak on capacities of countries. So UNFPA, with other agencies, is working on a data system to be able to measure, report back, and develop the capacities of countries. I will move on now to the last point, which is that I have three challenges that I believe we will need to face as we go along.

The first one is the widening iniquities within each country and among countries. Even though we have a financial crisis, in many countries there are people who are getting richer and richer and people who are getting poorer and poorer. We have to look at the issue of inequities and we have to have in mind that mainly women are stroked by poverty. Let me give you some examples: in Sub-Sahara Africa women from the wealthiest households are more than three times as likely as those from the poorest households to give birth with assistance from a skilled provider. In Southern Asia, the rich are five times more likely to have assisted delivery. The whole use of contraception, of course, is significantly lower when women are poor. Birth rate is significantly higher in poorer countries. Rich women can have safe abortion; poor women have no access to safe abortion.

I just came from Geneva, attending a human rights Council. The Council had invited to a meeting in response to a human rights council's decision to look at cultural values and traditional practices. The idea was to make sure that the central piece is human rights, and how we can bring about the positive values in any society and in any religion to support human rights. It was a very interesting dialogue, and I think you all have to watch for these discussions. I see different winds coming through - positive and negative. We need to be sure that we are looking at these waves of winds that are talking about the values and the human rights. This seminar was a very interesting beginning which I think we have to watch and follow up carefully and see how we work with it in future.

Basically, what we are saying is that we need a human rights-based approach that is culturally sensitive and that has a gender perspective to promote human rights. So, human rights are central, but we have a gender perspective on it as well as a culture. I think some of you may ask later about the new organization UN Women, and, of course, we were among the ones who were very happy to have UN Women, and to have Michelle Bachelet, in particular, as the leader of UN Women. As she takes office by the 1st of January 2011, she has a transition team right now working with her on questions like: how will this UN Women look like? And to take the mandate, and to put it operationally, how does it work? But, we are all around her, trying to support her as she developed the model. It is a very new model for the UN.

Let me move to another important issue: Users' fee. When we talk about equity and accessibility we have to consider whether we have increased the inequality by intro-

ducing users' fees. I remember the General Assembly last year in 2009: we had a panel again of men only – inter alia Prime Minister of Norway, Prime Minister of the UK and President Clinton. Gordon Brown stated that we made a mistake by introducing users' fees. For the poor, we should not have it, and we should stratify the users' fees and so on. There is recognition that users' fees have harmed women and poor women in particular. So we need to relook the issue of users' fees as well.

The final point I would like to talk about is political leadership and funding. Of course because of the financial crisis, we are worried about funding. There were many declarations in the General Assembly, at the Summit, that additional money will come in. There was a response of the Secretary General on global strategy on women and child's health of about 40 billion US$ announced. There has been another commitment of five billion US$ at the G8 in Canada. But the question is: Is this new money, or is it money coming from somewhere else? I believe that part of your role is to monitor where this money is coming from and whether it is reaching the countries that deserve to get it. Nobody is clear yet how this money is flowing and where it is going to go. We have to look at how we can leverage resources for women - what ever resources are available. Let me give you one example. There is a lot of money for climate change adaptation; there is about 100 billion US$ for three years. If we are talking about climate change adaptation and resilience who at the community level is the resilient? It is the woman. Therefore, when we talk about climate change adaption, we need to see how we leverage resources for women within that package for resilience, for strength, for even technology adaptation. It is the woman who keeps the family together; she is responsible for energy, water, and so the woman has to be co-part of the discussions on climate change.

The other area also, where we should look for money, is leveraging national budgets from different resources of the budget itself. Women's health is more than health. Women's health is also roads, communication, transport, electricity in clinics that keep the clinics working. If there is a decision about a road, it doesn't have to go to the city. It can go to a village that is serving a number of villages and so on. So, how can women's health and women's rights be a political priority, where a government can look at all its sectors and see how they leverage those sectors to support women? If they have

women's health as a national priority, the different sectors should be able to respond and see how they can support the well being of women that way.

The last point is, of course, the fact that Target B, MDG 5 will remain a challenge, universal access to reproductive health: The question is, what are we going to do in 2014, when the ICPD programme of action, the programme of action agreed at the 1994 International Conference on Population will be completed? There are lots of questionnaires going around and discussions happening. May be an ICPD type of conference nowadays is not the modality to have. We would like to focus at the country-level, on experiences of countries, scaling up, expanding. We would like to focus on regional consultations and lessons learned among the regions – may be technical meetings. But there has to be something in the General Assembly, as an intergovernmental decision before 2014 when ICPD ends. If it is not extended, then there will be nothing. There is no mandate anymore. The minimum is to safeguard the mandate of ICPD by having it re-extended in the intergovernmental process in the General Assembly, and then opening - whether it is a special session or whatever- to discuss about issues that are emerging in this period since ICPD.

I see two issues that will be very hot: "abortion" and "sexual rights". I think we have to work together to see what kind of language can be promoted so that Member States can work with that. I will stop here, because I think I talked a lot, but I hope I have given you some panorama of what the challenges are that are awaiting all of you, as I am sitting home reading about what you are doing. ■

Working Groups on good practices from four countrys

Case study – Nepal

Working Group on good practices

Yasho V. Pradhan,
Director General, Department of Health Services, Ministry of Health and Population, Nepal

Input 1 – Government Representative

Before the introduction of democracy in Nepal, the national health situation was very alarming, with high rates of maternal mortality and unsafe abortion.

What had been the main obstacles for actions?

- Cultural practices around delivery (e.g. home delivery)
- Social taboos and stigmas on abortion
- Sex preference (low utilization of modern family planning methods
- Difficult terrain
- Inadequate number of service sites and service providers
- Inequitable distribution of service sites
- High proportion of unwanted pregnancy resulting in illegal abortion (abortion not legalized)

The main barriers keeping women from getting contraception are economic, social, technical. The geographical landscape of Nepal with all the mountains makes it difficult to ensure full access. There are lots of gaps. Also traditional cultural reasons are obstacles. Now, after introduction of family planning service as a fundamental right we are working to remove these barriers.

Then our government initiated a human rights-based approach. Sexual health and rights for every woman were on the agenda. Mortality and morbidity were reduced. Now abortion is legal and family planning is free. The message is: “It is your right not to have children”.

The Nepalese government provided a strong legal framework. The constitution and the

new national health strategy explicitly recognized basic and reproductive health respectively as a fundamental right for all. Essential health services were free, there was a legal basis for safe abortion, and education encouraged people to claim their rights. Strong women's groups had advocated for rights and data disaggregated by ethnicity has helped to track equity related changes.

The right to health imposed on the state the responsibility to respect, protect and fulfil this right, but there was still much to be done. Contraceptive prevalence was up, abortion had been legalized, maternal mortality was down, and so was infant and under-five mortality, but there was growing inequality between wealthy and poor women, and a major shortage of qualified personnel. Cultural challenges also remained, particularly among hard to reach groups, so the battle continued.

The rights approach is supported by donors. This engagement was part of our national health plan, it was drawn up jointly, and sexual and reproductive health and rights was part of it: women have the right to terminate pregnancy, and the right to a skilled attendant and so on. We had some problems but they did not hamper our work. Once government is committed to this approach, we comply.

In the last three years, Nepal's Equity and Access Programme had addressed the many obstacles women face in attaining their rights, especially those women marginalized by caste, living in remote areas, or isolated by poverty, language and traditional cultural practices. These were the people who were normally deprived of their rights every which way. This programme had had successes, not only in service provision but also in increasing knowledge, capacity and empowerment: "listening to the voices of the unheard". This was not just about direct health provision, but other areas too, for example, they had established emergency funds in 3,500 community groups, thus freezing out money lenders, and promoted the setting up of emergency transport such as cycle ambulances. ■

Case study – Nepal

Working Group on good practices

Ian McFarlane,
Representative, United Nations Population Fund (UNFPA), Nepal

Input 2 – Donor Representative

Nepal: Are we getting it right?

While it is easy to ask the question, finding the evidence for an appropriate answer is elusive in Nepal. There have been remarkable increases in the awareness and the realization of sexual and reproductive health rights in the last decade, at a time when Nepal faced internal armed conflict and a subsequent troubled transition to democracy and peace. There are also significant challenges remaining, in part due to the continuing political processes, in part due to the topography and vulnerability to on-going or ad hoc natural disaster.

The paper presents some of the context, obstacles and lessons for further debate in Nepal and abroad on what it might take to get it right.

Leadership and change towards a rights-based approach.

The country had a Nepal Health Sector Programme (NHSP) I, 2004 -2009. The national plan for 2010-2015 has now a vision statement, a mission statement and a values statement. Government's vision for the health sector in 2004 was "to bring about improvement in the health status of the entire Nepalese population with provision of equal opportunity for quality health care services through an effective health system and thus develop healthy and capable human power to support poverty alleviation."[1] Although there are elements of "rights" (entire population, equal opportunity"), the thrust in 2004 was a "public health" approach.

In contrast, NHSP II indicates a major shift towards a commitment to realize rights. The

1_NHSP I, Vision Statement, October 2004.

document states that "The Ministry believes in: equitable and quality health care services; patient/client centered health services; rights-based approach to health planning and programming; culturally- and conflict-sensitive health services; and gender-sensitive and socially inclusive health services."[2]

It can be argued that this shift is due to national leadership by health professionals, as well as support from External Development Partners (EDPs) and active engagement from civil society at all levels. Perhaps more important, however, is the way in which this discourse is set within and consistent with the wider political and social context of the period with a strong emphasis on rights. For example, the Comprehensive Peace Agreement of November 2006 stated that: "Policies shall be undertaken to establish the rights of all the citizens to education, health, shelter, employment and food security" The Interim Constitution, approved in 2007 (by a Constituent Assembly with 33 per cent elected women representatives), was even more explicit on rights, noting that "Every woman shall have the right to reproductive health and other reproductive matters. No physical, mental or any other form of violence shall be inflicted to any woman, and such an act shall be punishable by law. Son and daughter shall have equal rights to their ancestral property".

This language is remarkable in its aspiration, and the current discourse remains at the same level because of very articulate and active rights-minded Constituent Assembly (CA) members, non-governmental organizations (NGOs) and citizens.

2_NHSP II "Value Statement", July 2010.

It can also be argued that the global development agenda and its translation by government and EDPs in Nepal have furthered the rights-based approach and attainment of sexual and reproductive health and rights. EDPs are changing their behavior. Partly this is due to national political concerns in donor countries (and this is going to increase) about value for taxpayers money, for a kind of "reverse rights" – the rights of citizens in developed countries. But it is also due to how the development business has shifted from Paris to Accra – from mutual accountability to a much deeper inclusive process with language on civil society, accountability to parliaments etc. And this has been helpful in driving the rights agenda. In Kathmandu, EDPs are working closely together, using a mix of strategies, to support government address the rights issues.

The road from Paris to Accra to Kathmandu is a winding one, and for Nepal not without the occasional flood or landslide blocking the way. It cannot be claimed that the increased access of citizens to their reproductive health rights is due to these global processes, but it may have helped.

There is clear evidence of an improved trend in rights being realized. For example, maternal mortality reduced by about 50 per cent between 1996 and 2006 – greater access to reproductive health services such as skilled birth attendance (from 18 – 28 per cent); increase in access to contraception (up to 48 per cent), legalization and access to improved abortion services.

Nepal's realization of reproductive rights has been recognized and Nepal won the Millenni-

um Development Goal (MDG) 5 Achievement Award, presented on 19th September 2010 in New York. But there has been only a progressive realization of those rights, and significant challenges remain. There is a large unmet need (25 per cent, 33 per cent for adolescents); 400,000 women are in need of some form of surgery for uterine prolapse; highest cause of death for women is suicide (16 per cent).

The data analysis of only partial attainment of rights from these various studies is also reflected by women themselves. The Feinstein International Center's report, "Towards a Great Transformation?" in July 2010 quoted a young married woman in Dang saying that "The only change is that we have been told that we too have rights".

What is required to ensure the full attainment of the Interim Constitution's aspirations and the effective implementation of rights-focused national policies and strategies?

Money – more money for health, and better health for the money

Government has increased its allocation to the health budget – which is very encouraging, including the resources targeted towards essential health care. However, on the same day that it was announced that Nepal had won the MDG 5 award, an article in the "Himalayan Times" noted "No budget, no new health programmes". Government has not been able to approve the national budget because of the political situation. The Ministry of Health and Population is also a pilot ministry under the Ministry of Finance initiative for gender responsive budgeting, and Ministry of Health and Population has just agreed to a gender audit, supported by the United Nations Population Fund (UNFPA).

As well as providing resources to the health pool and through bilateral programmes and projects, External Development Partners (EDPs) are working to support the innovative approaches related to rights – such as supporting the Gender and Social Inclusion strategy and the future work on health financing/insurance. EDPs and government are also tracking governance and accountability to improve efficiencies through the governance and accountability Action Plan. Government is developing a pilot programme in several districts along with Ministry of Health and Population to see what can be done to enhance governance and service delivery, and social audits are part of the NHSP II strategy. All of this will help bridge the gap between rights holders and duty bearers.

More and better use of money can also be brought through closer collaboration among EDPs, reducing transaction costs and generating efficiency gains for government counterparts. Many EDPs have signed (and most concur with) the National Compact – a document that commits both Government and EDPs to harmonization, alignment and results. A Joint Financial Agreement was signed between Ministry of Finance and EDPs and we are working on a joint technical assistance plan.

More debate and action on reproductive health rights and sexual rights

A debate is needed to broaden the debate. Reproductive health rights are still largely narrowed down to pregnancy, and there is a need for more analysis, policy and action

on the full lifecycle of rights, morbidities etc. There is also the wider matter of sexual rights – related to violence against women and women's empowerment. This includes action to target the most marginalized.

The Ministry of Health and Population is to be congratulated on developing its own plan to the national campaign to end violence launched last year by the Prime Minister with support from UNFPA, the Department for International Development (DFID) and others. The Ministry of Health and Population's remote area guidelines and the Ministry of General Administration's efforts to boost incentives for civil servants to serve where they are most needed is also critical. Reports have also indicated that some of the basic elements to ensure access to reproductive health rights are still missing – staff, medicines, equipment – let alone appropriate quality of service provided by duty-bearers.

A final verdict

The politics, policies and plans, the aid agenda, as well as concerted efforts from government staff, civil society and EDPs have made a difference and are contributing to getting it right in Nepal. Progress and universal access will not be meaningful however if greater efforts are not made to reach the most marginalized and change attitudes. Listening to the voices of the most marginalized is perhaps the greatest source of change. The empowerment of those who are furthest from realizing their rights will require sustained efforts over some time to come.

From the Feinstein study

"After their monthly meeting, we asked the women what they thought about women's situation in the village. Before women could answer, a man replied to the question saying that discrimination had decreased in recent years. He said, "Women are no longer discriminated against; these days women have got rights. Things have changed considerably". A woman angrily reacted to his comments, "How can you say so? How do you know? You can't say just anything like that; you should ask us, what do you know about us?" ■

Case study – Nepal

Working Group on good practices

Bharat Devkota,
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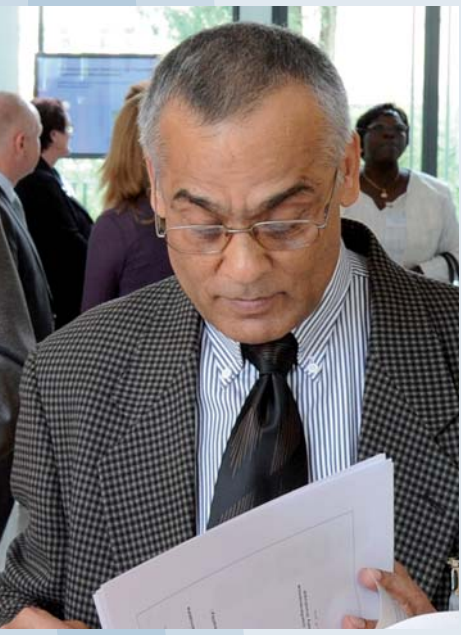
Input 3 – Non State Actor



Gender Equality, Social Inclusion and Rights (GESIR) in Health Sector in Nepal: Equity Access Programme (EAP) Experience

Context

The interim constitution of Nepal 2007 recognizes basic health as a fundamental right of all. The country has made significant progress in recent years in empowering citizens to claim health rights through programme initiatives and policy changes. Free essential health care, transport subsidy for safe delivery, legal basis for safe abortion, increased family planning and other non health interventions have contributed to increasing access to health services and right holders to claim rights. However, quality health services are yet to reach to poor[1], vulnerable and marginalized groups. Many challenges remain, including gender equality, social inclusion and rights forward. In Nepal, several factors like gender, ethnicity, language, location (remoteness), poverty etc influence exclusion from access to health services. Barriers to social inclusion include gender-based social stratification, which in turn must be placed in the prevailing ethnic and caste-based hierarchies that structure economic and social relationships. This defines how lives of girls and boys, men and women are shaped according to their caste and ethnic identities, their religion and the location. These social struc-

1_Definition: Poor: socially, economically, geographically excluded population, including women and children with low health status and low empowerment indicators in terms of HDI, GDI, and other context specific groups. Vulnerable: including women and children (displaced, destitute, disabled, elderly (above 60 years of age), people affected by trafficking). Marginalized by castes, ethnicity, language, disability and other factors: including women and children—*Dalits* (Hill and Terai), *Janajatis*, religious minorities, PLWHA, and third gender. In this paper Poor and Excluded (P&E) being used to represent all.

tures govern all spheres of an individual's life. Health status of Nepali is therefore broadly determined by their economic, social, physical, and geographical conditions with marginalized groups clearly having lower health status than others.

The current health care system is neutral to all citizens and aims for universal coverage. Unless special focus is given to the poor and excluded, the achievement of universal coverage cannot be attained. Nepal's constitution recognizes „basic health as a human right", but policy formulation, programme design and budgeting have not been done yet for its implementation. Constitution provides right to information, but advantaged people have better access on information than poor and excluded. These gap areas have led to different levels of health service utilization between advantaged and marginalized populations. The right to health means that the state must generate conditions in which everyone can be as healthy as possible. Such conditions range from ensuring reach to basic health care (availability, acceptability, accessibility and quality care) and other determinants (water, sanitation, food, housing etc) by all citizens.

What does it take to make health rights a reality: EAP[2] experience

– The knowledge on safe motherhood and newborn health increased, especially among poor and excluded, through behavior change communication activities. Behavior change was disseminated by communication, media and materials. Today multimedia and interactive activities are implemented.

– An environment was created for excluded women and families by addressing social, cultural, economic and physical barriers. Community mapping aimed at establishing areas of greatest concentration of poor and socially excluded. Emergency funds and transportation schemes were strengthened. This carried out social mobilization and provided support to service delivery points for improving basic physical environment. A mechanism for right holders and service providers' interaction is created.

– Capacity of equity and access support organizations (EASOs) were built, as well as local government. Reproductive Health Coordination Committees (RHCCs) and community groups are there to promote equity and access for safe motherhood and newborn health, especially among the poor and excluded. Developed innovative tools like social exclusion mapping, appreciative inquiry, public hearings, social audits and conflict-sensitive development tools are existing and strengthened the capacity of RHCCs to coordinate planning, implementation and monitoring.

– Voices were collected from unheard right holders and service providers and used to influence policy and programme develop-

2_Equity and Access Program (EAP) is implemented by ActionAid Nepal for Support to the Safe Motherhood Program (SSMP) managed by UK based Options Consultancy Services Limited funded by DFID. EAP was implemented between 2006-2009 in 10 districts of Nepal. It had 28 [local] partner organizations implemented the program which aimed increasing utilization of safe motherhood and newborn health services particularly by poor and socially excluded.

ment. This was used to support capturing of voices and they were disseminated at different levels so that management functions at village, district and national level formal and informal organizations.

– Cross cutting and thematic issues working on rights-based approach (RBA) empowered women to seek and demand better care and mobilized communities to engage with service providers to place pressure for more responsive and accountable services. They worked in partnership with local institutions mostly led by Dalits, Janjatis and women. The participation of planning and evaluation (P&E) increased and empowered them by formation of groups, federating them on networks and developing them as district level NGO or health cooperatives.

– Advocacy-related activities to change the power relation and improve quality of services arose through meaningful engagement and participation of poor and excluded at various levels. They built networks of community groups and empowered them to raise voices, claim their rights, demand accountability and influence power holders at household and community level.

What is achieved on claiming health rights by poor and excluded?

The service utilization increased across all social groups, with greatest changes occurring among Dalits and disadvantaged Janajatis. Women from Dalit and excluded community are empowered and able to demand their rights. They are sensitized and more aware about underlying causes of exclusion, power structure within family, community and society, causes of discrimination and violation of rights. They have gained knowledge and skills for doing systematic advocacy against various issues related to women's rights. A high proportion of women from poor and excluded groups have become able to hold key positions in community groups. In addition, there is a significant decrease in equity gaps:

– The equity gap between uses of Antenatal Care (ANC) by different ethnic groups has declined. Women have a significantly higher ANC user rate. The harmful traditional cultural practices have decreased remarkably.
– Knowledge of danger signs in pregnancy, labour and the post-partum have more than doubled.
– Mobilizing women, their families and communities to act upon social norms, traditional practices and cultural beliefs that work against safe motherhood, policy and service have increased access to services.
– Better information, better preparation for and better availability of emergency obstetric care has translated into more rational care seeking. Treatment of obstetric complications has increased.
– Women have better knowledge of danger signs, better knowledge of transport subsidy for institutional delivery (Aama), and are more likely to use an emergency transport scheme. ANC rates also have increased.
– Reduced social inequities in use of maternal and newborn health services. However, while Dalits and disadvantaged Janajatis have benefitted particularly well,

Madeshi castes and other religious minorities have fared less well.

Programme learning on rights to health

EAP, during its implementation, gathered a lot of experience and learning from conducting its various activities and the processes in women's rights, particularly safe motherhood rights.

- Targeting the poor and excluded is essential if universal coverage is to be reached.
- In the absence of poverty mapping data, disaggregation using (six) caste or ethnicity groupings is an effective mean to track equity related changes.
- Demand creation without concurrent service strengthening can demotivate communities for care seeking.
- Raising awareness of rights and social inclusion among both right holders and duty bearers is effective in improving service delivery and accountability.
- Working through women's groups and networks is effective in increasing equitable demand for and equal access to maternal and newborn health services.
- Voices of community members, community groups and service providers can be effective in improving local policies and service quality if used skillfully.
- Localization of behavior change communication materials, including materials written in local languages, increases local ownership and impact.
- Social empowerment through women's groups impacts on other sectors.
- Partnering with district level NGOs from poor and marginalized constituencies is highly effective.
- Empowering women to claim their health rights and redefine social norms around pregnancy and childbirth is a long-term agenda.

Recommendations for future programmes

Based on the learning of EAP the recommendations for future programming are:

- Need to place stronger emphasis on reaching marginalized through more tailored communication and mobilization approaches, and addressing supply side barriers and social discrimination.
- The success of EAP in the Hills and Terai also calls for the programme's adaptation to mountain districts where development indicators of remote communities trail behind.
- Ensure rights-based, socially inclusive, empowering approaches are at the core of community mobilization processes. Also ensure linkages of the programme with other sectors, particularly with livelihood and education.
- Ensure disaggregated monitoring rolled out across the country for all major health indicators.
- Ensure that demand for creation and service strengthening go hand in hand.
- Use networks to promote free care and support social auditing of demand side financing schemes.
- Support group, network and cooperative strengthening as a discrete programme goal for sustainability.
- Explore the potential of the national Equity and Access Agency to provide technical support to local "demand side agencies". ■

Case study – Tanzania

Working Group on good practices

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Input 1 – Government Representative

Introduction

Tanzania has a population of 42 million people. 31 per cent of the population is adolescent. Women in child bearing age constitute 20 per cent of the population. Total fertility rate is 5.4 per cent, modern contraceptive prevalence rate 28 per cent.

Tanzania has ratified international and regional conventions that promote sexual reproductive health and rights. The conventions were translated into national policies and laws. The Ministry coordinates sexual reproductive health through the Reproductive and Child Health Section and the National AIDS Control Programme. Key points of the programme are:

- Safe motherhood
- Family planning
- Adolescent reproductive health
- Reproductive health cancers
- Gender-based violence in reproductive health (GBV)
- Sexually transmitted infections and HIV/AIDS

Leadership and contextual factors leading to action

Leading activists on the regional level are the African Union (AU), the East, Central and Southern Africa Health Community (ECSAHC), the Southern African Development Community (SADC), the World Health Organization Regional Office for Africa (WHO/AFRO) and the East African Community (EAC). Contextual factors leading to action on the country level are:

- Focus on scale up of effective interventions
- Focus on systematic programming
- Ensuring coordination of partners
- Use of data in programming to address equity
- Human rights as a guiding principle

Obstacles to action and how to overcome them

Most important obstacles to action are limited resources (financial and human). To overcome these obstacles, effective means are:

- Strategic/action plans
- Advocacy
- Integration with other programmes, e.g. HIV/AIDS
- Effective coordination of partners

To overcome obstacles like social cultural factors, traditional moral or religious beliefs as well as gender inequality in a male dominated society, effective tools are:

- Information, education and communication as well as behavior change communication interventions
- Women empowerment interventions
- Male involvement interventions

Obstacles such as

- Inadequate knowledge and information on health issues are surmounted by information, education and communication as well as behavior change communication interventions
- Inadequate information on services as a right

- Community involvement in health services governing structures
- Conflicting policies and laws
- Advocacy for amendment

Has action improved health?

Action taken has improved access to adolescent friendly reproductive health services as well as access information on sexual reproductive health for youth. Furthermore, the awareness on the importance of family planning has increased at all levels. The contraceptive prevalence rate has risen from 20 per cent to 28 per cent the maternal mortality is beginning to decline. Other programmes are still in early phases.

What are lessons learnt? Recommendations to others

Governments should ensure coordination and systematic scale of effective interventions to ensure equity and focus on universal coverage. A rights-based approach to programming has been practiced in some instances. However, further capacity needs to be built at country levels.

Experience has shown that community involvement in governing health services is increasing community awareness and demand for services. It also turned out that information, education and communication as well as behaviour change communication interventions and campaigns have a major role in awareness-raising on reproductive health rights, including the right to services.

When it comes to the mobilization of financial resources, for reasons of sustainability it is recommendable to mobilize resources from multiple sources. Furthermore, in financial resource mobilization costing services and strategic plans are key steps.

Acknowledging the role of civil society and work in partnership with them to deliver services helps to reach out to more vulnerable groups. It also is important to take into account to work with other sectors, understanding that solutions to ensuring sexual and reproductive health and rights are multisectoral. Last but not least, advocacy to policy and political leaders also has supported progress. ■

Case study – Tanzania

Working Group on good practices

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Input 2 – Donor Representative

Individual, leadership and contextual factors leading to action

Most important is

- Recognition of the range of human rights that combine to make up "reproductive rights".
- Identification (as in the World health report 2008) of policies and laws acting as barriers to the availability, accessibility, acceptability and quality of sexual and reproductive health services (whether for the entire population or only for certain population groups), as an area of serious area of concern.
- Incorporation of human rights in diverse ways into the approaches used to address sexual and reproductive health, as well as other health issues including the provision of essential medicines, HIV/AIDS and child health.

Organizations are developing and applying a rights-based approach to sexual and reproductive health programming. These organizations include United Nations agencies such as the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA), and nongovernmental organizations such as CARE and Save the Children. They generally focus on three key principles

- participation of affected communities;
- ensuring discrimination does not occur in programme design or implementation;
- existence of accountability mechanisms.

Some organizations simply invoke these principles; others have used human rights as a conceptual framework for their actions; and still others have developed a checklist of actions tied to specific norms and standards. Taken together, this diversity has resulted in varied interpretations of what these linkages mean in practice, as well as raised questions about the practical value of human rights for improving population health.

Obstacles to action? How to overcome them.

Lack of awareness on side of duty bearers as well as right holders:

– Duty bearers: Health care service providers as duty bearers are often not aware of their obligations as professionals, e.g. medical ethics and code of conduct; or of their clients' rights or the existence of the patient charter, e.g. to privacy or have access to gender-based violence services.

– Right holders: A perception of reproductive health as a service that the government is encouraging to use, but not an entitlement of each individual to claim, has contributed to emphasis on the supply rather than on the demand side, with people understanding information about services as a request for them to use these services. In contrast, a human rights-based approach suggests that people are entitled to evaluate available resources in view of their needs, and to communicate to the government how to modify resources to better meet those needs. When it comes to family planning, the process of choosing a family planning method is viewed as complicated, as right-holders/clients often do not understand the associated biological issues and are inclined to ask providers to choose a method for them.

Lack of adequate responsiveness to diverse needs:

The diversity of needs could be addressed through different service delivery approaches; however, a lack of strategies for effective partnerships with non governmental organizations, community based organizations or the private sector (such as public private partnerships) limits the potential to address the diversity of needs at the local level.

Legal, policy and regulatory barriers exist both within and outside the health sector:

Even though Tanzania has ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and is therefore being committed to eliminate violence against women, the legal and policy framework is not yet appropriate and does not translate into action easily:

– Lack of sufficient data indicating the extent of the existing barriers and a systematic analysis of which groups of women are mostly affected. Also weaknesses in the existing health information systems to capture improvements in health status still exist.
– Lack of sufficient expertise in reproductive rights at all levels and of priority given to these issues by the Ministry of Health and Social Welfare. Also, the ca-

pacity of the government's implementing partners in a reproductive rights and human rights-based approach to health is weak. Only limited resources have been devoted to strengthening them.
- Despite a decentralization reform, few mechanisms for peoples' participation in policy and decision-making, such as community based organizations or civil society organizations involvement, exist. Both government and communities are reluctant to join hands.
- Lack of effectiveness to translate an increased awareness of policy and legislation into reform and to communicate adequately with lower levels where these reforms should be understood and implemented. Lack of sufficient monitoring and evaluation to assess effectiveness of implemented interventions.
- Weak documentation and analysis of lessons learned or good practices which lead from pilot approaches to scaling up into a coherent programme approach within the sector wide approach to health (SWAP).
- Lack of adequate resources for scaling up innovative approaches.

Has action improved health? Has it been sustained?

By drawing on the principles of human rights to guide policy, programme design and service delivery, reproductive health programmes can protect clients and increase effectiveness. In Tanzania, for example, this has led to improved access to comprehensive sexuality education, in addition to confidential and youth friendly sexual and reproductive health services.

In collaboration with young people and other stakeholders, the Tanzanian German Programme to Support Health (TGPSH) supports the Ministry of Health in a comprehensive approach to sexual and reproductive health and rights and HIV prevention. Print and audiovisual materials have been developed on different subjects, including reproductive rights, contraception for young people, how to avoid pregnancy after having unprotected sex, "Girls! If you don't want to get pregnant" as well as a booklet for albinos, their friends and families. Social marketing of condoms and a bilingual interactive web site are supported so that young people can request information about their health. See www.chezasalama.com ("chezasalama", Kisuaheli for "play safe").

The development of comprehensive policies, guidelines and standards for adolescent friendly health services has been supported. These serve as guidance for the many stakeholders involved in adolescent health and development. Initiatives to reach young people, including those with special needs, are mainstreamed into broader plans. In HIV prevention, orphans and vulnerable children (OVC) are reached out to with sexual reproductive health information and services which address the wider context including socio-cultural factors, gender considerations and rights aspects. Youth specific interventions include school based peer education which is delivered as extra-curricular activities, supported by counsellors, teachers and the communities' involvement to ensure support, sustainability and ownership.

What are the lessons learnt? Recommendations for others?

There are some important lessons learnt that can contribute to improving sexual and reproductive health and rights of Tanzanian women and men throughout the life-cycle.

Understanding state obligations

Men and women have to know about the governments' obligations in relation to sexual and reproductive health. Based on this knowledge, recommendations can be formulated to amend laws. Referring to human rights standards can help to lift discussions out of possibly entrenched positions on topics such as sex work, abortion and adolescents' access to information and services. Human rights concepts can be systematically internalized and then be translated into practical actions and decisions. Well intended policies are not always disseminated sufficiently or, if they are disseminated, they are not discussed and agreed upon. As a result, the policies and guidelines may be excellent but they are not translated into practice and can often be implemented wrongly.

Vulnerable groups

The discrepancy in health status among different population groups in Tanzania is recognized. However, only few, if any, mechanisms exist to systematically take into account the needs of vulnerable or marginalized groups in laws, policies and strategies for sexual and reproductive health. While stakeholders can easily identify vulnerable groups, it is often extremely difficult to find data about the health status of these groups. There is also lack of responsiveness of a legal and policy framework to address the needs of the identified groups, such as men who have sex with men or sex workers.

Involving other sectors

The involvement of ministries other than the Ministry of Health, such as the Ministries of Justice, Education, and Finance will help broaden the understanding of the barriers that have a negative impact on effective service delivery and to create consensus for and ownership of proposed actions. For example, while universal access to education is guaranteed in international conventions ratified by the state and in national law, pregnant girls are still expelled from school and efforts from activists for re-admission are still meeting deaf ears.

Civil society participation

Civil society organizations, and particularly the women's groups, help to ensure that the needs and rights of vulnerable girls and women are prioritized, and that barriers which might not be immediately apparent to government actors are recognized and addressed. ■

Case study – Tanzania

Working Group on good practices

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Input 3 – Non State Actor

Fit for future: A rights-based response to sexual and reproductive health and working conditions for girls in the informal sector

Introduction

Tanzania is to be classified as a young nation. According to the population census 2002, Tanzania's population was 34,443,603 people. With an annual growth rate of 2.3 percent, it is estimated that the country's population is now approximating 40 million people. Of this population, 55 per cent are under 25 years old. 25 per cent of the population is 10-19 years old; over 30 per cent are aged 10-24 years (2002 Census). Being the driver of current and future development, a healthy youth will ensure sustainability of the social, economic and political development. The Tanzanian government has invested heavily in education, health and infrastructure among others. Civil society organizations in the country work to accomplish the work of the government, especially in areas where the public is underserved or needs have been identified.

Youth and informal sector employment

On average, 650,000 people enter the labour market for the first time every year (2003 Economic Survey). Since formal jobs are few, most of the new job seekers find employment in the informal sector.

Of all the new job seekers, more than half are youth, aged 15 to 29 years. 3.5 per cent of the youth aged 15 to 29 years are employed in homes as security guards, domestic workers and gardeners. Others are in transport, agriculture, bars and

small scale mining (German Foundation for World Population has worked with youth in employment within informal small-scale mining at Mererani in Tanzania for the last five years). Though characterized by ease of entry, most informal sector jobs are associated with low incomes and unfavorable working conditions. This leads to a significant amount of youth migration and various efforts to supplement the low incomes earned in the informal sector.

Informal sector employment and sexual reproductive health

Some of the efforts to supplement income push some of the female youth within the informal sector to engage in risky behaviors including early debut into sexual activity, transactional sex, multiple sexual partners, cross generational sex, unprotected sex and prostitution. This increases their vulnerability to adolescent pregnancy and child bearing, complications of unsafe abortion, sexually transmitted infections and HIV/AIDS (Adolescent Health and Development Strategy, 2004 – 2008).

Fit for future: A rights-based response by DSW and partners

Informed by its work in the mines of Mererani, DSW in partnership with the Family Planning Association of Tanzania (UMATI) and the Tanzania 4H Organisation designed a rights-based project to address working conditions and sexual reproductive health needs of girls working in the informal sector. The goal of the action is to contribute towards poverty alleviation through enhancement of socio-economic status of working female youth. Immediate objectives are: (1) reduction of incidences of HIV/AIDS and sexually transmitted infections (2) improved access to sexual and reproductive health information and youth friendly sexual and reproductive health services (3) sustainable economic empowerment of female youth working in informal sector and (4) improved awareness and working conditions for female youth within informal sector work.

The project target is to directly reach 165,000 female youth in the three regions of Arusha, Kilimanjaro and Tanga. The three regions form part of the northern circuit of Tanzania, with a combined population of 4,316,137 (Census 2002) and a current population of approximately 5,110,306 at a 2.3 per cent annual growth rate.

Main achievements

- The project has support from nine district councils within the working clusters. The nature of support is stipulated in the memorandum of understanding (MoUs).
- Establishment of 90 female youth clubs. Each youth club has a minimum of 30 members totalling to 2,700 members. The clubs offer a unique space for the girls to provide peer support, solidarity and guidance on sexual and reproductive health and economic issues.
- Training of 72 health service providers on provision of youth friendly services.
- Strengthening provision of adolescent sexual and reproductive health youth friendly services in nine project clusters.
- Strengthening of six voluntary counseling and testing centres to provide adolescent sexual and reproductive health youth friendly services.

- Working with established companies in areas such as floriculture, textile and small scale businesses to improve working conditions and access to sexual and reproductive health services.
- 900 youth with sexual and reproductive health complications referred and assisted to get specialized medical services.
- Withdrawal and support for female youth in abusive work environments and those at risk for vocational training and placement in schools for education. (Assistance of 240 girls in total)
- Provision of sexual and reproductive health education, training and services to workers in plantations; in partnership with the Tanzania Horticultural Association (TAHA).
- Provision of sexual and reproductive health education, training and services to employees at the A to Z textile company (the company has over 7,000 workers, most of whom are working casually/temporarily).
- Working with bar, guest house, restaurant and other small business owners to provide sexual and reproductive health supplies, education and services to workers.
- Conducting outreach education works in informal sector concentrated areas.

Lessons learnt

- Working with employers is not easy. They are suspicious that your intention of working with youth is a covert way towards agitation for better salaries or unionisation. You have to address working conditions on periphery and concentrate on sexual and reproductive health before you can build adequate confidence to address working conditions and terms.
- Flexibility in meeting needs is essential – though the project was designed for support to single girls, some girls have children and could not be discriminated against on this basis. However, supporting them had to include child support as well.
- Community participation is important when it comes to the realization of needs of vulnerable groups, especially regarding youth in the informal sector. Some of the examples of how community support is demonstrated include:
  a. 'Ukiwa na Ubinafsi ni Uadui – Isolationism and Individualism is an Enemy Youth Club' at Mto wa mbu, where the village government gave the club financial and other support in a public fundraising.
  b. 'Mkombozi – Saviour Youth Club' – at Karanga in Moshi has been granted a meeting room to conduct its meeting by the village government.
  c. 'Mapinduzi – Revolution and Juhudi – Effort Youth Clubs' at Sanya station have been given plots by the community for horticulture.
- Conditions to access credit from existing microfinance institutions are not youth friendly.
- Life skills that improve decision making, communication and assertiveness in sexual and reproductive health are integral interventions targeting youth.
- Participation of key agents such as parents, teachers and religious leaders is crucial for the sustainability of sexual and reproductive health.
- The fundamental principals of work, especially decent work, are not easy to

attain in conditions where unemployment is high. This was demonstrated by the opposition to the labour institutions order, 2007 (regulation of wages and terms of employment), which were made to revise the old, minimum wage (TSH 48,000 for urban and TSH 35,000 for rural areas) with minimum wage for each sector (ranging from a low of TSH 65,000 to a high of TSH 350,000).

Recommendations

- Youth have special needs and can be supported and guided to establish their own savings and credit organizations (SACCOS).
- Government commitment to universal access to education for levels such as secondary school needs international support.
- Commitments to poverty eradication must be matched with resources – shifting of donors.
- There is need to integrate education, vocational skills training and support for income generating projects (IGAs) in projects targeting youth in areas where rights are violated.
- A project targeting out of school girls should have a child care component as some will have children or be pregnant due to rights violations.
- Youth friendly services depend on training of service providers and support of health facilities with equipment and supplies.
- The justice system should handle violations of girls' rights speedily to ease pain and restore hope in life.
- Advocacy for improvement of working conditions must be both participatory and decentralized.
- Life skills training – on issues like assertiveness and communication – empower the girls' decision making. ■

Case study – Burkina Faso

Working Group on good practices

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Permant Secretary of the National Committee of Fight against the Practice of Excision, Burkina Faso

Input 1 – Government Representative

Good practices from Burkina Faso: The example of promoting the abandonment of female genital mutilation (FGM)

Introduction:
Justification of the choice of the subject: "promoting the rejection of female genital mutilation (FGM)"

- Prevalence of female genital mutilation: It is estimated that up to 77 per cent of women aged between 15 and 49 in Burkina Faso are excised (Demographic and Health Survey, 2003). According an evaluation report of the National Committee's of Fight against the Practice of Excision (CNLPE) interventions from 1990 to 2005, this rate would be 49.5 per cent for women from 0 to 60 years and more.
- Female genital mutilations, due to their nature and their harmful consequences, affect several rights such as the right to physical integrity, to a fulfilled/joyful sexuality, to reproductive health as well as the right to life; because sometimes, the victims lose their lives because of the extreme pain or infections they cause. Article 4 of the Maputo Protocol recognizes that "Every woman has the right to respect for her life, physical integrity and security of her person".
- Female genital mutilation violates the rights to liberty and security which are fundamental rights of women, especially since they are mostly practiced on young children who have neither the opportunity nor the capacity to oppose and to defend themselves.
- Female genital mutilation is a violence offending the dignity of women and young

girls in that it concerns the woman's most intimate parts, namely her genitals.
- Female genital mutilation poses a threat to the reduction of infant mortality and safe motherhood (as advocated by the goals 4 and 5 of the Millennium Development Goals) because they can cause serious complications during childbirth and post- partum.
- The Burkinabé government has an obligation to achieve the realization of the right to the highest attainable standard of health because it has ratified international and regional commitments, including: the International Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child (CRC), the African Charter on Human and Peoples' Rights and the Protocol to the African Charter Human and Peoples' Rights on the Rights of Women in Africa (known as the Maputo Protocol).
- Also, sections 1 and 26 of the Constitution of Burkina guarantee the right of everyone to life and health. Furthermore, Article 2 states that "The protection of life, safety and physical integrity is guaranteed".

What individual, leadership and context factors led to action?
- Movements and associations of women in Burkina Faso aware of the harmful consequences of female genital mutilation who led advocacy and lobbying towards political and administrative leaders.
- Policy environment is favorable to promoting women's rights and equality between women and men.
- The Burkinabé government created the National Committee of Fight against the Practice of Excision (CNLPE) in 1990 and designed and implemented national action plans.
- Awareness-raising activities and campaigns have been undertaken by the civil society (non governmental organizations, community based organizations, associations, etc.) and public services (health, social welfare).
- Adoption of a law to ban this practice in 1996, followed by its application.

Obstacles to action and how these were overcome
- Families and individuals perpetuate female genital mutilation in the belief that it is what their social group expects of them and that it is for the sake of their daughters.
- Some traditional and religious authorities are in favor of the practice.
- The weak decisive position of women in the family: The man decides! However, the man is not targeted enough by information, education, and communication (IEC) and behavior change communication.
- There are neighboring countries which have no law prohibiting the practice or do not apply it rigorously when it exists; this is an obstacle to changing the behavior of families living on both sides of the border and could lead to cross-border practice.
- Men's desire to control female sexuality.

How these obstacles were overcome?

Conducting studies to better understand the foundations, analyzing strategies and opportunities for reorientation of interventions.

- The development of innovative approaches based on studies for more effectiveness.
- Developing and implementing a national action plan 2009-2013 with the support of international partners.
- The multisectoral approach involving several ministries, civil society organizations, traditional and religious leaders.
- The offer of medical intervention for victims of after-effects ("sequelae") of female genital mutilation.
- Increased pressure from the law on authors and accomplices of female genital mutilation.
- Establishing and supporting networks of associations, non governmental organizations, journalists and religious organizations to strengthen their capacity and autonomy of action.
- The personal commitment of the head of state of Burkina Faso who has decided to provide the leadership of the elimination of the practice of excision in Burkina Faso: He made an official statement on the 10th Memorial Day of the fight against the practice of excision in May 2009. A few citations: "An improved legal and social status of woman, her ability to access to knowledge, health advances, but also and especially the protection of her physical integrity, constitute a prerequisite to her full development and self-fulfillment." "Far from being a rejection of our customs and traditions, promoting the elimination of female genital mutilation reflects the will of the state to ensure the full development of an important component of our nation."
- The intensification of information, education and communication activities (IEC) and behavior change communication (BCC).
- Teaching modules on the harmfulness of female genital mutilation in primary and secondary schools.

Has action improved health? Has it been sustained?

Health improvement

- There is a reduction of the prevalence of female genital mutilation amongst girls from 0 to15 years, allowing them to avoid the adverse effects of the practice. Women who undergo female genital mutilation are significantly more likely to experience a caesarean section, postpartum hemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the newborn, and inpatient prenatal death, than deliveries to women who have not undergone female genital mutilation. These statistics are taken from women who could afford care and hospital for women who give birth at home. Postpartum hemorrhage and obstructed labor are likely to have more serious results outside hospitals.
- The strategy informing the population on health risks which the practice of female genital mutilation entails as well as offering medical treatment for cases of "sequelae" contribute to resolving health

problems of women and girls associated with female genital mutilation and improve their quality of life. From 2006 to date, more than 1,000 cases of "sequelae" of female genital mutilation have been supported by 154 physicians, obstetricians, gynecologists, surgeons, trained in the technique of repairing "sequelae".

– Teaching modules on female genital mutilation in schools is a service offering information on its harmfulness, its prevention, the promotion of rights in sexual and reproductive health of children, adolescents and youth belonging to future generations (the right to access information and services needed to support the rights to bodily integrity).

Sustainability

A sustainable improvement of health is ensured and proved by:

– The adoption of a National Action Plan 2009 – 2013: Promoting the Elimination of Female Genital Mutilation, in perspective of "Zero Tolerance".
– The increased funding of the government by increasing the budget allocated in favor of eliminating the practice of female genital mutilation.
– A strong commitment of international partners to support government efforts to eliminate this practice violating the rights of women and the set up by technical and financial partners of a basket funding of the national action plan.

- The involvement of religious, traditional and political leaders.
- Since 1996, a national law prohibiting the practice of female genital mutilation provides a legal frame for expression for the defenders of the physical integrity of girls and women.
- The synergy of action by all partners under the supervision and coordination of the Permanent Secretariat of the National Committee of Fight against the Practice of Excision (CNLPE).
- The integration of the teaching modules for the abandonment of female genital mutilation in vocational training centers for teachers guarantees the scaling up into the school system.
- It also promotes a change in long-term behavior in children, adolescents and young people and leads to a total abandonment over time. It prepares future generations to adopt attitudes of rejection of female genital mutilation which are sustainable because passed from generation to generation.
- The enhancement of communities and networks capacites ensures continuity of activities and promotes sustainability of effects (elimination of female genital mutilation).
- Female genital mutilation is no longer a taboo subject: It is discussed publicly and openly.

Lessons learnt

- The abandonment of entrenched practices such as female genital mutilation requires long-term actions at different

levels (political, community, etc.) with diverse approaches and adaption to the local context.
- An effective strategy for advocacy and lobbying led by credible and deeply committed individuals against the practice of female genital mutilation allows the indispensable involvement of community leaders and politicians for effective social mobilization and real political commitment.
- Strong political commitment, a clear legal framework (laws and application texts) and a coherent national program increase the effectiveness of the fight against female genital mutilation.
- The leadership of the fight against the practice of female genital mutilation at the highest level is a factor of resource mobilization.
- Repair of "sequelae" of female genital mutilation is a health service offer that gives back hope to the victims and is an opportunity to educate, inform and raise awareness among their family and friends.
- The national leadership can trigger a ripple effect on the international level: At the 65th United Nation's General Assembly starting on 14 September 2010, Burkina Faso, through its head of state, will introduce a resolution to ban the worldwide practice of female genital mutilation. Several African countries support this initiative.

Recommendations

- Intensify advocacy in countries where there is not yet any leadership of the high authorities of the state in order to promote its emergence.
- Allocate necessary funds and resources (by development agencies and states) to support the implementation of action plans.
- Encourage and support initiatives and interventions of the civil society to strengthen its capacity for action at communal and local level, as well as its role as counterbalance and for lobbying for the adoption and enforcement of laws relating to sexual and reproductive rights.
- Accompany interventions with baseline studies and monitoring to provide evidence of effectiveness. ■

Case study – Burkina Faso

Working Group on good practices

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Input 2 – Donor Representative

Making sexual and reproductive rights a reality: What does it take?
The donor's perspective:

KfW Entwicklungsbank (Development Bank) is the implementing institution of the German government's financial cooperation programmes. Our involvement is in line with the principles of the German government, which has made an international commitment to help achieve the goals set forth in the UN Declaration, in the Monterrey Consensus and in the Paris/Accra Declaration.

Sub-Saharan Africa is the regional priority of German development cooperation with about 40 per cent of commitments from budget funds each year. Within our cooperation, improving health care is one of the priority areas. We have a clear focus within our health projects support in Africa on reproductive and sexual health and rights of women and girls.

KfW Entwicklungsbank has been assisting the government of Burkina Faso in the fight against HIV/AIDS since the mid-90s, adding support to family planning and against female genital mutilation in 2006 (totalling close to EURO 30 millions). The Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) has an equally long-standing support regarding family planning and action research for improved quality of sexual and reproductive health services with a focus on young people and, since 2004, a programme on sexual health and human rights. The most active other donors with regard to sexual and reproductive health rights in Burkina Faso are the United Nations Chil-

dren's Fund (UNICEF), the United Nations Population Fund (UNFPA), and the governments of the Netherlands and Denmark.

What individual leadership and contextual factors led to action?

What can other countries learn from Burkina Faso? First of all, it is national ownership that is crucial for all development successes. The fact that we have an organization like the one Ms. Sawadogo is representing, namely the Comité National de Lutte contre la Pratique de l'Excision (CNLPE) is already a clear sign of such a national ownership. At the same time, Burkina Faso was among the first African countries to ban female genital mutilation by law already in 1996. It is punishable by up to ten years in prison and by substantial fines. Human rights are assured by the constitution of Burkina Faso and there is even a Ministry for Human Rights. There is a similarly encouraging picture regarding HIV/AIDS: with a strong national lead through the Secrétariat Permanent du Conseil National de Lutte contre le SIDA (SP/CNLS) and non governmental organizations such as the Projet de Marketing Social des Condoms (PROMACO). As concerns safe motherhood and family planning for all, the role of non governmental organizations such as the Association Burkinabé pour le Bien-Etre Familial (ABBF) or Mary Stopes/Burkina Faso can not be over-emphasized. The opening up of the health sector to work with such civil society structures, for instance in the framework of the health sector basket PADS (health development support programme) is a positive sign.

In addition to that, it is of course also the individual ownership of the people in charge that

carry the ideas of reproductive rights forward and make the whole effort successful.

What were obstacles to action? How were these overcome?

There are huge obstacles in each country and of course also in Burkina Faso. A human rights-based approach comes to its limits where it clashes with traditional beliefs and practices and where social norms override individual rights. One alarming tendency that we can see in Burkina Faso is that families tend to let their baby daughters be circumcized very early so that the cutting can remain unnoticed by the community. We also see families letting their girls being circumcized abroad where it is still legal. The only way to overcome these obstacles is the intensification of the dialogue with all groups of the society including religious leaders.

Has action improved health? Has it been sustained?

There are clear signs of improvements and we hope that they can not only be sustained but even improved further. Prevalence of female genital mutilation in Burkina Faso has dropped from 77 per cent in the 1990 to less than 50 per cent among women 15 to 49 years old in 2005.

We also see other successes in Burkina Faso with regard to health indicators. Even though some of the Millennium Development Goals will most probably not be met by 2015, Burkina Faso was able to reduce mother and infant mortality, HIV prevalence and contraceptive use considerably during the last years. A clear national leadership, focus on health issues and poverty reduction as well as political stability has made this progress possible. There is an urgent need now to concentrate further on the implementation of the national strategies and keep focussing on the set goals.

What were lessons learnt? What are recommendations for others?

From our experience in Burkina Faso and other countries, we would like to propose the following recommendations:

- We need a broad definition of sexual and reproductive rights including the right to decide freely on all aspects of sexuality. These rights have to be made known both to the right-bearers and to those who are crucial for their realization.
- National ownership is crucial for success and has to go beyond the formulation of strategies and laws. Their implementation is equally important and needs strong partnerships with civil society including private sector and international partners.
- We need to intensify the dialogue with all groups of society about sexual and reproductive rights. This has to happen at multiple levels starting from men and women in their communities, traditional and religious leaders, service providers and journalists to politicians and office bearers.
- We need to think in a long term perspective. Behavioral changes cannot be expected overnight and changes in social norms are hardly achieved within one generation. ■

Case study – Burkina Faso

Working Group on good practices

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Input 3 – Non State Actor

Introduction

Sexual and reproductive rights are a fundamental right that must be recognized to everyone, regardless of gender, academic standard, political, religious and ethnic affiliation, and sexual tendencies. What have we done as a civil society organization to facilitate and/or make these rights a reality? What were the difficulties, the results we have achieved and lessons learnt from this experience? Those will be the main lines of our announcement.

Individual factors that led to an action

We have personal predispositions to mention services access to teenagers and young people and also the access to safe abortion: When in 11th grade, without any specific training apart from some presentations given by teachers (in 9th grade) on sex education, I asked for a discussion and was allowed to discuss various subjects with my classmates like: relationships between boys and girls, sex education. At this time, I was already convinced of teenager's rights to sexuality information. Besides, this made at this time my academic guidance by the Headmaster easy. All I did was following his advice without really participating to the choice. The second individual factor is the sudden and tragic death of a classmate caused by an induced abortion at the same time in my 11th grade. From that time until maturity, I used to ask myself: why?

Factors related to leadership and context that led to an action

The Family Planning Association of Burkina Faso (FPAF) is an association founded in 1979. Since then, it works on health and ful-

fillment. Its view is "The advent of a society in which the population in general, teenagers and young people especially enjoy full use of their rights and sexual reproductive health services of quality and are responsible for their sexual life; a society in which FPAF is leader in the matter of sexual reproductive health." Some values that underpin the mission and view of FPAF are key factors. Some of these values are:

- Innovation and creativity spirit
- Taking a pioneering role where others are reluctant
- Being a Model
- Risk and courage
- Taking into account the needs of young people
- Pursuit of customers satisfaction

This individual and collective will in the level of the executive management and governance helped to integrate in the 2005 – 2009 strategic plan an intervention in matter of abortion, but it always remained an ambition in a context in which the subject was rarely mentioned. The innovation and creativity spirit, the pioneering role where others are reluctant and the spirit of risk and courage led to an intervention in the domain of abortion in the innovation fund in 2005. Unfortunately, this intervention was unsuccessful. It is only in 2007 that a fund for a PCCA project was provided by a special fund of the International Planned Parenthood Federation (IPPF). The intervention has a favorable legal context to the action: access to complete abortion services; post abortion care as a full component of sexual and reproductive health.

Some elements of this political and legal context that led to action

- Burkina Faso signed international agreements (Convention on the Elimination of All Forms of Discrimination against Women, ratified in November 1984; international treaties on civil and political rights on one hand and social and cultural rights on the other hand, ratified in September 1998), regional agreements (African Charter on Human and Peoples' Rights, ratified in September 1984; draft agreement on the African Charter on Human and Peoples' Rights relative to Women Rights in Africa or Maputo Draft agreement, ratified in 2006).
- Burkina Faso has laws authorizing abortion (even if restrictive). Voluntary termination of pregnancy is not authorized but termination is allowed when a pregnancy endangers the life of the mother. The fetus carries an incurable stigma in case of rape and incest.
- Abortion accounts for about 15 per cent of maternal deaths.
- IPPF provided a technical and financial support to promote access to safe abortion services in the programmes of the association.

Barriers to action

- On an individual level: the lack of motivation of providers to make the right decision on time in the starting of the action.
- Cultural barriers: the social and cultural context with the burdens of cultural and religious orders, stigma and silence, conscientious objectors.
- On the legal level: restrictive laws and regulations, long procedures to services.

- On the economic level: poverty of the population sometimes unable to afford the costs of the post abortion care.
- On the political, structural and health levels: unskilled health personnel lacking knowledge about the issue of post abortion care, lack of the drugs used for medical abortion. Even in cases where an abortion is not against the law, there often are no guides and standards for services and no national programme concerning the specific issue of post abortion care.

How were they overcome?

The objective of FPAF was as part of this intervention to increase the access of girls and women to complete abortion services as part of the legislation in force in the country and not a plea for law changing. Thus, the actions taken to overcome barriers to this access were:

- Values clarification remaining a safe, universal and efficient way to "be better understood in order to be better supported in the fight". Values clarification group discussions were organized on all levels: service providers, governance, young people and peer educators, partners.
- Service providers training on various aspects: post abortion care including manual vacuum aspiration (MVA), medical abortion, contraceptive technology.
- Creation of a network of service providers in partnership with 50 private organizations and public health groups as references and undertaking cases.
- Partnership with the Association of Women Lawyers and experts in order to work out a document describing the procedure to safe abortion access in accordance with the law.
- Establishment of a free care system for those who can not afford the costs of services because of their poverty.
- Undertake actions with the central and regional office of IPPF for the acquisition of the drugs used for medical method.
- With the technical support of IPPF, elaboration of a communication plan about the domain: identification of strategies, working out of suitable messages and media, consciousness-raising of targets concerned.

Did the action make improvements as far as health is concerned? Is it sustainable?

- Yes, the action brought improvements on health level. In a context mined by obstacles, Family Planning Association of Burkina Faso was able to provide abortion services to patients from July 2008 to June 2010. In three services providing areas: 97 cases of therapeutic abortion, 405 cases of incomplete abortion treatment and 399 cases of post-abortion contraception.
- Enhanced engagement of the association managers, which now claim to be a champion defender of the rights of women and girls for complete abortion services in accordance with law; which was not actual at all levels at the starting of the project.
- Firm resolution to extend the services to all the clinics of the association. Firm resolution also to commit in a process of advocacy for the decriminalization of abortion in Burkina Faso in its 2011-2015 strategic plans, if the financial resources are available.
- Service providers feel confident to offer the services.

Lessons learnt

Access to complete abortion services and post abortion care provided to women and girls improves the quality of life and helps to save lives.

Family Planning Association of Burkina Faso (FPAF) as a structure of the civil society is often in a vanguard of its commitment to improving people's health in general and women's and young people's in particular. Like all civil societies, it contributes and does not substitute the state because it is not able to serve the whole country. Abortion is a recurrent problem that deserves a special attention, a will and a political commitment, a community membership for not only expanding post abortion care services in basic health centers but also make integrated abortion services taking into account preventive pregnancy, the effective offer of abortion services in accordance with law and post abortion care.

Medical abortion without replacing other methods seems to be more convenient for service providers and better tolerated by recipients but the drafts agreements at national level are still being worked out.

Recommendations

- Popularization of the law at the population, legal practitioners and the health professional's level for a better enforcement.
- Carry out a study on the extent of the problem at national level in order to provide data to use for advocacy.
- Produce and bring into play an advocacy plan for the decriminalization of abortion in Burkina Faso.
- Make a plea to the political authorities for the working out and implementation of a national programme on the specific issue of post abortion care like the Prevention of Mother to Child Transmission (PMTCT), the Family Planning (FP), the fight against HIV/AIDS and sexual transmitted infections in the health sector rather than integrating it into the safe motherhood programme which compels its application to post abortion care.
- Speed up the finalizing of medical abortion drafts agreements in the country.

Conclusion

The issue of access to abortion is valued differently depending on countries, groups and social trends, according to personal values that are considered the best. But very often the question is not arisen in the same way when one is directly affected by the problem. The international and regional legal instruments are binding without any distinction in all states that ratify them. For their promotion, they usually have goals like respect for human rights in general and women's rights in particular.

The states that ratify a convention or treaty are obliged to ensure the respect of these international and regional laws internally in accordance with the international and regional instruments ratified and by providing penalties for their violations. Why to be silent when people are punished for requesting or providing services the law allows? Why to be silent when people intentionally obstruct the access to these services by procedural barriers? Is it not worth to save the one who gives life? Live giving is an act of love. Let us act in such a way that it becomes planned, desired and accepted. ■

Case study – Colombia

Working Group on good practices

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Input 1 – Government Representative

(given by Patricia Dávila de Navas)

The sexual and reproductive rights situation in Colombia

Since 2003, Colombia has been implementing a National Policy on Sexual and Reproductive Health based on the mandate of the International Conference on Population and Development (IPCD, 1994) and the fourth World Conference on Women (1995). Both conferences are based on the major aims of improving the sexual and reproductive health and promoting the full excercise of the sexual and reproductive rights, focusing mainly on the reduction of the vulnerability factors and risk behaviors, the strenghtening of protective factors and the delivery of services for specific groups.

During the process of building a public policy on the matter, Colombia had to promote scientific, philosophic, ethical, moral and religious discussions from relevant opposite directions. The goal was to build a social consensus among many social, political and scientific parties towards human, sexual and reproductive rights. A strategic alliance has been consolidated and has become the basis for the following interventions:

1. Education for sexuality and citizenship. A programme of the Ministry of Education and the United Nations Populations Fund (2006) that involves the whole school community and promotes the development of basic and citizenship habilities, gender equity, participation, peaceful coexistence and excercise of sexual and reproductive rights. Since 2006 until now, the programme has been implemented in more than 1,000 institutions in different regions around the country.

2. The programme of rights promotion and peace building networks. A programme of the national presidency (Consejería de Programas Especiales) which works to strenghtening the social networks in order to implement the National Policy on Sexual and Reproductive Health and to promote the sexual and reproductive rights exercise. Since 2003, it has reached to 243 municipalities of eight focalized departments in critical public order conditions.

3. Information, education and communication strategies to promote the sexual and reproductive rights. The strategies are made to improve the awareness, to refer to services and to give information to the most vulnerable groups and to service providers. The strategies are focalized and segmented using mass and alternative media.

4. Friendly health services for adolescents and young people have been developed since 2007 by the Ministry of Social Protection along with the United Nations Populations Fund (UNFPA) in order to reduce access barries to comprehensive services for physical, sexual and reproductive health of young people. Up until this day, Colombia has 559 services of this kind in 445 municipalities of 21 departments.

5. Programmes to guarantee safe maternity have been developed too, improving management habilities of the service providers and intervening on some of the social and cultural determinants of maternal mortality.

6. In order to keep the HIV prevalence rate under 2 per cent, HIV/AIDS and other sexually transmitted diseases' prevention and care actions have been possible through the implementation of the Management and Programmatic Model, the Guidelines for Comprehensive Care and the National Response Plan on HIV and AIDS (2008-2011). These tools have improved the surveillance of blood transmissions, the guaranty of blood quality, the National Observatory on HIV and AIDS, the "Integra" Strategy, the aim of universal access to antiretroviral therapy (today in 80 per cent) and the National Programme on Mother-to-Child Transmission.

7. The domestic and sexual violence prevention and care programme has a strong legal framework and is implemented by an interinstitutional network in which participates among others the general attourney, the human rights bodies, the family welfare institute, the forensic institute, the national police and the education and social protection ministries.

Although Colombia has made many achievements in the field, there are barriers that remain and limit the full exercise of sexual and reproductive rights. Populations are still unaware of their rights and responsabilities on sexual and reproductive matters, there is resistance to apply the guarantee of rights-based on ignorance, denial, prejudice or on conscientious objection grounds. The personnel is not trained enough to properly treat sexual and reproductive health under a comprehensive and rights perspective, and also to advice on contraceptive methods and voluntary abortion in cases where the law allowed it (sentence of the constitutional court C 335 2006), among others. ■

Case study – Colombia

Working Group on good practices

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Input 2 – Donor Representative

The governmental partnership in Colombia to guarantee sexual and reproductive rights of youth

Despite the important fertility decline in Colombia, with reductions in the total fertility rate from 6.7 children per woman in 1960 to 2.4 children in 2005, teenage pregnancy rates and birthrates have increased substantially. The specific fertility rate among women aged 15-19 years has risen from 70 per one thousand in 1990 to 90 per one thousand in 2005. According to the National Demographic and Health Survey of 2005 (Profamilia), one in five women under 20 has been pregnant at least once.

The government and civil society have recorded this growing trend with concern, in view of its strong link with urban poverty and its effect on intergenerational transmission of poverty. Although early pregnancy used to be a rural phenomenon, it has shifted to large cities due to internal displacement generated by the armed conflict that for decades has affected the country. This trend exacerbates the lack of opportunities that urban youth face and has restrained them from progress and development.

These circumstances have led the national government to revise its strategies and to design policies and programmes that can break the development described. This paper provides an overview of the evolution of these policy changes, especially those that United of Nations Population Fund (UNFPA) has had the privilege of supporting both technically and financially.

In 2003, the Ministry of Health formulated a National Policy on Sexual and Reproductive Health (SRH) with rights-based and gender approaches. This policy includes action lines that promote safe motherhood and family planning, and aim to reduce unwanted pregnancy, especially among adolescents, sexually transmitted diseases and AIDS, and gender based violence. Although this policy was prepared within the health sector, it was received and adopted by other institutions belonging to the education, justice and protection sectors.

Under the umbrella of the Sexual and Reproductive Health Policy, each sector has been adapting its programmes seeking effectiveness. But not only have these sectors revised their principles and strategies, they have also placed especial emphasis on the implementation of the National Policy at local levels. Most of the work has been done on the development of capacities of different actors in departments (states) and municipalities. It also led them to revise their institutional competencies and complementarities, seeking to design cross-cutting programmes in the pursuit of a more comprehensive approach.

The health sector (Ministry of Social Protection since 2004) after testing the development and dissemination of standards for teenage care and the development of mass media campaigns aimed at promoting their right to access health services, found that health care units and service providers were not prepared to deliver adequate services to young people. In 2007, the Ministry asked UNFPA to design a model of youth-friendly health services, seeking to overcome existing access barriers, promote demand by young people, and improve the quality of services. During the last two years, dissemination and monitoring strategies have been implemented by the Ministry in order to increase the coverage and quality of these services. Today, 559 youth-friendly health services are in place in 445 municipalities (out of a total of 1,100 municipalities).

Since 1994, Colombian schools are obliged by law to provide sexual education. In 2004, after evidencing the low impact of this programme, the Ministry of Education decided to rethink and build a new model which seeks to modify the previous approach which was limited to presenting biological aspects and the risks associated with sexuality. UNFPA supported the design, the piloting and currently the expansion of the Programme of Education for Sexuality and Citizenship Competencies. This programme aims to create pedagogical practices that promote development of life skills among students, so that they can understand and exercise human and reproductive rights, and thus make decisions that allow them to develop as individuals and live a healthy sexuality, fully and responsibly, to enrich their life projects. Nowadays, the Ministry works with 74 education secretariats and 2115 educational institutions (with pre-schools, primary and secondary levels) strengthening their capacities to implement educational projects that promote the exercise of sexual and reproductive rights. In addition, the programme has developed a training through universities, colleges and other higher education institutions.

The Presidential Office for Special Programmes developed a Programme for the

Promotion of Rights and Peace-Building Networks. Through this Programme, institutional coordination, community organization and local communication strategies have been promoted in 240 municipalities, all combined to prevent early pregnancies and to ensure the full exercise of sexual and reproductive rights amongst highly vulnerable groups.

In 2008, the above mentioned entities formed the Intersectorial Committee on Adolescence and Youth, with UNFPA as the technical secretary. This committee has been established to generate social mobilization and communication strategies to ensure public awareness, political will and cross-sector partnerships to guarantee that adolescents and youth have access to information and services to fully exercise their sexual and reproductive rights. This initiative has had, to a lesser extent, the support of the Ministry of Communications, the ICBF (Colombian Institute for Family Welfare), Colombia Joven (the National Programme for Youth) and the SENA Institute (the institute in charge of informal education and technical training). At the end of August 2010, the former President and his Ministers, aiming to ensure the stability and sustainability of this achievement, in light of the change of government, institutionalized this instance as the "Intersectorial National Committee for the Promotion and Guarantee of Sexual and Reproductive Rights", and assigned its precise functions and responsibilities.

Recently, public opinion was informed of a new ruling by the Colombian Constitutional Court (No. T-388/2009), whereby the Minister of Social Protection and the Minister of Education have the obligation to design and develop a sustainable, continuous and intense campaign to promote sexual and reproductive rights of women and youth, and to inform the circumstances in which abortion may be carried out legally (abortion was recently found to be legal under three specific conditions).

In order to fulfill the legal rulings, and comply with target results of the different agencies, and implement the role given to the commissions, governmental institutions are embarking on an important set of activities that will close my speech. In addition, I intend to offer some reflections and lessons learned from these important efforts. ■

Case study – Colombia

Working Group on good practices

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Input 3 – Non State Actor

Beyond health services, Profamilia Colombia promotes healthy lifestyles and changes the way of seeing and doing things

Profamilia is a private, not for profit organization. Doctor Fernando Tamayo, Profamilia's founder, recognized in 1965 the need for family planning in Colombia, especially among poorer women, and from the beginning, the goal was to promote and defend the right of family planning access.

Colombia's birth rate was among the highest in the world. Women had an average of seven children, and the country's population was rapidly increasing. Thanks to the efforts of Profamilia Colombia, around 25 million unwanted pregnancies have been prevented.

Profamilia was the first organization in Latin America to use radio to promote family planning. It recognizes that men's involvement and participation can make the difference in reproductive health services. In the early 1970's, Profamilia began offering surgical contraception in its clinics, first to men (in 1971) and then to women (in 1973).

Another approach to delivering contraception – social marketing – was initiated in 1973. Profamilia's Contraceptive Social Marketing Programme was part of its non-clinic-based services. Through the Contraceptive Social Marketing Programme, Profamilia supplied contraceptives at subsidized prices to commercial outlets (pharmacies, supermarkets, etc.). In 1976, Profamilia established mobile units to provide sterilization and other services in rural and marginalized areas.

The adolescents programme was started in 1990 and is one of the few such programmes specifically for young people in Colombia. Training peer educators is a key component of this programme which also provides an array of health services.

In 1986, Profamilia launched a Legal Services Programme specializing in sexual and reproductive rights with a gender perspective. Ten years later, Profamilia established the Office for Sexual and Reproductive Rights and Gender in order to study, design and implement institutional policies on these issues.

Since 1990, and with governmental and international cooperation funding, Profamilia has produced a demographic and health survey. In 1991, the new Colombian constitution explicitly recognized family planning as a basic human right. In 1991, Profamilia

advocated to have family planning included in the new constitution. In 2000, Profamilia took a dramatic turn by incorporating sexual orientation in its programmes and services. In 2001, Profamilia started the distribution and sale of the first dedicated emergency contraception product. In 2006, the first LGBT (lesbian, gay, bisexual, and transgender people) community center began operation in Bogotá. Profamilia was part of it. Profamilia Educa, the virtual education project (focusing on gender and rights) was also launched that year.

There are many lessons learned from 12 years of working with internally displaced persons (IDPs) and 20 years of offering services as well as education to adolescents.

Particularly for adolescents, there is a wide range of social, economic, administrative, and geographical barriers. These include under-employment, lack of negotiation skills, lack of knowledge and confidence to exercise their sexual and reproductive rights. Other barriers are violence and rape, sexual exploitation, limited power affecting the adolescents' autonomy and the fact that they are not having any influence in decision-making processes.

In 2009, 19 per cent of the total appointments by Profamilia and ten per cent of Profamilia's diagnostic exams were offered to young people between the ages of 13-24. Additionally, 286,153 planning methods (birth control pills, implants, condoms and injectables) were distributed to young people, which represent an increase of eight per cent from 2008.

Family planning is the most cost effective strategy. It is important and necessary to renew the governmental and international commitment and responsibility to advocate for family planning in Latin America. Family planning is not an issue for our youth and adolescents, but unwanted pregnancy is leading the list of causes for school dropouts.

Family planning has to be part of the international cooperation strategy of reducing poverty and reach development for our countries in Latin America. There still is a long way to go to fulfill the unmet needs for family planning - now more than ever.

Today, 45 years after its establishment, in a land of contradictions and severe social conflicts and tensions, it is Profamilia's commitment to continue the search for ways to improve sexual and reproductive health of the Colombian people. In the focus of attention are especially the most vulnerable, such as youth and adolescents.

Profamilia continues its work to identify the best approaches for increasing family planning for youth. Right now we have used innovative approaches, like using popular Colombian actors and singers as youth advocates. It must be kept in mind, that beyond health services, Profamilia promotes healthy lifestyles. The challenge is to maintain the social mission in a healthy (sustainable) organization. ■

Panel discussion

Summary Panel discussion

The participants of the 8th International Dialogue, as well as other invited external guests, all in all about 100 parliamentarians, experts from NGO, academia and private sector, followed the invitation to attend the panel discussion titled: 'Can human rights improve health?' The venue was the Federal Ministry of Economic Cooperation and Development (BMZ) building, in the Marie Schlei Saal on the 11th floor.

Klaus Müller, KfW Entwicklungsbank, Frankfurt welcomed all of the participants to the panel discussion. The moderator of the panel discussion was Melinda Crane, anchorwoman at Deutsche Welle-TV. The panelists were: Gill Greer, Director General, International Planned Parenthood Federation, School of Hygiene and Tropical Medicine (LSHTM), University of London, United Kingdom; Helena Nygren-Krug, Health and Human Rights Adviser, Department of ethics, equity, trade and human rights, information, evidence and research, (IER/ETH), World Health Organization (WHO) and Yasho V. Pradhan, Director Child Health Division, Department of Health and Population, Ministry of Health and Population, Nepal.

Gill Greer emphasized that talking about sexual and reproductive rights as human rights means talking about universal rights, rights for everyone, for all people. However, there are societies which tend to exclude young people, who are not supposed to be sexually active in many cultures. This attitude still prevails, despite the fact that there are 1.8 billion young people living on earth today, 80 per cent of them in the developing countries. One crucial issue which occurs when people are prevented from having information and access to family planning is abortion, she stated. These often result in death. She also stressed that half of all sexual assaults are on girls under 15; and for many, their first sexual experience happens when they are still very young, often with a much older man. One in seven are married before they are 15 and subsequentially get pregnant at an early age, often resulting in conditions such as fistula and uterine prolapse. Pregnancy and childbirth are the major cause of death among girls in the developing world. A study of a number of Sub-Saharan African countries indicates that young people, young men as well as women, want to have fewer children than their parents, yet only 10 per cent of married adolescents in those countries use modern contraception. Many are denied their right to information and education about critical issues, and that determines their lives. These statistics represent a denial of human rights, and highlight a public health issue that is preventable.

Nepal was mentioned in terms of best practice, as an example of what can be done

when health is connected to human rights. Before emphasizing the human rights' approach to health the rate of unwanted pregnancies was up to 30 per cent. Yasho Pradhan reported from Nepal that abortion has been legalized, so safe abortion services are available throughout the country in 75 districts. The maternal mortality rate has also been reduced significantly in Nepal. Helena Nygren-Krug took a look back at the history of the right to health. It was first enshrined in the World Health Organization's constitution in 1946 as "the right to the enjoyment of the highest attainable standard of physical and mental health". In 1948 the Universal Declaration of Human rights endorsed by the United Nations proclaimed that "everyone has the right to a standard of living adequate for the health and well-being of oneself and one's family, including food, clothing, housing, and medical care." The right to health was again recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights. She pointed out that a human rights approach is necessary in order to remind governments that health is not only a national, but is also subject to international standards. John Cleland opposed the human rights-based approach. In his opinion, a great deal of the rhetoric is just dressed up to appear new. Meetings on rights are cuddly experiences about empowerment, where no hard choices are made; cost effectiveness or what do you get for your money is not looked at. Some rights are just pious. The right not to die in childbirth is not a right; it is a highly desirable goal.

In the discussion that followed, one participant pointed out that the human rights approach changes working conditions, and accountability moves away from donors towards the citizens of the country. If there is a right to health in the constitution of a country, supported by Supreme Court decisions, it changes the way priorities are set and the way civil society works. Participants were in agreement that there must not necessarily be a contradiction between the population issue and the human rights approach. There was aconsensus that an increase in investment in family planning programmes is something all participants wanted to see. People need to know why this is so relevant to emerging issues such as climate change and within the context of population dynamics and development. Explaining these linkages will hopefully give rise to increased investment in family planning. ■

Critical Statement

John Cleland,
Professor of Medical Demography,
London School of Hygiene
and Tropical Medicine,
University of London, UK

(1) The 1994 International Conference on Population and Development (ICPD) signaled a shift from a demographic/economic rationale for family planning to a broader agenda of reproductive health and rights. This weakening of the link between family planning and poverty-reduction proved to be a disaster for family planning. International funding fell by over 50 per cent and international discourse about the dangers of rapid population increase almost stopped. One consequence is that the governments of poor countries (mainly in Africa) have received very little international encouragement over the past 15 years to promote family planning or to express concern about population growth. This lack of attention is one reason why fertility declines that started in Africa in the 1980s have slowed down in many countries. Poverty and hunger reduction as well as other Millennium Development Goals (MDGs) will be much more difficult to achieve because of continued high fertility and population growth.

(2) Real political power to decide priorities and allocate funds are held by Ministers of Finance. They are most unlikely to be swayed by a human rights approach and are often baffled by the complex concept of sexual and reproductive health and rights. To re-invigorate family planning, it will be necessary to return to the pre- ICPD rationale of linking family planning to social and economic progress.

(3) Related to point (2) above, a rights approach is hopeless for setting priorities. For instance, Niger's population is expected to grow from about 17 million to over 50 mil-

lion by mid-century and as a result faces a demographic disaster with dim prospects of escaping from poverty and famines. Yet, according to a World Bank report of 2005, there had been more meetings in that country on sexuality in old age and infertility than on family planning or population. This is a grotesque distortion of priorities. Priorities have to be based on economic or public health considerations, not on rights.

(4) Part of the problem with rights is that they proliferate in number and now embrace an extensive wish list – education, employment, clean water etc.. The greater the number, the less value they have. It's rather like a central bank increasing the money supply – sooner or later the value of the currency drops.

(5) Some countries in Africa, such as Niger, not only have high fertility but have high desired fertility and low unmet need for family planning. The instinct of a rights devotee is to proclaim "no problem". But this stance is very dangerous and short sighted. A more beneficial approach would be to challenge people's reproductive desires and point out that, while they may have been reasonable 100 years ago when life expectancy was 25-30 years, they now spell disaster in the long term.

(6) No poor and poorly educated country has achieved high levels of family planning use and a sustained reduction in fertility and population growth without a high profile family planning programme, backed by political support at the top and adequate international funding. A rights approach is most unlikely to lead to such a desirable combination because of unjustified fears that pressure will be exerted on couples to change their reproductive behavior.

(7) Rights and concerns about population problems can be reconciled. The latter determines priorities and the former constrains actions and ensures that customers or clients are given correct information and are treated with respect. This emphasis on quality has been part of family planning programmes for many years and much of the rights rhetoric is no more than old wine in new bottles. ■

Exhibition

Opening of art exhibition

After the panel discussion Dirk Niebel, Federal Minister for Economic Cooperation and Development (BMZ) invited all participants to the opening of the exhibition “Health – it’s my right!”.

The exhibition brought together expressions of art from three countries:

1- Malawi: Right to Life. Right to Health. Exhibited in Lilongwe in 2008
2- Kenya: Health and Human Rights. Exhibited in Nairobi in 2007
3- Bangladesh: Right to Health. Exhibited in Dhaka in 2008

Every exhibition has been set to serve a different purpose with one common thread: Expressions of health as a human right. All the works shown were produced by artists from the country of origin. The works were of different styles and media.

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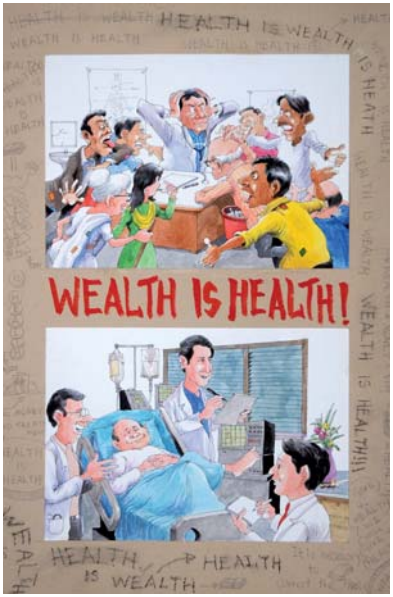
1 Stop Child Labour, Andrew Jackstone Orengo Kenya
2 Faces, Taona Makunje, Malawi
3 Health for All, Mehedi Haque, Bangladesh

4



5

6

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4 No Food, No Health, Nahid Roksana (Ananna), Bangladesh
5 Wealth is Health, Sumon Wahed, Bangladesh
6 The Right to Health, Morshedul Quagymon, Maraz
7 Untitled, Joseph Bertiers, Kenya

Presentations of inputs for track working groups
Guidance for seven specific action areas

Input Track 1: Advocating

Initiating a rights-based approach/ campaign for sexual and reproductive health, raising awareness, using evidence, engaging stakeholders, proposing policy change, countering opposing forces

Jon O'Brien,
President, Catholics for Choice, Washington, USA

Questions to be considered

- How to bring sexual and reproductive health into the (inter)national human rights discourse?
- Engaging rights and values: How to deal with certain controversial issues and counterarguments?
- What are good practice examples to show how policies can be influenced via evidence-based data?
- How to identify areas needing strengthening? What are next steps to be taken?

Recommendations

Identify new partners

- We need to move away from the existing model where we spend far too much energy talking with the people who already agree with us. They are already our champions – we need to develop a cohort of new ones also. This is for two reasons. Sometimes our existing champions take us for granted and let us down. Other times, our existing champions aren't numerous enough and we need to find more to expand our influence.
- We need to remember that the International Conference on Population and Development 1994 in Cairo, which was a long time ago. Few of those who attended or supported its passage are still in power. We need to carry out a new political education to explain why it is still relevant.

Raise awareness using the evidence we have and new evidence as it becomes available

- We need to be constantly on the look out for new ways to advocate the im-

portance and success of family planning and its role in saving lives. For example, the recent figures showing a 30 per cent decline in maternal mortality should be embraced and heralded and their link to better provision of family planning investigated and promoted.

– We all need to know why the International Conference on Population and Development was such a turning point and is still relevant today. Keep practicing the facts and figures. Have an elevator speech. Make it compelling and adaptable, depending on your audience.
– Having all the facts at our fingertips makes our jobs easier. Know the basics, at the very least, and continually seek to expand your knowledge, and that of your staff and partners. Practice asking and answering basic factual questions and the difficult ones that may come your way. Have good answers.

Engage stakeholders: Use the media more imaginatively

– There are a lot of different forms of media out there. Not everybody can master them all. Figure out which are your

strongest shots and make the most of them. Then build your repertoire.
– We need to find new ways of improving the world's understanding of why our issues are important. Support for family planning and development aid is the right thing to do in and of them. For those who need more convincing, the benefits they give in the fields of poverty alleviation, education and other areas about which policymakers are concerned make them a useful means to an end. Figure those out, and push them in meetings and communications with their offices.

Counter opposing forces: See the opposition for what it is

– In most cases our opposition is marginal. Having access to the key facts about the opposite party's influence means, that we can remind policymakers and stakeholders of this fact at every moment.
– Keep a perspective: How many countries issued reservations to the original the International Conference on Population and Development's document? Out of a total number of 179 countries present in Cairo, only 13 (Afghanistan, Brunei Darussalam, El Salvador, Honduras, Jordan, Kuwait, Libya, Nicaragua, Paraguay, the Philippines, Syria, United Arab Emirates and Yemen) made statements expressing reservations or comments on specific chapters, paragraphs or phrases in the Programme which they requested to be recorded in the final report of the Conference. Ten states (Argentina, Djibouti, the Dominican Republic, Ecuador, Egypt, Guatemala, the Holy See, Iran, Malta and Peru) submitted written statements for inclusion in the report. In expressing dissent from the majority of countries who supported the International Conference on Population and Development without reservation, the majority of these countries did not represent the wishes or best interests of the people that they represented.
– Remind policymakers that they should not pander to the extremes. Just because some people are screaming the loudest does not mean that theirs is the most compelling case. In fact, it is likely they are screaming because there is no substance to what they have to say.

Propose policy changes: Work to overcome stigma

– The most compelling arguments around family planning are often the simplest: because it's the right thing to do. Why do people see family planning as controversial? Because we let them drive the conversation. We are in the majority; most people see family planning as a nonissue or support it. Only the fringes oppose it. Let's keep that perspective, remind our colleagues to do the same. But rather than shrugging our shoulders, let's keep reminding the world about this as well. Only then will the marginal be marginalized. ■

Input Track 2: Claiming

Using human rights institutions and the courts to support people in claiming their rights to health.

Roselyn Karugonjo-Segawa,
Director Division 'Monitoring and Inspections', Uganda Human Rights Commission, Uganda

Which legal and institutional mechanisms need to be put in place to ensure that people can have access to justice and claim their sexual and reproductive rights?

We need:

- Domestication (enactment of national laws and policies) of international human rights treaties that provide for sexual and reproductive rights such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on Elimination of All forms of Discrimination Against Women (Women), among others.
- Establishment and/or strengthening of judicial and quasi-judicial mechanisms to help in the implementation of the sexual and reproductive rights.
- Provision of low cost and quick justice delivery models to enable all to claim sexual and reproductive rights.
- Provision of legal aid services to enable all to have access to justice, especially people living in poverty, and other vulnerable groups to enforce their sexual and reproductive rights.
- Provision for alternative dispute resolution such as mediation and conciliation.

How can national human rights institutions and the courts contribute to improve governance by holding governments accountable for their obligation to respect, protect and fulfill the right to health, including reproductive and sexual health for all?

National human rights institutions, as bodies established by governments under

the constitution, or by law or decree for the promotion and protection of human rights, can engage in the following:

- Investigating allegations of violations of reproductive and sexual health;
- Carrying out human rights education on reproductive and sexual health;
- Monitoring and documentation of the state of reproductive and sexual health;
- Advising governments on their compliance with established human rights standards, e.g. on proposed legislation and policies that affect reproductive and sexual health.

Courts play an important role in the enforcement of human rights, including reproductive and sexual health, in their decisions. They have been vital in making socio-economic rights such as the right to health justifiable, as has been the case in countries like South Africa and India.

It is important to note that the success of both national human rights institutions and courts in the enforcement of human rights, including the right to reproductive and sexual health in any country, is dependant on many factors such as the existence of a strong, vibrant, credible and competent civil society, an informed citizenry, independent judiciary, an enabling legal and policy framework and a government that has respect for the rule of law.

Recommendations

- Strengthen civil society organizations so that they can carry out social mobilization and advocacy for sexual and reproductive rights.
- Carry out Human Rights Education to empower the citizenry.
- Use strategic litigation to secure recognition and implementation of sexual and reproductive rights.
- Advocacy for good governance and for governments that have respect for the rule of law that create an enabling environment for national human rights institutions and courts to function.

To take it into one's own hand: How to empower people to know and claim their sexual and reproductive rights?

- Human rights education on reproductive and sexual health for communities and individuals to ensure that people and communities have access to education and information on their sexual and reproductive rights and how they can claim them.
- Advocacy campaigns for health promotion.
- Avail services both legal and health to ensure that all people especially the poor and the vulnerable can enjoy their sexual and reproductive rights. ■

Input Track 3: Measuring

Monitoring and evaluating sexual and reproductive health and rights (SRHR)[1, 2]

Sivananthi Thanenthiran,
Programme Manager
Information, Communications
and Research, Asian Pacific Resource
and Research Centre for
Women (ARROW), Malaysia

Sexual and reproductive health and rights (SRHR) are inextricably intertwined with human life. However, the body continues to be a political site: where interests of the individual continue to be pitted against interests of governments, markets and religious beliefs. This is the primary reason that SRHR issues are till today, highly contested and still remain in a flux, despite 15 years after Cairo. Although progress in SRHR is perceived as being fundamental to the social and economic development of communities, economies and nations, however the much-needed consistent and continuous investment in and political will to SRHR is still not realized to its fullest extent.

Global conferences of governments, organized by the United Nations (UN), have asserted sexual and reproductive health and rights as being fundamental to human rights and development. Sexual and reproductive health and rights were identified and acknowledged on a governmental level at the 1994 International Conference on Population and Development in Cairo and reaffirmed in the 1995 Fourth World Conference on Women in Beijing. Specifically the ICPD Programme of Action and the Beijing Platform for Action recognize sexual[3] and

1_This paper draws heavily from Thanenthiran, S; Racherla S.J. (2009). *Reclaiming & Redefining Rights – ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia.* Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

2_I am indebted to my colleagues Sai Jyothirmayi Racherla and Maria Melinda Ando for providing feedback for this paper; and to Suloshini Jahanath for editorial support. Acknowledgement also needs to be made to the experiences of ARROW's partners, researchers and reviewers in the ICPD+15 and the ARROW Programme Advisory Committee (PAC) who have helped developing and enriching the thinking around ARROW's ICPD+15 indicators.

3_ Although "sexual rights" as a term has not been established in international agreements, its definition and content were adopted within the human rights framework in the Beijing Platform for Action, Paragraph 96.It is worth noting that even governments expressing reservations in opposition to "sexual rights" used the term in their statements at the closing session of the Beijing Conference.

reproductive rights as human rights, thereby affirming them as an inalienable, integral and indivisible part of universal human rights.

SRHR has also found a place in The World Conference on Human Rights, (Vienna, 1993), World Summit for Social Development (Copenhagen, 1995), and the 2005 World Summit – follow-up to Millennium Summit 2000 (New York, 2005), reflecting government commitments that need to be acted upon at national levels.

Apart from global conferences, governmental commitments to sexual and reproductive health and rights are drawn from the International Convention on Economic, Social and Cultural Rights (ICESR, 1976); the International Covenant on Civil and Political Rights (ICCPR, 1976); Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979); The Declaration on the Elimination of Violence Against Women (DEVAW, 1994); and the Convention on the Rights of the Child (CRC, 1989).

The key message and principle in all the above conferences was that individuals should be able to enjoy all human rights and fundamental freedoms.

Why monitor?

Monitoring government commitment to international conferences and international covenants is a key activity of non-governmental organizations in holding governments accountable. 2009 marked the fifteenth year of the implementation of the Programme Action adopted at the International Conference on Population and Development (ICPD PoA), and 2014 will mark the target year for the commitments stipulated in the ICPD PoA. 2010 marks the tenth year of the implementation of the Millennium Development Goals.[4]

Progress on the sexual reproductive health and rights (SRHR) agenda has been chequered in these past 16 years: ICPD PoA was sidelined by the MDGs; universal access to reproductive health was only incorporated into the MDGs seven years later; the Global Gag Rule was in force for eight years of the Bush administration; continued hostility to many dimensions of SRHR (especially the 'rights' dimension) in many countries; application of a market-driven model on health services; and rising religious conservatism and fundamentalisms.

There is an urgent need to ensure that the complete SRHR agenda, which promotes, respects and fulfills the sexual and reproductive rights of all, especially individuals, survives in this context.

It is also important to understand and know what progress has or has not been made, in order to inform inter-governmental organizations, governments and civil society on the actions that need to be taken.

Hence, the pivotal reasons we from Asian-Pacific Resource and Research Centre for Women (ARROW) as an non governmental organization engage in monitoring is three-fold:

1) To hold governments accountable to their international commitments and its

4_'MDG5B: Achieve universal access to reproductive health' was only lobbied for in 2005, and indicators were added in 2007. Due to this late introduction of 5B, few countries are monitoring this indicator.

implementation through national development plans at the national level thereby, fulfilling their commitments to their citizens.

2) To identify gaps, especially with regard to marginalized groups and their rights that may not be reflected within mainstream data.
3) To keep pushing the boundaries to ensure the realization of sexual and reproductive rights and sexual and reproductive health for all.

What are we monitoring?

The positioning of our monitoring work is crucial – we are using international commitments in order to track progress and hold governments accountable to the SRHR agenda and to advocate for further investments to ensure that pathways are created for the realization of sexual and reproductive rights for all. The term sexual and reproductive health and rights (SRHR) covers four different, inter-linked components- reproductive health, reproductive rights, sexual health and sexual rights.[5]

While the term 'reproductive health' was first developed by institutions, such as the World

5_For reproductive health, we use the WHO definition; for reproductive rights, we use the ICPD definition; for sexual health, we use an adapted definition from the UN; for sexual rights we use the working definition from the WHO.

Health Organization (WHO), in the early-1980s, the term 'reproductive rights' was initially first used in feminist meetings in the late 1970s and was clearly defined in the International Women and Health Meeting (IWHM) of 1984.[6] The term 'sexual health' has been defined as early as in 1975 by WHO.[7] These terms found a place in UN documents for the first time in the ICPD PoA and the Beijing Platform for Action (BPfA). The Cairo and the Beijing Conferences established and legitimized notions of reproductive rights, as well as 'sexual health' and 'sexual rights'.[8] Sexual rights were also written for the first time in the ICPD PoA though it was not retained in the final text.[9]

Paragraph 7.2 of the ICPD Programme of Action[10] talks about a 'safe and satisfying sex life' and the interpretation of what constitutes this and the conditions that provide for this, include key aspects of sexual rights including the choice of sexual partners.

Sexual rights issues are because the majority of women, who live in patriarchal societies, still continue to struggle for sexual rights. The concept of sexual rights is also so closely intertwined and interlinked with that of reproductive rights so much so that, in some aspects, it is difficult to separate both. In order to achieve desirable SRH outcomes, it is crucial to empower men and women with rights which enable them to be equals[11] in the public and in the most private spheres of life. It is also important to empower women to exercise their decision-making with regards to sexuality and reproduction.[12] It is also imperative to establish rights for women, where those rights may not currently exist, in order to enable women's decision-making capacities.[13] All of these have been established in the ICPD PoA itself, 15 years ago.

Paragraph 96 of the Platform for Action of the Beijing Conference, although it does not explicitly mention sexual rights, spells out the elements of sexual rights: "The human

6_Petchesky, R.P. (2003) Transnationalizing Women's Health Movements. In ***Global Prescriptions: Gendering Health and Human Rights*** (pp. 4). London, United Kingdom: Zed Books.

7_World Health Organization (WHO). (1975). *Education and Treatment in Human Sexuality: The training of Health Professionals, Report of a WHO Meeting. World Health Organization (WHO) Technical Report Series Nr. 572.* Geneva, Switzerland: WHO

8_Although "sexual rights" as a term has not been established in international agreements, its definition and content were adopted within the human rights framework in the Beijing Platform for Action, Paragraph 96.It is worth noting that even governments expressing reservations in opposition to "sexual rights" used the term in their statements at the closing session of the Beijing Conference.

9_Correa, S; Careaga, G. (2004). *Is Sexuality A Non Negotiable Component of the Cairo Agenda?* Retrieved 26 August, 2009, from Development Alternatives With Women from a New Era (DAWN) Web site: http://www.dawnnet.org/publications/docs/non-negotiable-2520sexuality-2520aug04.doc

10_"Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide, if, when and how often to do so..."

11_As is said in Paragraph 7.34: *"Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the physical integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behavior."*
This is reiterated under the section's objectives in Paragraph 7.36: *"permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals." Paragraph 7.35 also recognizes that: "In a number of countries, harmful practices meant to control women's sexuality have led to great suffering." Paragraph 7.38 encourages governments to "base national policies on a better understanding of the need for responsible human sexuality and the realities of current sexual behavior."*

12_ Paragraph 4.1 states that: *"The power relations that impede women's attainment of healthy and fulfilling lives operate at many levels of society, from the most personal to the highly public …. In addition, improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction."*

13_Paragraph 4.4 (c) under Actions proposes: *"Eliminating all practices that discriminate against women; assisting women to establish and realize their rights, including those that relate to reproductive and sexual health."*

rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."

It is not possible to extricate and exclude sexual rights from the Cairo agenda, although it was framed within a health, violence and disease lens and not within a freedom, rights and choices lens.[14]

Using the human rights framework

The framing of SRHR within a human rights' framework is a critical step in pushing the envelope for the SRHR agenda. Most governments have binding human rights agreements, through the ratification of treaties such as Committee on the Elimination of Discrimination against Women (CEDAW), International Covenant on Economic, Social and Cultural Rights (ICESR) and International Covenant on Civil and Political Rights (ICCPR) and states have an obligation to promote, respect and fulfill the rights described in these treaties.

Analyzing policies and programmes with a human rights lens also helps to uncover the inter-linkages between causes, factors, issues and impact of SRHR: discriminatory impact of policies, violations either at the individual, group or national levels, access to life-saving procedures and medicines, affirming sexuality, arresting sexual and reproductive socio-cultural norms which result in death and disability for women.[15]

Concretization of rights within policies and international documents is the first step in holding governments accountable. A rights-based approach describes a strategy for promoting SRH based on the acknowledgment that SRH are human rights, and includes components of gender equity and equality; sexual and reproductive rights, and client-centered sexual and reproductive health care.[16]

The second step is to look at indicators which embody the concepts of rights around SRHR issues especially taking into account the needs of the vulnerable and marginalized groups.

The ARROW experience with 'rights' indicators

There is a pressing need to reiterate the rights of individuals to achieve autonomy over their sexual and reproductive lives. ARROW has been consistently monitoring the ICPD PoA at the plus five intervals. We recently worked on looking at the achievements of the ICPD PoA in the last fifteen years and we attempted to describe the 'rights' aspects of sexual and reproductive health through the extrapolation of already available data.

The value of a human rights approach and analyses to health and sexual and reproduc-

14_Correa, S; Careaga, G. (2004). *Is Sexuality A Non Negotiable Component of the Cairo Agenda?* Retrieved 26 August, 2009, from Development Alternatives With Women from a New Era (DAWN) Web site: http://www.dawnnet.org/publications/docs/non-negotiable-2520sexuality-2520aug04.doc

15_Bakker, S; Plagman, H. (2006). *HeRWAI: Health Rights of Women Assessment Instrument. Aim for Human Rights. The Netherlands: Humanist Committee on Human Rights.*

16_Harris, F; Murthy, R.K.; Romero, M; Ramos, S.; Holland-Muter, S; et al. (2005). Session 2: Sexual and Reproductive Rights. In *The Right Reforms? Health Sector Reforms and Sexual and Reproductive Health: Training Manual* (p.20). Johannesburg, South Africa: The Initiative for Sexual & Reproductive Rights in Health Reforms (Women's Health Project).

tive health has been well-documented[17] and presented in different international fora.

ARROW's work is in line with the thinking that "A human rights-based approach to health indicators is not a radical departure from existing indicator methodologies. Rather, it uses many commonly used health indicators, adapts them so far as necessary (e.g. by requiring disaggregation), and adds some new indicators to monitor issues (e.g. participation and accountability) that otherwise tend to be neglected. In short, a human rights-based approach to health indicators reinforces, enhances and supplements commonly used indicators."[18]

On indicators around fertility and contraception and family-planning: we have looked at Wanted Fertility Rates in comparison with Total Fertility Rates (how many children did you want to have in comparison with how many children did you have); we have looked in-depth at what constitutes the Contraceptive Prevalence Rates (CPR) i.e. range of methods used, reasons for non-use of contraception; provision of informed choice (all of this to indicate rights and choices around contraception decisions); access to safe abortion and

17_Hunt, P. (2006). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Retrieved 17 August, 2010, from OHCHR Web site: http://www2.ohchr.org/english/issues/health/right/annual.htm

18_Hunt, P. (2006) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Retrieved 17 August, 2010, from OHCHR Web site: http://www2.ohchr.org/english/issues/health/right/annual.htm

barriers (legal and non-legal); access of marginalized groups (women belonging to lower wealth and education quintiles; rural/urban/remote areas of location; age groups; ethnic minorities; migrant; sex workers) within the CPR and Maternal mortality rate (MMR) data.

Although gender-based violence has always been a traditional indicator of both, gender equality and women's health, indicators around this have been neglected by the MDG agenda. We chose to look at laws on sexual violence and provision of services from public health facilities for survivors of violence as indicators of rights.

In addition we felt it was critical to also look at how governments are providing access to prevention, treatment and care for reproductive cancers through examining the cancer registries of the respective countries. In the same manner, it was also important to look at sexually transmitted infection (STI) prevention, treatment and care beyond the risk-behavior modality of HIV/Aids.

It was also feasible and possible to attribute indicators from already established data sources for many aspects of sexual rights such as: median age of marriage in comparison with legal age of marriage, existence of forced/arranged marriage, traditional practices such as female genital mutilation FGM and child marriage, access to sex and sexuality education for unmarried young people, recognition of previously marginalized groups such as sex workers, people of diverse sexual orientation and gender identities and the recognition of their rights within the broadest possible spectrum of SRH, beyond HIV/Aids interventions.

This enabled a narrative of rights to be woven around the data. These examples can be seen in ARROW's MDG campaign "Women are Watching their Governments" available at http://www.mdg5watch.org[19,20]

It was also possible to use the mainstream data and supplement it with qualitative evidence generated by smaller studies, in order to present the rights aspects more clearly to show provider biases,[21] government policies,[22] and how low quality family planning counseling and post-abortion counseling limits the choices of women and couples.[23,24]

The need for a reporting and reviewing process and mechanism which has 'teeth'

While we as an SRHR community discuss and debate data and indicators and assessment, it is equally important for us to ask for a process where our data and indicators can be incorporated within international review and reporting processes and mechanisms. It is not only data monitoring that is required but processes of reviewing data and coming up with recommendations to the governments on their course of actions for progress which will help us ultimately achieve our agenda.

An example already exists in the Committee on the Elimation of Discrimination against Women (CEDAW) reporting processes. Each country that has signed onto CEDAW is required to periodically report on progress; when governments compile their reports a coalition of national level NGOs (which cannot include NGOs involved in the government report) compile a shadow report. The CEDAW committee reviews both reports and welcomes oral statements from both parties and then makes recommendations to governments on the necessary actions to take.

Governments are also required to report on the progress on the CEDAW's recommendations. NGOs also observe and monitor follow-up by government to the recommendations.[25]

A thorough process like the CEDAW process should be mandatory to ensure transparency and accountability of governments and donors especially for development agendas like the MDGs which drive huge funding flows into countries. The SRHR community can be greatly strengthened by using such rigorous methodologies of process in order to advocate for our issues. ■

19_MDG3: India. *Women are Watching their Governments: MDG5 Watch*. Retrieved September 15, 2010, from http://mdg5watch.org/index.php?option=com_content&view=article&id=94&Itemid=156#_edn39 Or
International Institute for Population Sciences (IIPS) and Macro International. (2007). *National Family Health Survey (NFHS-3),2005–06: India. Deonar, Mumbai, India*: IIPS

20_Thanenthiran, S; Racherla, S. (2010) *MDG 5 in Asia: Progress, Gaps and Challenges 2000-2010*. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW). Retrieved from Women are Watching their Government: MDG5 Watch Web site: http://mdg5watch.org/Regional/MDG5Regional-Brief.pdf

21_World Health Organization (WHO) et al. (1999).Reducing the Recourse to Abortion. In *Expanding Options in Reproductive Health-Abortion in Vietnam: An Assessment of Policy, Programme and Reproductive Issues* (p. 16). Geneva, Switzerland: WHO.

22_United Nations Population Fund (UNFPA) Country Technical Services Team for East and South-East Asia, Bangkok, Thailand. (2005). Reproductive Health and Rights. In *Reproductive Health of Women in Thailand: Progress and Challenges Towards Attainment of International Development Goals* (pp. 37-8). Bangkok, Thailand: UNFPA Country Technical Services Team for East and South-East Asia, Bangkok, Thailand

23_Hoang, T. A.; Bui, T.T.M; Nguyen T.V.; Pham, K.L. (2008). *Exploratory study on knowledge, attitude and practice related to emergency contraceptive pills*. Vietnam: Pathfinder International.

24_Hoang, T. A.; Bui, T.T.M; Nguyen T.V.; Pham, K.L. (2008) *Post abortion counseling and use of condom*. Vietnam: Pathfinder International.

25_CEDAW Reporting/Review Process. Retrieved 20 September, 2010 from Women's UN Report Network Web site http://www.wunrn.com/news/2007/11_07/11_26_07/112607_cedaw.htm

Input Track 4: Targeting

Addressing the special need for action to support the sexual and reproductive rights of women and young people.

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(Input given by Seri Wendoh, IPPF, London)

Context

– Sexuality in Africa is still shrouded in mystery and discourse around it is linked to only sexual intercourse, all within the purview of recognized relationships between women and men (i.e. marriage).

– There is a shift towards more fundamentalism and conservativeness in looking at sexuality and sexual relations in Africa. This is as a result of new waves of Christianity, especially the Pentecostal movements exported from the United States that have now been firmly rooted in Africa as well as with Islam.

– While sexuality have been expressed in different ways, and to fulfill different needs (albeit not always recorded except in oral history) in Africa, the new elements of conservatism are becoming more and more vocal and organized in ensuring laws and practices on how sexuality can be legitimately expressed or not.

– This has implications for the sexuality and sexual health of people, and in particular, young women and men.

– Despite all the advances made in women's education/economic empowerment, young women continue to be at the most risk of HIV/AIDS, sexual transmitted diseases (STDs), unplanned pregnancies, risk of mortality and morbidity from unsafe abortions, FGM, child marriages, sexual abuse.

Challenges

– Unequal power relations between women and men now again being reinforced

by fundamentalist religious movements (women must submit to men, only men are equipped to take decisions about sexuality, seeking information about sexuality and exercising sexual rights is a sign of a 'bad' woman, virginity tests, HIV/pregnancy compulsory tests before marriages in churches) This put girls still in difficult positions – refuses to seek sexual health information and put their sexual needs at the mercy of men who also do not know, have low contraceptive prevalence rates and high unsafe abortions (have sex but pretend not be having it by not seeking information and not using contraceptives because that would indicate that you are having sex and so a 'bad woman').

– Lack of comprehensive sexuality education grounded in rights in schools, religious institutions and homes. Sexuality education remains equated with sexual relations and there continues to be wide spread belief that once young women and girls know about sexuality, they will start to engage in sexual relations. Gender relations deem sexuality knowledge inappropriate for unmarried persons, especially girls and women. The definition of 'young' in most of Africa is linked to marriage. If you are unmarried, then you are 'young' and should not be having sex and no matter your age, once you are married, you are an 'adult'. This has implications for the provision of sexuality education and in particular in promoting the sexual rights of women and girls.

– A nearly universal acceptance of child marriages for girls in Africa. In Sahelian West Africa, about 40 per cent of girls are married in the rural areas by the time they are 16 years old. Marriages of girls of between the ages of 12 – 18 are the norm rather than the exception in most of Africa. The principle behind both child marriages for girls and female genital mutilation (FGM) are the same – control women's expressions of sexuality so that they do not become 'bad' before marriage.

– Inability or unwillingness to separate sexuality from reproduction. This is evidenced in laws that equate safe abortion with murder, and in some ways, being pregnant and having babies even when not ready as punishment for the 'sin' of having sex before marriage for young women. Laws against homosexuality.

– The lack of sexuality education for men that focuses on interpretations of masculinity of equality, shared responsibility, respect for women's bodies and their sexual choices and autonomy. Gender stereotypes of men as superior, providers, decision makers are still being reinforced in schools, religious institutions that makes young men confused especially since young women are much more empowered and continuing to contribute to the abuse young women face in their relationships with men.

– Sexual and gender based violence targeting young girls and women are increasing. There is no passion for dealing with it by policy makers, religious institutions. The outrage and organizing to oppose laws and policies by key religious

leaders, parliamentarians, community leaders etc. that promote safe abortion, or decriminalize same sex activities and relationships are totally absent when it comes to sexual and gender based violence and abuse that particularly target young girls and women. This increases impunity as law makers often then feel that this is not an important issue.

– Sex and gender-based violence (SGBV)/ coerced sex – as the main key of control of women, especially young women. Nearly half of women surveyed in Nigeria and Kenya for example claimed that their first sexual initiation had been forced or done under the threat of violence. Violent conflicts and displacements remain a threat for young women. Domestic violence or threat that makes women unable to take decisions concerning their sexuality.

– Trafficking in young girls for domestic help and often preyed upon for sex – high unmet SRHR needs, violence, sexual abuse – illiterate, most girls often as young as nine, no family and very completely dependent on the families they stay with, and often illegally

– Most sexual and reproductive health and rights (SRHR) laws in Africa are antiquated, dating back to colonial times and have not been reformed. Attempts to reform have often been met by well organized groups led by the church, always been SRHR policies are not passed – to create access for services especially to young people, to allow for safe abortion as a reproductive right, right to information, for sexuality education, budget not enough and critical agreements at international levels are not implemented.

– Restrictive abortion laws, getting more restrictive as evidenced with the new Constitution being proposed by Kenya (human life begins at conception, making Kenya the only 4th country in the world to declare this if the clause is not removed in the Constitution and it is passed, and the first in Africa). Floodgates of other conservatives using the Kenya Constitution to push for such changes in their countries in Africa.

– Laws that criminalize same sex activities, sex work and HIV transmission.

– Sexual health services that do not specifically target young people and in particular young women. This includes trained young people to provide services, information that is appropriate and not judgmental and rights-based, centers that target young people and are discreet being built into the public healthcare systems.

Opportunities/strategies for engagement

– Young women continue to organize and build movements to resist the conservatisms and fundamentalisms that put women's lives and wellbeing at risk. One strategy used by IPPF in Africa for example is increasing women in decision making within its service centers as a cornerstone of its work. To provide opportunities for young women to lead

these Member Associations and provide guidance on how best to address young women's needs.

- Youth Friendly services led and run by young volunteers, including women and using women to reach out to other women in communities.

– Integrating sex and gender-based violence (SGBV) support and counseling within service delivery to understand the root causes of violence against women and girls.

– Feminist movements in Africa – challenging patriarchy and the unfair advantages and denial of rights for women that compromises their power.

– Promoting young men's involvement and taking responsibility for their sexual health as a way of protecting young women.

– Supporting multi thronged approach to integrating sexual and gender-based violence with the provision of SRHR services – (i) raising community awareness on

sexual violence and using it as a strategy for supporting communities to talk about violence against women (VAW) and let women know they can seek help/support in IPPF SRHR Clinics; (ii) working with young men to challenge inequalities as a way of reducing impunity; and (iii) supporting medical personnel who provide SRHR services to produce evidence for persecutions as well as provide referrals for women and girls seeking legal assistance.

– Strengthening of women's, in particular, young women's networks and organizations.

– Supporting countries emerging from armed conflict to have comprehensive policies and actions to target young girls/women who were traumatized by acts of sexual violence. To improve evidence based research and develop post trauma interventions.

– Scaling up access to services specifically targeted for deaf and physically challenges/differently-able young women.

– Comprehensive sexuality education aimed at reviewing school curriculum to include sensitive topics on safe abortion, gender based violence, and sexual diversity.

Focusing SRHR programmes on particularly vulnerable young women as follows:

That means:

– Young married women/girls – newly married, 1st pregnancy, 1st post partum, (child marriages, lack of education, no peer support network, very low decision making, no mobility, dependence on older family members, husbands).

– Women/girls living with disabilities (low sexual image, vulnerable to SGBV because of perception that they are asexual and should be grateful for any sex, not all services are appropriate, lack of access, poverty – lower educational attainment depending on level of disability).

– Women/girls living with HIV/AIDS (stigma, right to sexuality, to have children or not, to enjoy highest level of sexual health, to take cognizance of ARV and interaction with contraception, cervical cancer screening).

– Young women/women/girls working as domestics (high level of sexual abuse, total lack of access to information, no control over resources, not documented so cannot report any violation, usually at the cusp of adolescent when they first start working, mostly trafficked).

– Women, young women, girls living in urban slums (high SGBV, low access to SRHR, usually abused for child labor, high levels of poverty, low or infrequent schooling, high intergenerational and transactional sex, high incidences of abortion). ■

Input Track 5: Championing

Responding to and addressing the unmet need for family planning as a rights-based issue within the framework of population policies

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USA

Universal access to reproductive health — a human right

Elimination of all forms of discrimination is at the heart of a human rights-based approach to meeting the world's health needs, including for family planning and reproductive health. In 2007 the United Nations General Assembly recognized this, agreeing that "universal access to reproductive health by 2015" be included as a target for Millennium Development Goal (MDG) 5: Improving maternal health. What does this really mean? For millions it means overcoming financial and political barriers to provide them with full information on family planning, access to quality contraceptive services and supplies, and assurance that what a woman believes is best for her and her family will be paramount in decisions about pregnancy and birth. It means acknowledging and overcoming the impact of inequity within societies to compromise access, rights and justice.

An estimated 215 million women who want to avoid a pregnancy are not using an effective method of contraception, despite increases in use in recent years.[1] By 2015, the United Nations estimates that the demand for family planning will grow by 40 per cent as record numbers of young people enter their prime reproductive years. While more than half of women with an unmet need for contraception live in Asia, the proportion of women with an unmet need is largest in Sub-Saharan Africa.[2] Meeting the need for both family planning and maternal and newborn health services would

1_Singh, S., et.al., *Adding it Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*, Guttmacher Institute, 2009.
2_Gillespie, D., et.al., *Making the Case for U.S. International Family Planning Assistance*, Baltimore, MD, 2009.

be dramatic. Unintended pregnancies would drop by more than two thirds, from 75 million in 2008 to 22 million per year. Seventy per cent of maternal deaths would be averted – a decline from 550,000 to 160,000. 44 per cent of newborn deaths would be averted – a decline from 3.5 million to 1.9 million. Unsafe abortions would decline by 73 per cent, from 20 million to 5.5 million (assuming no change in abortion laws), and the number of women needing medical care for complications of unsafe procedures would decline from 8.5 million to two million.[3]

Much of what needs to be done requires less of a financial investment by countries and donors than a commitment to informed consent and support for the women's decisions to prevent pregnancy or to have a child. It also requires governments to ensure that whatever services and supplies exist, they are non-coercive and provided to all and especially those most in need, whether they are young, poor, living with HIV, or otherwise unable to attain full sexual and reproductive health. At the 1994 International Conference on Population and Development in Cairo, 179 countries agreed to put "human needs, both individual and social, and specifically those of women, at the center of population and development policies. (ICPD, Principle 2 & 3, Para. 3.4 and 3.16) The human rights approach adopted in Cairo is the guarantor that those needs will remain central to the way polices, services, and programmes are developed and delivered".[4]

Financial resources are, however, needed and are currently inadequate to achieve the MDGs. According to the UN Foundation, with only 11 per cent of the world's population, Africa accounts for more than half of all maternal and child deaths. Despite advances in global health outcomes worldwide, progress towards achieving the health MDGs in Africa has been slow, hindered by a lack of resources for health and, at times, inefficient use of available resources. It added that with one in five maternal deaths linked to HIV, progress in maternal health was closely linked to the fight against HIV/AIDS.[5] In 2001, Heads of State of the African Union (AU) met in Abuja, Nigeria, and committed to allocating at least 15 per cent of their annual government budgets to the health sector in their respective countries as part of this fight.[6] Unfortunately, almost a decade later, only a few countries have made recognizable progress toward the achievement of this joint commitment.[7] In July 2010, 117 African civil society organizations sent an appeal to the African Union (AU) summit, requesting that the commitment of the Heads of State be upheld, following concerns of Africans that Heads of State had been asked to renounce this 2001 Abuja commitment on health.[8] According to

3_Singh, S., et.al., *Adding it Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*, Guttmacher Institute, 2009.

4_"ICPD +5 Factsheet: Reproductive Health Rights are Human Rights," International Women's Health Coalition, 1999.

5_Wakabi, W. "Africa faces an uphill struggle to reach the MDGs", *The Lancet*, Volume 376, Issue 9745, Pages 943 - 944, September 2010.

6_African Union Heads of State (2001) 'Abuja declaration on HIV/AIDS, tuberculosis and other infectious diseases and plan of action', *African summit on HIV/AIDS tuberculosis and other infectious diseases, 24–27 April* OAU, Addis Ababa, at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf

7_Govender V, McIntyre D, Loewenson R (2008) 'Progress towards the Abuja target for government spending on health care in East and Southern Africa,' *EQUINET Discussion Paper Series 57*. EQUINET: Harare.

8_Letter from 117 African Civil Society Organisations to July 2010 African Union Summit on Upholding African Health and Social Development Commitments http://www.who.int/pmnch/events/2010/ausummit_117afrorg_letter.pdf.

the World Health Statistics 2010, budget allocations to health in the European region and the Americas in 2007 were 15.3 per cent and 17.1 per cent respectively, compared with Africa's average of 9.6 per cent.[9] Most African countries spend less than half the World Health Organization (WHO) recommended minimum package of 40 US$ per person on health. Given this scenario, information and services will remain out of reach for many and new drugs and technologies to prevent pregnancy and sexually transmitted infections (STIs) and manage childbirth will be unattainable for most.

Recommendations

To ensure that human rights are at the center of population and health policy development and implementation and the achievement of MDG 5 requires action on the following recommendations:

– **Equity and non-discrimination.** National health plans and budgets should end the compromise of women's health, by prioritizing sexual and reproductive health including: family planning, maternal and newborn health, safe abortion, and prevention and treatment of STIs, including HIV. Governments should be held accountable for ensuring that access to quality family planning information and services provided by trained health personnel is available to individuals regardless of their age, gender, marital or economic status, or where they live. In expanding access, it is imperative that special attention is given to providing women and men with contraceptive methods that best suit their own needs,

9_World Health Organization. World Health Statistics 2010:138.

in particular long-acting methods or emergency contraception, both of which are out of reach for many individuals. All governments should be held accountable for their human rights commitments as they relate to sexual and reproductive health.[10]

– **Participation and inclusion.** The role of civil society should be transformed from one of watchdog and advisor to development and implementing partner. Women and young people should be at the center of priority setting, programme design, operations research and clinical trials, and contraceptive development. Transparent, democratic mechanisms, such as those of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, should be hardwired into donor processes.

– **Accountability.** Funding for family planning – from donors to countries or programmes, or from countries to districts – should be tied to results. These results would include outcomes from equitable, voluntary and quality delivery of services as well as metrics that capture the extent to which human rights are being upheld. As suggested by Paul Hunt, countries lagging behind in achievement of MDG 5 should establish independent bodies to accelerate progress toward reduction of maternal mortality that report directly to the Parliament, the Prime Minister's office or both. "Enhancing monitoring, accountability and redress for maternal mortality in the public and private sectors, including public-private partnerships, demands the sustained attention of national and state human rights and women's institutions, civil society and community-based organizations, the courts and the media."[11]

– **Greater alignment of funding and financing.** In laying out new efforts needed to achieve the MDGs by 2015, the World Bank has pointed out that "more progress is needed to develop a global partnership for development." This is even more relevant for family planning and reproductive health funding at both the country and global level, where greater collaboration and commitment from the highest level of leadership in donor agencies and with governments is needed. Similar coordination and specific attention to affordability of reproductive health commodities is needed between donors, the public sector and pharmaceutical manufacturers. Greater agreement on health objectives among these agencies will be essential to meet MDG 5 and, in particular, to ensure universal access to reproductive health. ■

Notes:
This issue note was prepared by Beth Fredrick, Advance Family Planning, Bill and Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, USA, with Funmilola M. Olaolorun, Johns Hopkins Bloomberg School of Public Health. The views expressed here are solely those.

10_Hunt, P., Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, Mission to India, Human Rights Council, Fourteenth session, United Nations General Assembly, 2010.

11_"Unfinished Business: Mobilizing New Efforts to Achieve the 2015 Millennium Development Goals," 2010 World Bank, Washington, DC.

Input Track 6: Strengthening

Health system capacities to address sexual and reproductive health and human rights, especially of poor and/or marginalized people.

John Skibiak,
Reproductive Health Supplies Coalition, Brussels, Belgium

Issue 1: A hallmark of health reform and much systems strengthening has been the devolution of decision making authority from central to local authorities. Part of the thinking behind this shift is that local decision making will be more attuned to the needs of the community. But does local decision making also serve better the needs of the poor and marginalized?

– The effect of decentralization of services on SRH services is mixed – largely because of the diversity of local influences on the determination of which components of sexual reproductive health (SRH) are considered "appropriate". In decentralized settings, the role of civil society can be especially critical.

– World Health Organization (WHO's) Rights and Reform Initiative Global Literature Review drew attention to the importance of disaggregating the different components of SRH. Some SRH services are socially and politically "safer" than others (e.g. perinatal care) are easier to target by governments and other decision makers as development priorities. Other areas may be more challenging (ARH).

Issue 2: What is a reasonable level of impact any systems strengthening can have on equity, particularly in the absence of larger movements within society towards improvements in equity and social justice?

– Jeanette Vega and others have argued that certain health system impact indicators of equity, particularly with respect to the poor and marginalized, may be more

related to the historical development of the society than the performance of the health sector at any given moment in time.

– "Given that persistent health inequities are primarily rooted in the influence of social and environmental determinants of the population, monitoring of interventions for the achievement of equity should not be limited to the health sector. Exogenous influences from other sectors, such as education, labor, social security, transport, should be considered for a more comprehensive understanding of how equity is improved by reform." (Solar, Irwin and Jeanette Vega 2004)

– The notion of a "right to health", enshrined in the 1948 Declaration of Human Rights, was soon eclipsed by an approach that aimed to "obtain the largest possible health benefits for the poor from finite foreign aid budgets". The "rights to health have made a comeback" – but which "right" seems to increasingly be the outcome of political battles. William Easterly, economist at New York University argues that "Rights advocacy often favors some aspects of health relative to others". "The right to health" skews public resources towards the most politically effective advocates, who will seldom be the neediest."

Issue 3: How does one measure success at achieving health equity?

– The "Benchmarks of Fairness" framework was conceived of in the US in the early 1990s to evaluate planned health insurance reforms. It is now used widely to evaluate the "fairness" of health sector reforms and other efforts at systems strengthening. Studies that use the methodology develop locally agreed-upon scoring methods to assess three dimensions of fairness: equity, efficiency, accountability. Nonetheless, the author of the methodology acknowledges that the benchmarks are not intended for cross-country comparisons because local contextual factors will influence the scoring criteria.

– Are there universal standards – internationally recognized legal agreement that encode agreed definitions and specify reproductive rights – and that cut across discussions of cultural relativism and avoid cross-national comparisons?

– There is widespread recognition of the importance of targeting reproductive health (RH) care services by socioeconomic criteria. Evidence from five country studies (Bangladesh, India, Nepal, Pakistan) carried out by the World Bank's South Asian Women's Health Study found that for a wide range of health outcome and service use indicators, the differentials by social characteristics (such as education, religion, caste or poverty) are greater than those by biological characteristics (age, parity, birth order).

Issue 4: Inadequate public provision has caused large segments of the population in many countries (including the poor) to utilize private sector providers.

– There is substantial evidence that contracting out primary health care services can increase access to services by increasing their provision, utilization and coverage. However their impact on outcomes relating to equity, quality or efficiency is less conclusive.

– There is also substantial evidence to suggest that without careful consideration of the total market, unilateral decisions by government to provide free RH commodities can undermine a functioning private sector and, in the process, disproportionately burden the public sector.

Key questions

Providers perspective

– Do we achieve better outcomes by strengthening the capacity of providers to understand, accept and implement a right-based approach, or simply by just paying them (or paying them on top) if they deliver a pre-defined package?)

Users Perspective

– Do patients know and claim their rights? How could this be achieved?
– Do providers know of and accept the rights of the clients and how can this be achieved?
– How to establish choice for clients and competition among providers?
– How can users be given a stronger voice?

Systems perspective

– How can health sector reform ensure access to SRH services for the poor and marginalized?
– How can affordable SRH services for under privileged groups be financed?
– Which approaches (to service delivery) strengthen the right to health?
– How does a human rights-based approach impact the design of health care systems? ■

Input Track 7: Linking

Rights-based approaches to sexual and reproductive health to national and international action to achieve the Millennium Development Goals (MDGs) especially those focused on Maternal and Child health and HIV

Sara Seims,
Director of Population Programme, The William and Flora Hewlett Foundation, USA

Issue 1: What are experiences in working with a rights-based approach in the areas of maternal health and safe motherhood?

– Rights-based approaches have been effective in motivating and maintaining enthusiasm within the SRHR community. This is particularly the case for non governmental organizations (NGOs) in the Global South, as well as the "like-minded" European bilaterals. It is not clear that a rights-based framework for maternal health, safe motherhood and other aspects of sexual and reproductive health is meaningful for developing countries, particularly ministries of finance, which is where resource allocation decision making is centered.

– Unfortunately, this support for rights-based approaches has not translated into significant consistent improvements in all aspects of maternal and child health and HIV, particularly for the world's poorest people. For example, between 1990 and 2005 maternal mortality declined only by 2.13 per cent in Sub Saharan Africa. South Asia and Sub Saharan Africa together account for 87 per cent of the world's maternal deaths. Much more progress was made in reducing maternal mortality in other regions. However, improvements in maternal mortality lagged behind improvements in infant mortality and under-five mortality in all regions of the world. Similarly, reductions in HIV prevalence among adults have not been consistently widespread. In Sub Saharan Africa, HIV prevalence declined

from 5.54 per cent to 4.95 per cent between 2000 and 2007. In East Asia and Latin America where prevalence rates are considerably lower, there has basically been no change between 2000 and 2007.

– It is impossible to track the flow of donor and government funds to sexual and reproductive rights. The data collection systems do not allow for this to happen. As a result, we do not know how much money (or how little) goes to ensuring any of the basic elements of a rights-based approach to health. It is not practical in the short to medium term to expect any significant changes in these data collection systems so other accountability mechanisms need to be found.

– Given the structures of development cooperation such as basket funding to health sectors and more focused efforts to reduce poverty and promote economic growth, there is an urgent need to document how sexual and reproductive rights affect health and how the health status of individuals has an impact on reducing household poverty and spurring economic growth. For example, a study in South Africa finds that childbearing among teens has an adverse effect on their children's health and on the educational attainment of the teen parents. Another study in Vietnam illustrates how parents with fewer children are able to invest more in their education, thus setting the stage for future economic growth. There are surprisingly few first-rate studies of this nature.

Recommendations:

– Develop practical outcome metrics to measure progress in the reproductive health, including sexual reproductive health and rights, gain consensus for these measures, and hold donors and governments accountable. There should be different measures for short, medium and long term periods.
– Improve and monitor Official Development Assistance (ODA) flows so that resources for maternal health, safe motherhood and other aspects of sexual and reproductive health, reach the poorest of the poor.
– Invest in strengthening the evidence concerning the links between reproductive health/sexual reproductive health and rights and poverty reduction and economic growth. Communicate more effectively the existing studies especially to economists in the development banks and to ministries of finance and plan.

Issue 2: "My body belongs to me": how can we better understand the interrelations of women's rights and the right to health?

– Laws and policies that directly or indirectly affect women's rights also have an impact on their health. For example, laws and policies concerning the legal age at marriage, control of economic resources and gender-based violence have clear health implications. Even when countries have reasonable laws

and policies, enforcement mechanisms are often weak. In most developing countries the civil society structures that monitor rights and advocate for reform are underfunded and often lack experience. This leaves women, particularly poor women, extremely vulnerable.

– There is a need to identify practical steps to make rights a reality. Better laws and policies and enforcement mechanisms are important. Other sectors can also play a useful role. For example, expanding access to quality education for girls and boys would reap enormous benefits. Educated girls are less likely to accept infringements on their liberty such as being married off at a very young age and experiencing multiple unwanted pregnancies and unsafe abortions. Education also equips people to better navigate health systems and to be more demanding of the health sector.

Recommendations

– Donors should invest heavily in strengthening civil society structures in the Global South. This support should include practical training to get governments to adhere to their reproductive health obligations and to promote sexual reproductive health and rights (SRHR).

– SRHR community should expand their collaboration with other stakeholders, especially those promoting improvements in access and quality of education to the world's poorest and most vulnerable children.

Issue 3: How to bring rights into Millennium Development Goals (MDGs) maintaining the momentum beyond 2014/2015?

– The various reviews of the MDGs offer opportunities to update stakeholders on how RtH/SRHR promotes the achievement of the targets and how the lack of rights negatively affects progress. For example, stigma greatly complicates both HIV/AIDS treatment and prevention efforts. The provision of safe motherhood services is affected not only by resources but also by the on-the-ground ability of women to access these services. This information is found in many different sources but is not yet collated in a reader-friendly manner.
– It appears that the United Nations Population Fund (UNFPA) will not be holding an international conference on population and development in 2014, when the Cairo Programme of Action expires. It is also not clear at this point in time whether the MDGs will continue beyond 2015. Recent interviews with SRHR stakeholders from the North and the South uncovered a strong desire to have a major event or series of events in 2014 that could
  a. inspire the entire field about the importance of SRHR,
  b. educate and mentor younger people, and
  c. prepare practical, concrete and data-based recommendations of the importance of SRHR and the RtH that would prepare our community to successfully advocate for a more prominent place in the post 2015 development frameworks.

Recommendations

– Prepare policy relevant briefs using available data to illustrate how the availability of rights, including SRHR, promotes the achievement of the health MDGs and, conversely, how the lack of these rights impedes achievements. This should be completed within the next year so as to inform the planning processes for 2014/2015.

– Donors should support in 2014 a conference similar to the Cairo + 5 Hague meeting. The purpose would be to take stock of RtH/SRHR progress in the last 20 years, prioritize remaining actions to improve RtH/SRHR and review the relationship between RtH/SRHR on poverty and economic growth. ■

Concluding remarks

Renate Bähr,
Executive Director, German Foundation for World Population (DSW), Hanover, Germany

"What does it take to make access to sexual and reproductive health information services and supplies a reality to all women, men and young people in developing countries?" This was the question that we started with when we first met in December 2009 to plan this conference and this also turned out to be the guiding question for us here in this room during the past two days. Now what does it take? It certainly takes: Advocating, Claiming, Measuring, Targeting, Championing, Strengthening and last, but not least Linking; these were the headlines of the World Café tables as well as the working groups. We have just heard the various recommendations that were the result of our collective thinking.

Let me take this opportunity to share with you some of my thoughts over the past two days and put them into the context of the challenging, but at the same time to some extent encouraging environment we are all working in at the moment as advocates for sexual and reproductive health and rights.

This year has seen the issue of maternal and child health lifted right to the top of the political agenda, the G8 committed themselves to this issue at the G8 summit in Muskoka/Canada and at the recent Millennium Development Goal (MDG) summit in New York the Secretary General's Global Strategy for Women's and Children's Health confirmed this commitment and widened the scope to a global partnership of stakeholders. At this point I would like to welcome the new initiative on voluntary family planning that Germany is developing right now where resources pledged in Muskoka for the area of mother

and child health will be made available for family planning and reproductive health and rights. In my opinion this is a positive sign that all of us together, civil society, private sector, development partners, not donors and partner country governments will collectively succeed to put sexual and reproductive health and rights including family planning right at the heart of development.

This is what we will have to do in the next five years in the run up to 2015 and beyond. These years will not only be crucial for our goal to make access to sexual and reproductive health a reality for all as set out at the ICPD, International Conference on Population and Development, in Cairo in 1994, but we will have to make sure that we will be part of the process and discussion that will shape whatever comes after the Millennium Development Goals.

The post 2015 agenda has to hold a firm place for sexual and reproductive health and rights - and population for that matter - as a cross cutting issue for all development sectors. A human rights-based approach is central as it means that we can hold governments accountable to their obligations, it can react to the needs of most vulnerable

groups and thus ensure an equal access to services. But we have to make sure that we also provide these services at a high quality, and not only raise expectations that later on cannot be met.

Therefore it is important that investments are made in this area: health systems are strengthened, health providers are trained and adequately paid, supplies are provided.

But for these investments we need convincing, target group specific arguments, and I would like to come back to the Ministers of Finance again: I can only support those of you that think that you can talk about population as a factor in poverty reduction and sustainable economic development and at the same time pursue a human rights-based approach to sexual and reproductive health. And make sure that they understand the benefits for investing in women.

It is equally important that we reach out to other sectors that will help us to make sexual and reproductive health for all a reality, be it education, gender, employment, environment and – why not – climate change. If we listen to the needs of the beneficiaries in our projects, and in our case these are mostly young people, we end up with a multi-sectoral approach. Young people need access to sexual and reproductive health, but at the same time they need training in order to get enhance their chances on the employment market, and they want to – as Gill Greer reminded us - engage in environmental protection, as they would like to make this planet a better place for them to live in.

This brings me to my last point: What does my organization – German Foundation for Population (DSW) take away from this meeting? What does it mean for our work in the future? Well, we are just in the process of designing our strategic plan for the next five years and I am very happy (and a bit proud) to see that many of the recommendations listed just now meet our thinking so far in a perfect way. We already work with a rights-based approach, and Peter Munene presented our project “Fit for the Future” in Tanzania as a good practice example. But our goal is now to firmly anchor this approach in all our interventions. At the same time we have taken the decision to include linkages to other sectors into our work, for example environment and employment and of course global health in general. I would like to encourage all of us to rethink our work and consider the recommendations that we take away from this meeting, because change starts at home. As change agents our advocacy should be firmly rooted in our conviction that we are all accountable for what we do: “so that we are not only doing what is right or what we think is the right thing, but what is right for the people”. If I may elaborate on a quote from Karen Newman, only then can our arguments be strong and convincing, because they are evidenced-based.

I thank you all again for coming here and sharing your expertise, experiences and enthusiasm with us. We, as the organizers of this meeting are looking forward to you sharing your follow up activities with us, because this is what we had hoped for: a conference that not only talks about change, but guides us all to action. ■

Summary report

Eighty representatives from leading non-governmental organizations in the area of sexual and reproductive health and rights, as well as those from the government and private sector met at the 8th International Dialogue in Berlin from October 5 to 6, 2010 to discuss and find answers to the question that was the focus of this International Dialogue: “Making sexual and reproductive rights a reality: what does it take?”

In his speech, the German Federal Minister for Economic Cooperation and Development, **Dirk Niebel,** clearly stated the importance of human rights, including the right to health (RtH), on the way to making the sexual and reproductive rights and the health of women and men a reality. Not only Germany, but also a growing number of bi- and multilateral agencies and civil society organizations have declared their interest in or committed themselves to a human rights-based approach to promote sexual and reproductive health. Looking ahead, discussions surrounding strategies that go beyond the Cairo ICPD Programme of Action (in 2014) and the Millennium Development Goal (MDG) target date of 2015 might be enhanced by a clear focus on human rights.

An experts’ meeting

This International Dialogue was designed and planned by all of the partner organizations involved in close coordination with one another; these were the German Foundation for World Population (DSW), Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH and InWEnt – Internationale Entwicklung und Weiterbildung gGmbH.

Welcome

Joachim Schmitt, Federal Ministry for Economic Cooperation and Development (BMZ), Division for Health and Population Policy, Bonn, **Klaus Brückner,** Director GTZ Office Berlin, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH and **Klaus Brill,** Vice President Corporate Commercial Relations, Bayer Schering Pharma AG, Berlin welcomed the participants. They expressed their hope that the Dialogue will enable participants to learn from best practice examples, to identify the challenges, and ways to overcome them; to network, meet new partners, discuss how to work together; and learn how best to strategize and move the agenda forward in the ministry, the donor community and the countries. They emphasized that MDG 5, improving maternal health, remains the least successful of the MDGs - for complex reasons, and not only due to a lack of resources. Maternal mortality and morbidity are not only a question of human health, but are the consequence of a denial of human rights in general. It was pointed out that this dialogue, which would be addressing the difficult question of what it takes to make sexual and reproductive rights a reality, would form the basis of a guide for action on how to make reproductive health initiatives successful.

Keynote Speech by Thoraya Ahmed Obaid

In her keynote speech Thoraya Ahmed Obaid underlined that, during the ten years she worked at United Nations Population Fund (UNFPA), a great deal of progress in development was achieved. She said that, when she started, "reproductive health was an agenda for women, but it is now becoming an agenda for men". She also welcomed the increasingly stable policies and the better legal foundations that have been put in place during the past two decades to improve maternal health. However, we can only measure progress, she stated, if the statistical capacities within countries can also be developed. She specified three challenges in reaching SRH for all:

- Inequity between and within countries. The rich are getting richer, the poor poorer. The poor are women.
- User fees which might hinder accessibility and increase inequity.
- Funding: there were many declarations in the UN General Assembly, at the MDG Summit, that additional money will come in for MDG 4 and 5. There was a response of the Secretary General on the Global strategy for women's and children's health of about 40 Billion US$ and another commitment of five billion US$ at the G8 in Canada. But the question is, whether these are new funds, or just redirected funds. It has to be monitored whether the money reaches those countries, which deserve to get it. Nobody is clear yet how this money is flowing and where it goes to. We have to look at how we can leverage resources for women, what ever resources are available.

Day One – A Conference with interaction

While organizing this conference, one issue was how to get all participants involved and

how to ensure that all participants communicate with each other. Therefore, the partners decided to have working groups and a World Café.

On the first day there were four working groups on four countries: Nepal, Burkina Faso, Tanzania and Colombia. These countries where chosen because, in them, many programmes and intitiatives use the rights-based approach and they are good examples of best practices. Furthermore, the partners involved have projects there. In each country group, a representative from government, as well as a donor and a non-state actor, all of whom work with country-specific, rights-based approaches to sexual and reproductive health, were asked to give their input on the following questions:

What individual, leadership and contextual factors have led to action?

1. *What obstacles to action were there? How were these overcome?*
2. *Has action improved health? Has it been sustained?*
3. *What lessons were learned? What are the recommendations for others?*

The target was to have examples of best practice which can provide a practical framework of principles and approaches and provide information for the day 2 discussions on developing a strategic action guide that deals with advocating, implementing, sustaining and strengthening a human rights approach to sexual and reproductive health.

Nepal

In the last three years, Nepal's Equity and Access Programme (EAP) has addressed the many obstacles women face in attaining their rights, especially those women marginalized by caste, living in remote areas, or isolated by poverty, language and traditional cultural practices. These are the people who are normally deprived of their rights in every sense. This programme has had successes, not only in the area of service provision but also in increasing knowledge, capacity and empowerment: "listening to the voices of the unheard". This is not just about direct health provision, but also about other aspects, for example, the fact that government and non-governmental organizations have established emergency funds in 3,500 community groups, thus freezing out money lenders. They have also promoted the setting up of emergency transport services such as cycle ambulances.

The Nepalese government has provided a strong legal framework. The constitution and the new national health strategy explicitly recognize basic and reproductive health respectively as a fundamental right for all. Essential health services are free, there is a legal basis for safe abortion, and education encourages people to claim their rights. Strong women's groups have advocated rights and data disaggregated by ethnicity has helped to track equity-related challenges.

The right to health forced the state to accept responsibility for respecting, protecting and fulfilling this right, but there is still much to be done. Contraceptive prevalence has gone

up, abortion has been legalized, maternal mortality has gone down, as have infant and under-five mortality. However, there is growing inequality between wealthy and poor women, and a major shortage of qualified personnel. Cultural challenges also remain, particularly among hard to reach groups, so the battle continues.

Tanzania

Tanzania has seen an increase in youth-friendly services, and different initiatives including advocacy in parliament. Nevertheless, there are still major gaps in the practical provision of SRH information and services for young people, and there is still much to do at the local level.

In collaboration with young people and other stakeholders, the Tanzanian German Programme to Support Health (TGPSH) led by the GTZ, supports the Ministry of Health in a comprehensive approach to sexual and reproductive health and rights as well as HIV prevention. Print and audio-visual materials have been developed on different subjects. The social marketing of condoms and a bilingual interactive web site are supported so that young people can request information about their health. The development of comprehensive policies, guidelines and standards for

adolescent-friendly health services has also been supported. Youth-specific interventions include school-based peer education, which is delivered in the form of extra-curricular activities, supported by counsellors / teachers and community involvement to ensure support, sustainability and ownership.

The 'Fit for the Future' programme of the German Foundation for World Population (DSW) in Tanzania targets girls who are poor, have little education and work in the informal sector with low pay and poor working conditions. They generally work in bars, markets, plantations, textile factories, guest houses, tailoring, and in commercial sex work. Typically, the young women are vulnerable and have unprotected sex, unwanted pregnancies, multiple partners, and unsafe abortions, sexually transmitted infections and HIV/AIDS. They often live in abusive circumstances. 'Fit for the Future' aims to improve their situation. It offers referrals and strengthens health facilities to offer quality, youth-friendly health serv-

ices, vocational training and educational opportunities. It has established 90 youth clubs and trained 2,700 peer educators and 72 service providers. It realized that any project targeting school girls should have childcare facilities, as girls with children would not be able take up training without it. The project also highlighted the need for youth-led micro finance. This is just one example of the need to take other sectors into account when addressing these rights.

Burkina Faso

Significant initiatives have taken place in Burkina Faso, and many rights are supported in the constitution: however they are not always implemented. There has been a particularly successful campaign to outlaw female genital mutilation (FGM). The campaign has had to overcome many obstacles ranging from family and social norms and aspirations, the low status of women, to the desire and expectation among men to control female sexuality; it also faced opposition from some religious authorities. FGM is now illegal and punishable by ten years in jail. Investment has been made in education, and communication on health risks, and this has been accompanied by offers of medical treatment to repair and treat the consequential diseases related to FGM. Networks have been set up; an action plan has been prepared, and increased funding has been found. The campaign is backed personally by the head of state. This means that FGM is no longer a taboo subject. When women come for help, their most pressing problems are met in an integrated way. The result is that incidents of FGM have been reduced, but it is still being carried out on nearly 50 per cent of women.

A human rights approach however comes up against its limits when it clashes with traditional beliefs and practices, and when social norms override individual rights. Burkina Faso - where families circumcise their baby daughters very early (and now go abroad to do it) - one answer seems to be that, in Africa, it is not only the message, but also the messenger that counts. This means you have to work through key traditional and religious gatekeepers. Behavioral changes cannot happen overnight, or even within one generation, but take place gradually.

Colombia

In Colombia the non-governmental sector has led the way on women's access to services. Since 1965, the non-government organization Profamilia has been the main promoter of family planning in Colombia, but the government is taking on an increased role and is showing more commitment. The birth rate has now dropped from 6.7 children per woman in 1960 to 2.4 in 2005. Profamilia also has a men's programme, training peer educators, providing legal services and carrying out demographic and health surveys. Despite all this, the rate of teenage pregnancies has currently been on the rise, and the Ministry is combating this with interventions such as youth-friendly services and sex education in schools. They have had to cope with obstacles such as opposition from the higher levels of the church, decreased funding, and the gap between what was legal and what actually happened.

Human rights are universal, and using a human rights-based approach to reach those who are deprived of these makes clear where the priorities must lie, namely in legislation.

Day Two – Looking ahead: strategic recommendations on the way forward

On day two participants were asked to engage in a series of sequential small group activities aimed at capturing their collective wisdom and hearing about their experiences in the area of reproductive health and rights. The day started with a World Café. The aim was for participants to share stories on human rights-related action in seven different categories, and to identify key factors that had determined success or failure. In the plenary meeting, an appointed speaker presented the outcome of the discussions at

the World Café tables as well as the resulting recommendations that came from the working groups later that day. The organizers had identified seven areas for action. These were:

Advocating: initiating a rights-based approach or campaign for sexual and reproductive health, raising awareness, using evidence, engaging stakeholders, proposing policy change, countering opposing forces.

Claiming: using human rights institutions and the courts to support people in claiming their rights to health.

Measuring: monitoring and evaluating the health impact of human rights-related sexual and reproductive action.

Targeting: addressing the special need for action to support the sexual and reproductive rights of women and young people.

Championing: responding to and addressing the unmet need for family planning as a rights-based issue within the framework of population policies.

Strengthening: health system capacities to address sexual and reproductive health and human rights, especially of poor and/or marginalized people.

Linking: rights-based approaches to sexual and reproductive health and to national and international action to achieve the MDGs, especially those focused on maternal and child health and HIV.

The conference closed with a summary by **Renate Bähr,** Executive Director of the German Foundation for World Population (DSW). She expressed her thanks to the Federal Minister for Economic Cooperation and Development, **Dirk Niebel,** all organizers and all participants. She emphasized that this year the issue of maternal and child health has gone to the top of the political agenda, both at the MDG summit and the G8. She welcomed the new initiative of the German government on voluntary family planning as a great opportunity to make family planning, and sexual and reproductive health and rights a reality for all women, men and young people. In the run up to 2015, she continued, we must make sure that sexual and reproductive health and rights and population as a cross cutting issue for all development sector plays a prominent rolein the discussion that will shape the final phase of the MDGs and the post 2015 agenda. It is equally important to reach out to other sectors in order to make sexual and reproductive ealth for all a reality, be it education, gender, employment, environment and climate change. DSW is just designing the next five-year strategic plan, and many of the recommendations made here form part of it. She closed her speech by praising the fact that this conference not only talked about change but also pointed the way towards action. ■

Appendices

Programme

5 – 6 October 2010, Berlin, Germany, GTZ-House, Reichpietschufer 20, 10785 Berlin

Programme | Day 1 (5th October)
Learning from good practices: setting the scene

12.30 p.m. Registration and informal lunch

1.00 p.m. **Opening**
Brief words of welcome
Joachim Schmitt, Federal Ministry for Economic Cooperation and Development, Division for Health and Population Policy, Bonn

Welcome Address
Klaus Brückner, Director GTZ Office Berlin, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, Berlin

Welcome Address
Klaus Brill, Vice President Corporate Commercial Relations, Bayer Schering Pharma AG, Berlin

Moderator: **Franklin Apfel,** Managing director, World Health Communication Associate (WHC)

1.30 p.m. **Keynote Speech**
Thoraya Ahmed Obaid, Executive Director, United Nations Population Fund (UNFPA), New York

2.30 p.m. **Working Groups on good practices from four countries**

Working Groups – Day 1- Introduction
Key stakeholders including donors, government officials, and NGO advocates, will share perspectives and practical experiences based on their experience with country-specific rights-based approach to sexual and reproductive health. This will include sharing of perspectives, and practical experience on how actions were developed and implemented; how obstacles were addressed; what impact on health has been achieved; and, what lessons learn could be useful to others in different contexts. Recommendations from case studies

and best practices will provide a practical framework of principles and approaches that will inform Day 2 discussions related to developing strategic action guidance related to advocating, implementing, sustaining and strengthening human rights approaches to sexual and reproductive health.

3.45 p.m. **Wrap up of the outputs of the discussions**

4.30 p.m. Transfer to Federal Ministry for Economic Cooperation and Development (BMZ) building (11th floor)
Coffee at BMZ

Country group Nepal

Input 1 – Government Representative
Yasho V. Pradhan, Director general, Department of Health Services, Ministry of Health and Population, Nepal

Input 2 – Donor Representative
Ian McFarlane, Representative, United Nations Population Fund (UNFPA), Nepal

Input 3 – Non State Actor
Bharat Devkota, Former Team Leader Equity and Access Programme, Action Aid International, Nepal

Rapporteur – lessons learnt, concrete recommendations
Ilse Worm, Consultant, Germany

Country group Tanzania

Input 1 – Government Representative
Neema Rusibamayila, Director Reproductive and Child Health Division, Ministry of Health and Social Welfare (TGPSH), Tanzania

Input 2 - Donor Representative
Inge Baumgarten, Principle Technical Advisor Health, Programme Manager, Tanzanian German Programme to Support Health (TGPSH), Tanzania

Input 3 – Non State Actor
Peter Munene, Country Director, German Foundation for World Population (DSW), Dar es Salam, Tanzania

Rapporteur – lessons learnt concrete recommendations
Joseph Matimbwi, Tanzanian German Programme to Support Health (TGPSH), Tanzania

Country group Burkina Faso

Input 1 – Government Representative
Marie Rose Sawadogo Ouédrago, Permanent Secretary of the National Committee of Fight against the Pratice of Excision, Burkina Faso

Input 2 - Donor Representative
Marion Kneesch, Sector Economist, Chief Sector Division Health, Education, Social Protection Sub Saharan Africa, KfW Entwicklungsbank, Frankfurt

Input 3 – Non State Actor
Angèle Sourabié, Association Burkina Bé pour le Bien-Être Familiale, Ougadougou, Burkina Faso

Rapporteur – lessons learnt, concrete recommendations
Guy Zoungrana, Programme Santé Sexuelle et Droits Humains (PROSAD), Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, Burkina Faso

Country group Colombia

Input 1 – Government Representative
Lenis Urquijo, Director de Salud Pública, Ministerio de la Protección Social, Colombia

Input 2 - Donor Representative
Lucy Wartenberg, Assistant Representative, United Nations Population Fund (UNFPA), Colombia

Input 3 – Non State Actor
Liliana Schmitz, Public Relations Manager, Profamilia, Colombia

Rapporteur – lessons learnt, concrete recommendations
Seri Wendoh, Rights and Gender Advisor, International Planned Parenthood Federation (IPPF), UK

Panel discussion: Stronger Rights – Better Health?

5.30 p.m.

Welcome Address
Klaus Müller, KfW Entwicklungsbank, Frankfurt

Panel
Moderator: **Melinda Crane,** Deutsche Welle-TV

John Cleland, Professor of Medical Demography, London School of Hygiene and Tropical Medicine, University of London, UK

Gill Greer, Director General, International Planned Parenthood Federation (IPPF), United Kingdom

Helena Nygren-Krug, Health and Human Rights Adviser, Department of Ethics, Equity, Trade and Human Rights, Information, Evidence and Research (IER/ETH), World Health Organization (WHO)

Yasho V. Pradhan, Director General, Department of Health Services, Ministry of Health and Population, Nepal

7.00 p.m.

Public opening of the 'Health – it's my right' exhibition

Dirk Niebel, Federal Minister for Economic Cooperation and Development (BMZ), Germany

Reception

9.00 p.m.

End of Day 1

Programme | Day 2 (6th October)
Looking ahead: Strategic recommendations on the way forward?

9.00 a.m. **Summary of key findings and recommendations from Day 1**

Moderator: **Franklin Apfel,** Managing director, World Health Communication Associates (WHCA) ltd., UK

Rapporteur: **Sabrina Cecconi and Viv Taylor Gee,** World Health Communication Associates (WHCA) ltd., UK

9.30 a.m. **World Café**

Participants are asked to share stories pertaining to brief human rights-related action related to one of the section action tracks listed below. 'Storytellers' will be asked to identify key factors related to the success or failure of the described actions. After twenty minutes of conversation, participants will be invited to move to another table and repeat the process for a second action area.

7 Tables/ 7 Tracks

Table 1/track 1: Advocating – Initiating a rights-based approach/campaign for sexual and reproductive health, raising awareness, using evidence, engaging stakeholders, proposing policy change, countering opposing forces.

Host table 1A **Jon O'Brien,** President, Catholics for Choice, Washington, USA

Host table 1B **Nancy Northup,** President, Center for Reproductive Rights, New York, USA

Table 2/track 2: Claiming – Using human rights institutions and the courts to support people in claiming their rights to health.

Host table 2A **Roselyn Karugonjo-Segawa,** Director Division 'Monitoring and Inspections', Uganda Human Rights Commission, Uganda

Host table 2B **Paul Hunt,** Former UN Special Rapporteur on the right to health, professor and member of the Human Rights Centre of University of Essex, UK

Table 3/track 3: Measuring – Monitoring and evaluating health impact of human rights related sexual and reproductive actions.

Host table 3A **Sivananthi Thanenthiran,** Programme Manager for Information and Communication, Asian-Pacific Resource and Research Center for Women (ARROW), Malaysia

Host table 3B **Gabriele Gahn,** Senior Project Adviser, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, Germany

Table 4/track 4: Targeting – Addressing the special need for action to support the sexual and reproductive rights of women and young people.

Host table 4A **Seri Wendoh,** Rights and gender Advisor, International Planned Parenthood Federation (IPPF), Africa Regional Office, Kenya

Host table 4B **Elke Thoß,** Executive Director, pro familia, Germany

Table 5/track 5: Championing – Responding to and addressing the unmet need for family planning as a rights-based issue within the framework of population policies

Host table 5A **Beth Fredrick,** Bill and Melinda Gates Institute for Population and Reproductive Health/John Hopkins Bloomberg School of Public Health, Deputy Director, USA

Host table 5B **Gilda Sedgh,** Senior Research Associate, The Guttmacher Institute, New York, USA

Table 6/track 6: Strengthening – Health system capacities to address sexual and reproductive health and human rights, especially of poor and/or marginalized people.

Host table 6A **John Skibiak,** Director, Reproductive Health Supplies Coalition (RHSC), Brussels

Host table 6B **Tania Boler,** Head of Research and Metrics, Marie Stopes International (MSI), London, UK

Table 7/track 7: Linking – Rights-based approaches to sexual and reproductive health to national and international action to achieve the Millennium Development Goals (MDGs) especially those focused on Maternal and Child health and HIV.

Host table 7A **Sara Seims,** Director of Population Programme, The William and Flora Hewlett Foundation, USA

Host table 7B **Anders Zeijlon,** The Nordic Trust Fund, OPCCS, The World Bank, USA

11.15 a.m. **Working groups**

Track 1: Advocating – Initiating a rights-based approach/campaign for sexual an reproductive health, raising awareness, using evidence, engaging stakeholders, proposing policy change, countering opposing forces.
Input: **Jon O'Brien,** President, Catholics for Choice, Washington, USA
Rapporteur: **Huzeifa Bodal,** Senior Programme Manager, Health Systems Strengthening Team – German BACKUP Initiative, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), Eschborn, Germany

- How to bring sexual and reproductive health into the national and International human rights discourse?
- Engaging rights and values: how to deal with controversial issues?
- What examples of good practices show how policies can be infl uenced via evidence-based data?
- Identifying areas that need strengthening and follow-up.

Track 2: Claiming – Using human rights institutions and the courts to support people in claiming their sexual and reproductive rights.
Input: **Roselyn Karugonjo-Segawa,** Director Division 'Monitoring and Inspections', Uganda Human Rights Commission, Uganda
Rapporteur: **Ruth Charo,** Social Development Specialist, former Coordinator Health NGOs Network, African Development Bank, Kenya

- Which legal and institutional mechanisms need to be put in place to ensure that people can have access to justice and claim their sexual and reproductive rights?
- How can national human rights institutions and the courts contribute to improve governance by holding governments accountable for their obligation to respect, protect and fulfi l the right to health, including reproductive and sexual health for all?
- How can we empower people to be aware and act on their sexual and reproductive rights?

Track 3: Measuring – Monitoring and evaluating health impact of human rights-related sexual and reproductive actions.
Input: **Sivananthi Thanenthiran,** Programme Manager for Information and Communication, Asian Pacific Resource and Research Center for Women (ARROW), Malaysia
Rapporteur: **Siegrid Tautz,** Trainer and consultant, Evaplan GmbH am Uniklinikum Heidelberg, Germany

- What are the consequences of human right to health violations, and what best practices can be used to monitor data to ensure the human right to SRHR for all?
- Consequence of human right to health violations: What are good practice examples on how to use monitoring data to enforce the human right to SRH for all?
- How policies can be infl uenced by evidence-based data?

Track 4: Targeting – Addressing the urgent need to support women's and young peoples's SRHR. Taking a rights-based approach in SRH, we need to go beyond business as usual and truly understand sexual rights of women and girls and how they are linked to their right to health. Only then can we address barriers to access to effective, stigma free and gender sensitive services and programmes.
Input: **Olufunmilayo Balogun-Alexander,** Director, External Relations and Advocacy, International Planned Parenthood Federation (IPPF), Africa Regional Office, Kenya
Rapporteur: **Hilkka Vuoremaa,** Senior Advocacy Officer, Väestöliitto, the Family Federation of Finland, Helsinki

- What are the root causes in preventing women and girls from achieving their sexual and reproductive health and rights?
- What strategies have proven successful to eliminate these root causes and create supportive and safe environments for women and girls to make informed choices related to sex and pregnancy?
- How can we empower with women and girls to make informed decisions on sex and SRH?

Track 5: Championing – Responding to and addressing the unmet need for family planning as a rights-based issue within the framework of population policies.
Input: **Beth Fredrick,** Bill and Melinda Gates Institute for Populationand Reproductive Health/ John Hopkins Bloomberg School of Public Health, Deputy Director, USA
Rapporteur: **Sonja Weinreich,** Senior Health Advisor at EED, Church Development Service (Evangelischer Entwicklungsdienst – EED), Germany

- How should population dynamics as a global challenge be approached in the context of human rights?

- With regard to the unmet need for family planning, how can we ensure that the rights of women and families are at the centre of the population debate?
- How can we build and use Public Private Partnerships to ensure the development of new technologies? And what role should these technologies play in implementing a rights-based approach to sexual and reproductive health?

Track 6: Strengthening – health system capacities to address sexual and reproductive health and human rights, especially of poor and/or marginalized people.
Input: **John Skibiak,** Reproductive Health Supplies Coalition, Brussels
Rapporteur: **Karen Newman,** Population and Sustainability Network (PSN), UK

- How can health sector reform ensure access to SRH services for the poor and marginalized?
- How can affordable SRH services for underprivileged groups be financed?
- Which approaches (to service delivery) will strengthen the right to health?

Track 7: Linking – rights-based approaches to sexual and reproductive health to national and international action to achieve the Millennium Development Goals (MDGs) especially those focused on Maternal and Child Health and HIV.
Input: **Sara Seims,** Director of Population Programme, The William and Flora Hewlett Foundation, USA
Rapporteur: **Laura Reichenbach,** Head, Reproductive Health Programme, ICDDR, B, Bangladesh

- What are experiences in working with a right-based approach in the area of maternal health and safe motherhood?
- 'My body belongs to me': How can we better understand the interrelations of women's rights and the right to health?
- How to link human rights with the Millennium Development Goals (MDGs), maintaining the momentum beyond 2014/2015?

1.00 p.m.	Lunch Break
2.00 p.m.	**Closing Plenary** Short presentations of recommendations/outputs coming out of the working groups and final round of Q & A and discussion
3.30 p.m.	**Concluding Remarks** **Renate Bähr,** Executive Director, German Foundation for World Population (DSW), Hanover, Germany
4.00 p.m.	**End of 8th International Dialogue**

Visualization of conference structure – Flowchart

Day 1 (5th October)

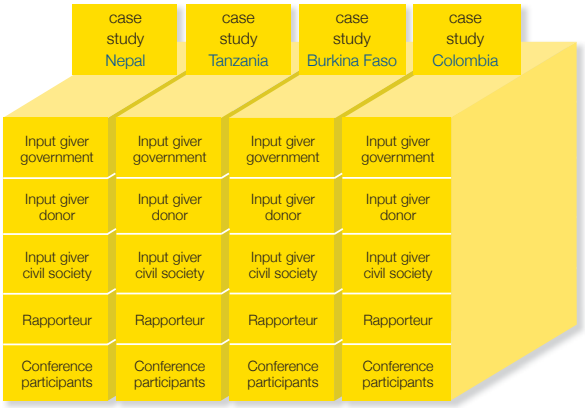
Learning from good practices: setting the scene

1.00 p.m.

Step 1 Introduction goals objectives

2.30 p.m.

Step 2 Country groups and discussion

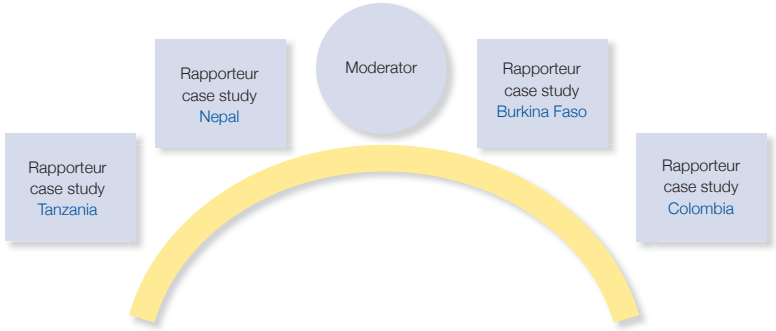


Questions:

1. What individual, leadership and contextual factors led to action?
2. What were obstacles to action? How were these overcome?
3. Has action improved health? Has it been sustained?
4. What were lessons learned? What are recommendations for others?

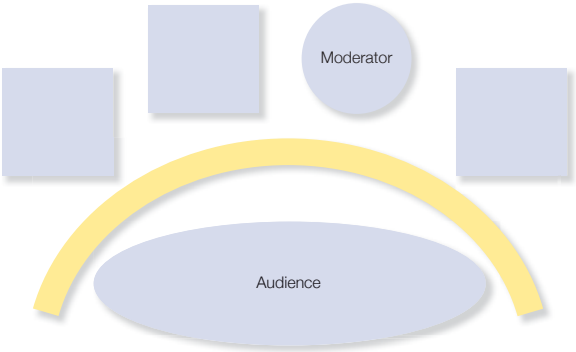
3.45 p.m.

Step 3 Roundable/output of the discussions



5.30 p.m.

Step 4 Panel discussion – can human rights improve health? Stakeholders‘ perspectives



7.00 p.m.

Step 5 Public opening of the „Right to Health“ exhibition

Day 2 (6th October)

Looking ahead: strategic recommendations how to move forward

9.00 a.m.

Summary of key findings and recommendations from day 1 by moderator

9.30 a.m.

Step 6 World Café / discussions

14 tables – 2 rounds of story telling
(5 participants each)

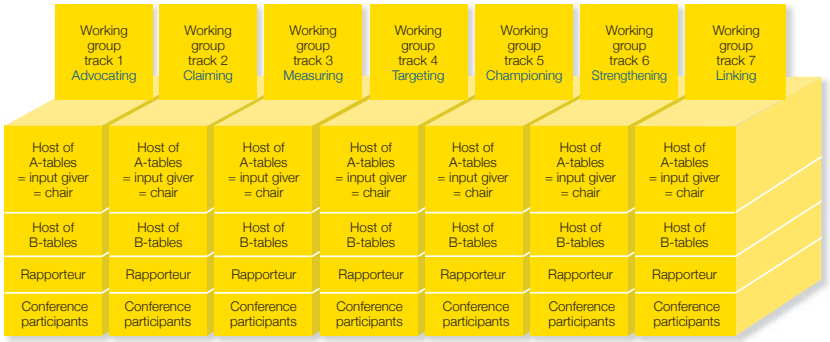
World Café tables will identify issues to be discussed in working groups

11.15 a.m.

Step 7 Practical case study discussions

Seven working groups will build on the conversations of the World Café, address specific questions and agree (strategic recommendations how to look forward) action recommendations: related to what works, ways to overcome
obstacles and adress action areas which need strengthening.

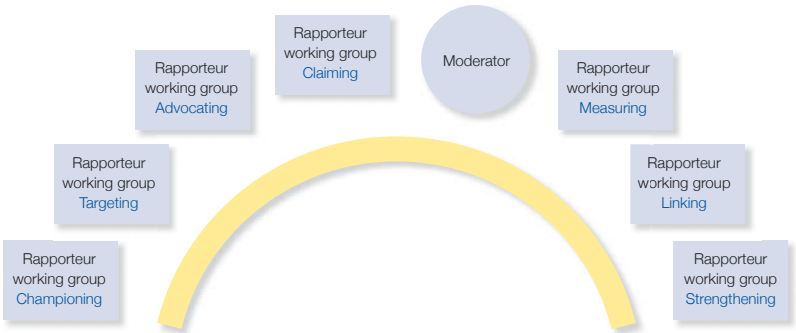
Host of the A-tables are asked to give a brief input (attn. please no power point) and to chair the working groups related to the issues discussed at their table at World Café.



Recommendations from working groups

2.00 p.m.

Step 8 Final recommendations



Curricula Vitae

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is Managing Director and founding partner of World Health Communication Associates (WHCA) Ltd. and serves as a visiting faculty member of the Health Science Department at the University of West of England.

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is the Executive Director of the German Foundation for World Population (DSW). Ms. Bähr has a long-standing record of successful media and public awareness work for population and sexual and reproductive health issues in Germany and around the world.

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is Head of the Tanzanian-German Programme to Support Health (TGPSH) and Priority Area Health Coordinator of German Development Cooperation in Tanzania.

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is currently working for "the German BACKUP Initiative", a GTZ programme that provides technical support to over 60 countries on various processes related to the Global Fund, based in Eschborn, Germany.

BOLER, Tania

is Head of Research and Metrics at Marie Stopes International MSI), an international NGO providing sexual and reproductive health services in over 40 countries.

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BRÜCKNER, Klaus

is Director of the GTZ-Representation in Berlin. From 2002 to 2008 he worked for the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) in Pretoria/South Africa as a Programme Manager for the cooperation with Panafrican Institutions – NEPAD and the Pan African Parliament – and as Senior Advisor to the Presidency of the South African Government.

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began her career as a World Bank Group–Employee. Since 2008 she has worked as a Social Development Specialist for the African Development Bank in the Human Development Sector in Kenya.

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is Professor of Medical Demography at the London School of Hygiene and Tropical Medicine. He manages a research programme funded by the Department for International Development (DFID) on sexual and reproductive health.

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is a journalist and TV-presenter. Melinda Crane produced documentaries for German and US television and wrote for the Christian Science Monitor, The Boston Globe and The New York Times Magazine.

DEVKOTA, Dr., Bharat

is working as an independent consultant. Previously he worked as a Consultant for the Department for International Development (DfID) and the Nepalese Ministry of Health and Population to prepare a concept paper on Gender Equality, Social Inclusion and Rights (GESIR) in the Health Sector in Nepal.

FREDRICK, Beth

is the Deputy Director at the Bill and Melinda Gates Institute for Population and Reproductive Health. She is Executive Vice President within the International Women's Health Coalition and has spent more than two decades promoting and protecting sexual and reproductive rights and health.

GABRIEL, Annette

has her educational background in African studies and development economics. She has worked in reproductive health and family planning since her first professional assignment with UNFPA in 1991. For the past five years she has been a health and population specialist for KfW Entwicklungsbank. She is member of the steering group of the 8th Dialogue.

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is Director General of the International Planned Parenthood Federation (IPPF), appointed in 2006. She is a highly experienced and committed sexual and reproductive health professional and has been the Executive Director of the New Zealand Family Planning Association since 1998.

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is the Director of Communications and Advocacy of the German Foundation for World Population (DSW). She has more than 16 years of experience working in the field of information, communication and advocacy on development issues with a special focus on population issues and sexual and reproductive health. She is member of the steering group of the 8th Dialogue.

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is adjunct professor at the University of Waikato, New Zealand, and professor at the University of Essex, England. From 2002 to 2008, he was appointed the UN Special Rapporteur on the Right to Health.

KARUGONJO-SEGAWA, Roselyn

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is Country Director of the German Foundation for World Population (DSW) Tanzania. Mr. Munene has 11 years of experience as an advocate for the vulnerable, particularly for children and youth.

NEWMAN, Karen

is coordinator for the Population and Sustainability Network (PSN). She was one of the main architects of the IPPF Charter on Sexual and Reproductive Rights.

NORTHUP, Nancy

is President of the Centre for Reproductive Rights, a global human rights organization that uses constitutional and international law to secure women's reproductive freedom.

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OBAID, Dr., Thoraya

is Executive Director of the United Nations Population Fund (UNFPA). Formerly, she was a member of the United Nations Strategic Framework Mission to Afghanistan.

O'BRIEN, Jon

is President of Catholics for Choice (CFC). He heads the leading pro-choice organization, addressing sexual and reproductive rights from a standpoint of culture, faith, and morality.

PRADHAN, Dr., Yasho V.

is Director General of the Department of Health Services in the Ministry of Health and Population in Nepal. He was Director in different divisions of the Department of Health Services before he became chief of Policy Planning and International Cooperation Division of the Ministry of Health and Population.

REICHENBACH, Dr., Laura

is a social scientist and Head, Reproductive Health Programme at ICDDR,B in Dhaka, Bangladesh. Dr. Reichenbach's research interests lie in the area of global health policy with a particular focus on reproductive health, policy processes, and gender dimensions of the health workforce.

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works in the Division for Health and Population Policy in the German Federal Ministry for Economic Cooperation and Development in Bonn. His main working areas are MDG 4 and 5, sexual and reproductive health and rights, population dynamics as well as the right to health. He is member of the steering group of the 8th Dialogue.

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works for the Guttmacher Institute and is currently engaged in a study on unsafe abortion in Burkina Faso and documenting unsafe abortion levels and patterns in Indonesia.

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is Director of the Population Programme of The William and Flora Hewlett Foundation since October 2003, and former president of the Guttmacher Institute.

SKIBIAK, John

is Director of the Reproductive Health Supplies Coalition (RHSC). Previously, Mr. Skibiak was Director of the Population Council's Expanding Contraceptive Choice Programme in Africa, and Co-ordinator of ECafrique.

SOURABIÉ, Angèle

is Programme Director of the Association Burkina Bé pour le Bien-Être Familiale (ABBEF). She is an expert in the fields of development and management of reproductive health programmes and the training of trainers in the field of sexual rights.

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is Executive Director of pro familia, German Association of Family Planning, Sexuality, Education and Sexual Counselling (founding member of IPPF). She worked as consultant to governments, UN-Agencies such as WHO Europe and NGOs on sexual and reproductive health and rights issues.

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is Assistant Representative at United Nations Population Fund (UNFPA), Colombia. Most of her professional carrier she has been a lecturer and researcher at Externado University of Colombia, Faculty of Social Sciences. Her research work mainly focused on population, gender, women and family.

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is consultant with expertise in public health and human rights; sexual and reproductive health and rights; impact assessment and evaluation of development programmes. Since 2007 Ilse Worm is giving continuous support to the GTZ, the BMZ and the WHO in the field of health and human rights.

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Publications of International Dialogue on Population and Sustainable Development

8th International Dialogue
Making sexual and reproductive rights a reality: What does it take?, Berlin 2010

7th International Dialogue
Exploring Cultural Diversity and Gender Equality: towards universal access to sexual and reproductive health and rights, Berlin 2009

6th International Dialogue
Meeting the Challenge – Sexual and Reproductive Health and Rights in an Urbanising World, Berlin 2008

5th International Dialogue
Demographic Dynamics and Socio-Economic Development, Berlin 2007

4th International Dialogue
Promoting Adolescent Sexual Knowledge and Responsible Behaviour, Berlin 2006

3rd International Dialogue
Implementing the Millennium Development Goals, Berlin 2005

2nd International Dialogue
Ways out of the Crisis - Reproductive Health in Need of New Ideas, Berlin 2004

1st International Dialogue
Reproductive Health - Stepchild of the International Community?, Berlin 2002

Most of these publications are also available on our website:
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The International Dialogue on Population and Sustainable Development underlines the interdisciplinary importance of sexual and reproductive health and rights (SRHR) and population dynamics as key factors in achieving international development goals such as the Millennium Development Goals (MDGs). The conference series is designed to facilitate the networking of national and international players and encourage the exchange of information and experience.
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