

Report of the EuroNGO Conference

Poverty, Politics and Sex: Will the Millennium Development Goals Deliver Sexual and Reproductive Health and Rights?

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- + Speakers and panellists
- + Facilitators and chairs
- + All participants, especially the youth participants, who shared their expertise and enthusiasm

ACRONYMS AND ABBREVIATIONS

AIDS Acquired Immune Deficiency Syndrome

DFID UK Department for International Development

EC European Commission

ECOSOC United Nations Economic and Social Council

EPWG European Parliament Working Group on Population, Sustainable Development and Reproductive Health

EU European Union

FPA Family Planning Association

GAERC General Affairs and External Relations Council of the European Union

GNP Gross National Product

G77 Group of the Seventy-Seven Developing Countries

HIV Human Immunodeficiency Virus

ICPD PoA International Conference on Population and Development Programme of Action

IEC Information, Education and Communication

IPPF International Planned Parenthood Federation

MDGs Millennium Development Goals

ODA Official Development Assistance

OECD Organisation for Economic Co-operation and Development

OVC Orphans and Vulnerable Children

PLWA Persons Living With AIDS

PRSPs Poverty Reduction Strategy Papers

SRHR Sexual and Reproductive Health and Rights

UN United Nations

UNDP United Nations Development Programme

UNFPA United Nations Population Fund

TB Tuberculosis

WHO World Health Organisation

FOREWORD

Dear all,

It was about 10 years ago that the EuroNGOs network came to life in Ghent, a small but very nice city in Belgium. So it was an honour for me and my organisation Sensoa to host the 2005 EuroNGOs conference in Brussels. Not only because of the symbolism, but also because 10 years after Cairo there is still a long way to go.

The goals that were set on sexual and reproductive health and rights in Cairo are, as you all know, still not met. And since a lot of focus is now on the Millennium Development Goals we also have to shift our attention and work much harder to put sexual and reproductive health and rights on that agenda too.

That is why Sensoa was happy to host this timely meeting of the EuroNGOs network. A timely meeting that has put sexual and reproductive health and rights where it belongs: on top of the agenda and at the heart of the MDGs.

I sincerely hope that our international high level speakers provided you with updated information. I sincerely hope that the speeches, workshops, interaction with other participants inspired everyone present to go ahead with the hard work they are doing. And I also hope and wish that we all can get the message across that sexual and reproductive health and rights for all are as important to the well being of every individual as drinking water is. Let's go for it.

Dirk Pyck
Executive Director Sensoa

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EXECUTIVE SUMMARY

140 participants representing a wide range of technical and geographic expertise gathered in Brussels for the first EuroNGOs International Conference. The Conference incorporated the EuroNGOs Membership Meeting and it provided an opportunity to exchange ideas, experiences and strategies to mobilize support for increased attention to sexual and reproductive health and rights (SRHR) issues in view of the Millennium Development Goals +5 review¹ to be held in September 2005.

Representatives from numerous NGO networks, EU officials and parliamentarians, as well as UN experts and academics were invited to present different viewpoints on the achievement of the three Millennium Development Goals (MDGs) relevant to SRHR. Much of the input and discussion anticipated events and review processes throughout 2005 that will be assessing progress in achieving the MDGs and specifically the SRH-related goals.

As indicated in the title, the objective of the Conference was to analyze the gaps between the ICPD Programme of Action (PoA) and the MDGs with a focus on the three SRHR-related MDGs (maternal health, gender equality and HIV/AIDS) and to devise strategies and possible directions to guide EuroNGOs' work and the work of all those involved in ensuring that SRHR are prioritized in the run up to the MDG review process.

Participants noted that there was significant compatibility between the goals of the ICPD Programme of Action and the MDG framework. However, there was general consensus that the MDGs narrowed down the broader SRHR issues highlighted in the Cairo agenda². Participants also stressed the synergies between the actions needed to implement the ICPD PoA and the MDGs. However, it was noted that the measures recommended in the Cairo agenda were more comprehensive and detailed than those indicated in the MDGs – particularly in the case of maternal mortality, the promotion of gender equality and the fight against HIV/AIDS.

Dirk Pyck, the Director of the Flemish expert organisation on sexual health and HIV host organisation, Sensoa, welcomed the Conference participants. Susan Crane, Chair of EuroNGOs also welcomed members and guests and summarized the purpose of EuroNGOs. Both hosts thanked the sponsors of the Conference, the William and Flora Hewlett Foundation and John D. and Catherine T. MacArthur Foundation, both of which helped to make the Conference and Membership Meeting possible.

Mr Hugo-Maria Schally, Head of the Relations with the UN system, Member states and other OECD Donors Unit at the European Commission Directorate General for Development, gave the opening address which focused on the European Community's role in helping developing countries to achieve the MDGs.

¹ The United Nations system has embraced the Millennium Declaration and the MDGs as the blueprint for its work in economic and social development in the coming decade. Reproductive health, however, is not explicitly included in any of the 8 goals.

² The Cairo Agenda – a set of international agreements – which came out of the International Conference on Population and Development in 1994, shifted policy focus away from population control. Access to good quality reproductive health care for both women and men was promoted as a right.

Keynote speaker Amado Vaz Dos Santos, Executive Director of the Associação Santomense de Promoção Familiar, gave an inspirational and thought provoking account of the situation in São Tomé and Príncipe, as well as examples of progress and obstacles faced in Sub-Saharan Africa to reach the overall goals set by the ICPD PoA and the MDGs.

Presentations on three key MDG Task Force reports followed the opening session. The presentations were made by Sandra Kabir (ICOMP), France Donnay (UNFPA) and Kevin Osborne maternal health and HIV/AIDS respectively, and explored practical steps to institutionalize new SRHR targets and indicators in the monitoring of MDG progress.

In his presentation, Stan Bernstein, Senior Sexual and Reproductive Health Policy Advisor for the UN Millennium Project, reported on the progress of the Millennium Project in ensuring greater attention to sexual and reproductive health in the discourse and mechanisms of the Millennium Development Goals. Mr Bernstein also made specific recommendations for "Quick Win" priority interventions with special attention to those relevant to the SRHR community.

In the afternoon, participants divided into three parallel discussion groups on gender, maternal health and HIV/AIDS to discuss the findings of the MDG Task Forces and develop recommendations on priorities and strategies. The recommendations were presented to Lieve Fransen, Head of the Social and Human Development Unit at the European Commission Directorate General for Development, who gave the closing speech during the final plenary session. The text of the recommendations was finalized after the Conference and they are included as an Annex to this report.

In her address, Ms Fransen insisted on the need to operationalise and articulate the MDG framework with other development agendas. She stressed the need to make the MDGs more practical at the field level and to create more opportunities for the support and inclusion of SRHR.

The recommendations from the discussion groups fed the discourse in the afternoon plenary panel debate which focused on the challenges and progress in achieving SRHR in the MDGs. Panellists included Joana Almeida (YouAct), Lieve Fransen (EC), MEP Ann Van Lancker, Wendy Harcourt (WIDE), Stuart Tyson (DFID) who each held different viewpoints and strategic concerns about how to ensure SRHR was firmly on the agenda. All of the panellists reaffirmed that access to good quality reproductive health care for both women and men is paramount in the struggle for poverty eradication and sustainable development.

A final plenary discussion was held summarizing the key issues from the day. Speakers focused on ways for SRHR advocates to take part most effectively in the events that will be reviewing progress in attaining the MDGs, particularly to ensure the balanced reflection of SRH concerns leading up to the MDG Summit itself. Participants deplored the fact that the goals and targets of the Cairo PoA and the MDGs would not be met within their respective timeframes. This is due to the absence of political will among governments to provide the resources, policies and information needed to make the goals a national priority. In addition, inadequate financial resources caused by shortfalls in Official Development Assistance (ODA), bad governance, insufficient public awareness and a failure to mobilize community-level understanding and support through civil society organisations and the media were also identified as causes.

The conference recommendations focused on overcoming the lack of a reproductive health goal within the MDGs whilst retaining the broad vision of reproductive health care contained in the Cairo PoA. Participants also stressed that advocacy efforts and careful coalition building between SRH and development advocates were needed both at international and national levels. This is particularly important to promote a progressive consensus against opposition from specific countries and conservative interests, which oppose the rights-based agenda.

SUMMARY OF THE CONFERENCE PROCEEDINGS

1 Welcome and Opening Session

1.1 Susan Crane, Chair of EuroNGOs



Susan Crane, Chair of EuroNGOs, opened the Conference. She explained that this was the first time EuroNGOs had attempted such a large Conference and that it would be followed by the 10th EuroNGOs membership meeting. Susan introduced the agenda and explained how this Conference would focus on how to ensure that SRHR are prioritised within the MDGs.

In pursuit of the implementation of the ICPD PoA adopted in Cairo in 1994, EuroNGOs has taken a lead role in bringing European NGOs operating in sexual and reproductive health together to form an effective forum for discussion and collaborative advocacy for greater efficacy and improvement of the quality of reproductive health in developing countries. At the 1st meeting held in 1996 in Hannover, EuroNGOs was mandated to advance the ICPD PoA in Europe and to follow-up on the implementation of the commitments made in Cairo.

1.2 Dirk Pyck, Executive Director, Sensoa

Dirk Pyck, Executive Director of Sensoa, welcomed all participants to the Conference on behalf of Sensoa. Dirk gave a brief introduction to Sensoa, the Flemish Belgian member association of IPPF. Sensoa's mission is to promote sexual and reproductive health, and they have a current media campaign on HIV/AIDS awareness for the Flemish population. For more information, please consult Sensoa's website (www.sensoa.be).

2 Keynote Presentations

2.1 The MDGs and the Monterrey Consensus: A Global Compact between Europe and the Developing World (Hugo-Maria Schally, European Commission)

Hugo-Maria Schally, Head, Relations with the UN system, Member states and other OECD Donors Unit, Directorate General for Development, European Commission

Mr Schally's opening address focused on the European Community's role in helping developing countries to achieve the MDGs. He referred to the Barcelona and the Monterrey Consensus which prove that the EC is committed to providing additional resources for poverty elimination. However, he stressed that these commitments must have strong partnerships with developing

countries, who also have responsibilities in delivering successful development. He also stressed the importance of gender equality, despite the current negative political climate, stating that the outcomes of the Beijing and Cairo summits ten years ago are still essential inputs to the poverty reduction framework provided by the MDGs.

Following Mr Schally's presentation, there was a lively discussion. He clarified the linkage between trade and development by stating that the big challenge facing EU development policy was to ensure that access to EU markets for developing country products was addressed in MDG 8. The EU should strive for all its policies to be supportive of the development agenda. For too long, the system has enabled trade policies to undermine the accomplishments of development policies. For instance, progress has already been noted in regard to EU agricultural policy.

Concerns were raised about how to support developing countries to claim ownership of the MDG processes. It was noted that this would entail strengthening an enabling national environment with a sound macro-economic framework that is respectful of the rule of law, encourages civil society and protects basic rights and addresses inequities.

Regarding the EU's participation in the Beijing +10 Review, Mr Schally explained that the European Commission would prepare a statement in support of existing achievements and further implementation.

Participants questioned whether there were opportunities for civil society input in the Millennium Review Summit in September in New York and whether the June General Assembly hearings would be useful? The MDG Summit in September will be the key event, although it was not clear yet to what extent civil society would participate. Mr Schally drew attention to the fact that civil society should activate the debate at national level as well as have its voice heard in the international debates leading up to the Summit.

2.2 A Developing Country Perspective: the Case of São Tomé and Príncipe (Antonio Amado Vaz, ASPF)

Amado Vaz Dos Santos, Executive Director, Associação Santomense de Promoção Familiar

Amado Vaz gave an inspirational and thought-provoking account of the sexual and reproductive health situation in São Tomé and Príncipe as well as examples of progress and obstacles faced in Sub-Saharan Africa to reach the overall goals set by the ICPD PoA and the MDGs.

Discussion after Amado Vaz' speech focused on the major cultural, religious and social obstacles for SRHR in São Tomé and Príncipe, including the role of the Catholic Church which opposes the MDGs and the use of condoms. Amado Vaz explained that the lack of access to SRH education and services, in this predominantly rural country, were strong impediments to progress. He also described how the Family Planning Association (FPA) is trying to involve churches, especially progressive ones, in their work and increase their understanding of SRHR. Responding to questions on the government's support to the FPA, Amado Vaz pointed out that the government

is using guidelines and studies developed by a group of in-country NGOs to tackle broad SRHR issues³.

3 Presentations on the MDG Task Forces



3.1 The Work and Conclusions of the MDG Task Force 3 on Gender Equality (Sandra Kabir, ICOMP)

Sandra Kabir, Programme Advisor, Programme Adviser, International Council for Management of Population Programmes

Goal 3 of the Millennium Development Goals is to promote gender equality and empower women. The indicators refer to primary, secondary and tertiary education of girls, women's literacy, women's wage employment and women in national parliament. The task force on gender equality and women's empowerment takes the perspective that gender equality and women's empowerment are central to achievement of the MDGs. To be empowered, women must have equal capabilities, equal access to resources and opportunities and they must have the agency to utilise those rights, capabilities, resources and opportunities. In the context of sexual and reproductive health and rights, girls and women particularly in countries of the south, continue to be unacceptably disadvantaged.

Ms Kabir highlighted the significant evidence that women and girls face unacceptably high levels of morbidity and mortality due to their low status and poverty. Ms Kabir highlighted all of the socio-economic constraints to achieving the 3rd MDG, and then analysed the various obstacles faced by the UN, governments and civil society in making progress. This includes opposition from the US administration, some fundamentalist countries and the Vatican working together to undermine SRHR. They are influencing fundamentalist elements in the G-77 to keep SRHR out of the MDGs, particularly the Summit in September 2005.

Ms Kabir closed by presenting a compelling list of recommendations for the Conference. This included garnering renewed political support, urging EuroNGOs members to actively take part in a wide range of development discussions (not just SRH-specific ones), and identifying allies in the South, Finally,

Ms Kabir urged that the links between gender issues, the MDGs and sexual and reproductive health and rights must be more eloquently described, promoted and implemented at every opportunity, not only in the MDG process, but beyond.

³ The full powerpoint presentation is available on EuroNGOs website: www.eurongos.org.

3.2 Presentation on the MDG Task Force Report on Maternal Health (France Donnay, UNFPA)

France Donnay, Chief, Reproductive Health Branch, Technical Support Division, United Nations Population Fund

Ms Donnay explained that today, the highest proportion of women's ill health burden is related to their reproductive role. Complications of pregnancy and childbirth kill half a million women every year, and for every woman who dies 20 more, or close to 9 million women, suffer serious injuries.



In addition, a leading cause of infant and child mortality is poor maternal health. Thus, reproductive health and family planning, clearly, play a key role in improving maternal health and reducing child mortality.

Ms Donnay noted that the links between reproductive health and rights and gender equality and the empowerment of women are also well established. The ability of women to control their own fertility is absolutely fundamental to women's empowerment and equality. Reproductive health services also combat HIV and AIDS. In their strategies to achieve the MDGs, countries should make available, accessible and affordable basic reproductive health services which include family planning, antenatal and postnatal care, skilled attendants at birth, and emergency obstetric care. Expanded access by young people to these services is also essential.

Ms Donnay noted that the links between reproductive health and rights and gender equality and the empowerment of women are also well established. The ability of

Global and national efforts to achieve the MDGs include strengthening linkages between reproductive health and HIV services so as to reach the largest number of women and young people.

The target of universal access to reproductive health by 2015 which was agreed to by the international community at the ICPD must be included as a target within MDG 5 to emphasize the central importance of reproductive health to the achievement of the MDGs and in particular for improving maternal health, preventing HIV/AIDS and achieving gender equality⁴.

3.3 'Business as Usual' or 'Business with a Difference'? A brief analysis of the work and conclusions of the MDG Task Force 5 on HIV/AIDS (Kevin Osborne, IPPF)

Kevin Osborne, Senior Advisor on HIV/AIDS, International Planned Parenthood Federation

The Task Force recognised early on that part of the very problem with MDG goal for HIV/AIDS which is to 'combat HIV/AIDS, malaria and other diseases' and its target to 'have halted and begun to reverse the spread of HIV/AIDS by 2015' was that both lacked quantitative benchmarks

⁴ The full powerpoint presentation is available on EuroNGOs website: www.eurongos.org.

that would in fact act on the lessons that have been learnt. By proposing two targets - carefully selected - to cover both key prevention and treatment interventions, the Task Force put into



action the importance of ensuring that the indistinguishable links between prevention and treatment are real.

This selection of targets provides a clearer framework from which to gauge action. While these two targets cleverly link prevention and care and provide much needed focus, the addition of a specific target to address the issues of human rights (broadly speaking) would have enhanced these two additional targets.

Mr Osborne noted that the importance of a new era and brand of HIV political commitment for all countries (including those in Sub-Saharan Africa) should not be underestimated. The importance of political commitment as a necessary ingredient for a sustainable response to HIV/AIDS is emphasised. However, what is needed are invigorated indicators of political commitment that are refined, sharper, crisper, and nuanced to reflect the realities of a world that has not remained at the cutting edge of this epidemic. The report could have been greatly strengthened by providing greater details or clarity on what the nature of political commitment for a post AIDS generation should be.

Despite the comprehensiveness of the report, the lack of specific detail means that a 'business as usual' approach is inadvertently being promulgated. While it is acknowledged that that 'ten imperatives' are not the sum total of the report, it's clear that they form the major thrust of the majority of the report's recommendations. Ranging from programmatic issues (including prevention, treatment, integration, OVC) to structural issues (health systems and addressing the root causes of the epidemic); from accountability to financing, the list of 'ten imperatives' does not pay sufficient attention to the building and strengthening of an HIV/AIDS competency and capacity on which many of the programmatic, structural and political imperatives actually depend.

Mr Osborne concluded his remarks by asserting that the global fight against HIV will be won by a combination of increased political commitment, adequate resources, sound accountable policies and robust comprehensive health systems. However, he noted that the fight must be won at the personal level. When individuals - be they policy makers or the poor; presidents or patients - have the ability and skills to live, love and find the light that glows in the very shadows of this most human of epidemics. And it is these, all too frequently supposedly unquantifiable measures that should form a consolidated part - in measurable terms - of the report. If we are to win the war, it is abundantly clear that we need to strategise in a different way. We have the necessary arsenal and ingredients at our disposal - but the answer lies in how these are strategically marshalled to ensure success⁵.

⁵ The full powerpoint presentation is available on EuroNGOs website: www.eurongos.org.

4 The Millennium Project Report. SRH and the MDGs: Process, Prospects and Priorities (Stan Bernstein, Millennium Project)

Stan Bernstein, Senior Sexual and Reproductive Health Policy Advisor, Millennium Project, UN Development Group



Mr Bernstein explained that there is still just enough time to meet the MDGs by 2015, even for countries that are now dismissed as being too poor or too off track, but it will require specific scaled-up actions.

Missing from the MDGs

Along with issues such as energy and transportation, reproductive health as a coherent concept is missing from the MDGs. Maternal health including mortality and morbidity is included as is HIV/AIDS. Gender is also included together with child health that includes neonatal health. Contraception and family planning are however included only as a misplaced indicator under the HIV/AIDS goal and while they are part of the ICPD agenda, there is no Goal for reproductive health. This has been a major concern not only to UNFPA but to the reproductive health NGO community as well. Some of these concerns have, however, been addressed in the Millennium Project Report. Yet we know – as many have concluded – that we cannot achieve the MDGs without achieving the ICPD Programme of Action.

An early champion of the cause of getting reproductive health on the MDG agenda was Dr Steve Sinding, Director-General of the International Planned Parenthood Federation. While initially calling for a 9th MDG which was a successful strategy in galvanising support for the inclusion of reproductive health, he has subsequently promoted and supported the concept, as included in the Millennium Project report, of the development of a target on access to reproductive health services and more appropriate specific indicators for their monitoring.

Fast action – Quick Wins:

While the list of 'Quick Wins' included in the Millennium Project report is far from comprehensive, some of them could bring vital gains in well-being to millions of people. Quick Wins that are relevant to sexual and reproductive health include:

- + Eliminating school and uniform fees to ensure that all children, especially girls, are not out of school because of their families' poverty;
- + Training large numbers of village workers in health, farming, and infrastructure (in one-year programmes) to ensure basic expertise and services in rural communities;
- + Eliminating user fees for basic health services in all developing countries, financed by increased domestic and donor resources for health;

- + Expanding access to sexual and reproductive health information and services, including family planning and contraception information and services, and closing existing funding gaps for supplies and logistics;
- + Expanding the use of proven effective drug combinations for AIDS, tuberculosis and malaria. For AIDS this includes successfully completing the 3 by 5 initiative to bring antiretrovirals to 3 million people by 2005; and
- + Launching national campaigns to reduce violence against women.

Mr Bernstein warned that achieving the Quick Wins will not be easy – but they will be catalytic.

Recommended target and indicators:

A new target is recommended by Task Forces 3 and 4 Millennium Project, based on that originally defined in the ICPD Programme of Action of:

Universal access to reproductive health services by 2015 through the primary health system, ensuring the same rate of progress or faster amongst the poor and other marginalized groups.

The following indicators, some already included in the monitoring, are also recommended:

- + Contraceptive prevalence rate (currently Goal 6, recommended to Goal 5)
- + HIV prevalence among 15-24 year old women (Goal 6)
- + Proportion of births attended by skilled birth attendants (Goal 5)
- + Proportion of demand for family planning satisfied (Goals 3 and 5)
- + Adolescent fertility rate (Goals 3 and 5)
- + Availability of emergency obstetric care (Goal 5)⁶

⁶ The full powerpoint presentation is available on EuroNGOs website: www.euronqos.org.

5 Parallel Group Discussions on Gender Equality, Maternal Health and HIV/AIDS and Recommendations

Three parallel groups were held to react on the key findings from the three Task Forces on Gender Equality, Maternal Health and HIV/AIDS. Each of the three discussion groups was structured to have the morning presentations on the Task Forces Reports to stimulate the discussion and propose specific recommendations on each of the three Goals for EuroNGOs' future work. These recommendations will serve as a contribution from the conference participants to the MDG Review through whatever mechanisms might be at their disposal (i.e. submission to donor agencies, governments, EU officials, etc). In an effort to facilitate the discussion groups, the Conference Drafting Committee had prepared draft recommendations as well as an overarching statement for review and refinement by each group. The participants agreed to allow a smaller drafting committee to finalise the recommendations that were adopted in order to make them more coherent and concise.



6 Key Note Address (Lieve Fransen, European Commission)

Lieve Fransen, Head, Social and Human Development Unit, Directorate General for Development, European Commission

The new commission has, as a first act on its first day of office, approved a resolution on SRH and HIV/AIDS. This is quite significant and reinstates the European Commission and the Council's commitment to keep the Cairo agenda strong with a particular emphasis on maternal health and gender equality.

Ms Fransen stated that in her capacity as Head of the Social and Human Development Unit of the European Commission, she believes that we should try to ensure that SRH is kept on the agenda but also that we find the means to make it operational.

She spoke about the role of the MDGs in this. The MDGs cannot be separated from the other development agendas. In line with this, we should defend a stronger political agenda to increase visibility and support for SRH in development planning exercises. The European Commission is also finalizing a synthesis report on the MDGs that will be presented to the General Affairs and External Relations Council. These are some of the opportunities we need to seize to ensure that SRH and gender issues are strongly in the foreground, and that enough emphasis is put on redefining new targets related to reproductive health services and universal access by 2015 as well as developing a range of related indicators.

Regarding maternal health specifically, the Making Pregnancy Safer Initiative (WHO/UNFPA/UNDP and the World Bank) will convene a major meeting to be held in Brussels in May or June 2005. This will provide another opportunity to include gender and SRHR issues in the discussions.

Finally, the Commission has identified priority areas for progress, such as health service providers. We are exporting more health providers from Africa than we can train, and this needs to be reflected upon and solved in cooperation with developing countries.

Recommendations

A number of key international events throughout the year offer key opportunities to make sure that the SRH agenda is maintained. Some of these events include the Beijing +10 review, the MDG +5 review and the ECOSOC High Level Meetings on the MDGs.

EuroNGOs has an important role to play in monitoring these events, mobilising broad political support and inputs from developing countries as well as initiating careful alliance building by linking with other rights and development groups.

7 Panel Debate: SRHR and the MDG Agenda - Progress and Challenges

This panel focused on deepening the understanding of the links between the MDG agenda and the SRHR agenda. Speakers from various disciplines were invited to present best practices. They were also asked to highlight implementation strategies, including any obstacles to be overcome in creating those strategies. Panellists commented on potential strategies to increase opportunities for SRHR advocates to be involved in the MDG review processes. They also advised on forging working relations and alliances among civil society organisations and policy-makers and highlighted key emerging issues related to SRHR and the MDGs.



7.1 Lieve Fransen, Head, Social and Human Development Unit, Directorate General for Development, European Commission

Ms Fransen started by offering insight into the European Commission's synthesis report on the MDGs. She noted that SRHR would be in the foreground and that the report would promote a target on reproductive health under Goal 5. She hoped that EU Member States and the successive Presidencies would support the report. She further explained that a series of events in May and June 2005 would create opportunities for more debate on targets and indicators. She expressed concern over the number of trained health professionals leaving Africa and the need to tackle this issue with African countries. Ms Fransen also spoke about the Global Fund, in particular its goal driven nature. She underscored the need to highlight to countries that they can use the Fund for their SRH/HIV strategies. She finally stressed the importance of thinking beyond 2005 and following through the technical work in recipient countries.

7.2 Stewart Tyson, Head of Profession, Health, UK Department for International Development

Mr Tyson stated that while there are now plenty of policies in place, the challenge lies in putting those policies into practice. He felt we should be more optimistic, that huge steps forward had been made since 1994. Although it is clear that resources are going towards other issues, we shouldn't be surprised, as it is a historical fact that support changes focus over the years. Mr Tyson urged for a move to a more rational focus in health. He noted that the international

architecture on health is chaotic and that a more consolidated approach is required. He also explained that Poverty Reduction Strategy Papers (PRSPs) guide DFID's approach.

"We need to engage countries, not necessarily health ministers, and convince finance ministers that investment in health and SRH in particular is worthwhile". DFID does not support a 9th MDG approach but will ask instead for revised and/or additional targets.

7.3 Anne Van Lancker, Member of the European Parliament, Chair of the European Parliament Working Group on Population, Sustainable Development and Reproductive Health

Ms Van Lancker described the work and importance of the European Parliament Working Group on Population, Sustainable Development and Reproductive Health (EPWG) and the recent integration of HIV/AIDS issues into its mandate. Ms Van Lancker is convinced that seeking a 9th MDG is a good approach and she is grateful to Steve Sinding for his leadership on this. She and the EPWG members believed that it created space for parliamentary pressure for integration of SRH and led to a strong statement from the Dutch EU Presidency. The EPWG now recognises that from this point on, the 'Badger' approach (looking for targets and indicators) is more reasonable. The European Parliament was not in a position to wait for the EC synthesis report on the MDGs. It has developed a strong statement which will be issued shortly. The EP statement supports the Task Force recommendations on SRHR and calls for safe abortion services. She said that support from civil society will be needed and called on EuroNGOs to lobby their members of Parliament. She reminded participants that the EPWG was indeed getting stronger but so was the opposition in the European Parliament, especially from Poland and Malta.

7.4 Joana Almeida, Steering Committee Member of YouAct - European Youth Network on Sexual and Reproductive Health and Rights

Ms Almeida gave a comprehensive overview of YouAct's activities, introducing in particular the transatlantic dialogue conference, which took place directly before the EuroNGOs Conference. She lamented the recent move away from youth friendly international agreements and asked why sexual health and rights were so hidden within HIV/AIDS. Joana Almeida finished with an appeal to those present to be brave and think young⁷.

7.5 Wendy Harcourt, Director of Programmes, Society for International Development, Chair of Network Women in Development Europe

Ms Harcourt introduced herself as a bit of an MDG sceptic and briefly explained why. She feared that while the issues raised were crucial they were not being raised as part of the broader context. The challenge is to make connections sharp and clear at both a global and national level. SRH advocates need to translate their language into a language governments and other development NGOs can hear. She also raised concerns that the Beijing commitments will not be reaffirmed, due primarily to the current US Administration and the Vatican objecting to the inclusion of SRH language in it. Do we really know how much our requests are going to cost?

⁷ The full presentation is available on EuroNGOs website at: www.eurongos.org.

The MDGs are set to fail if we keep talking in costs and measurable indicators. The alliances that we need to build might be difficult but absolutely crucial provided we bring them into the wider Millennium Campaign. Finally Ms Harcourt spoke about the importance of discussing MDG 8 in order to keep our governments responsible.

Discussion

The panel generated a lively debate and ideas on how to bring some of the recommendations developed by the parallel groups forward.

The following key points emerged from the debate and were put forward in the closing session:

- + International pledges for Cairo have yet to be fully realised.
- + The need to maintain a strong commitment to a consistent, rights-based approach to sexual and reproductive health.
- + Importance of developing countries in pushing for interventions and ensuring that they are not just donor driven.
- + The link between greater resources and better health outcomes is not necessarily direct and progressive and special attention should be given to the more vulnerable and underserved populations.
- + Provision of effective services is affected by factors such as poor governance and accountability as well as low salaries.

8 Closing Remarks and Recommendations

Participants concluded that reproductive health remains a powerful vision which has to be reaffirmed in approaches to the implementation of the MDGs. EuroNGOs members should not compartmentalise themselves but try to build on natural synergies with as wide a community as possible. Further, the EuroNGOs Secretariat should ensure that members pay due attention to key MDG events throughout the year and are kept informed of opportunities for collaborative advocacy.

The following next steps were agreed as the way forward:

- + Dissemination of the recommendations from the Conference to the EU, national governments, the agencies of the UN system and multilateral donors.
- + Advocacy for ICPD+10 goals and pertinent SRHR issues that include advocacy for HIV and AIDS.
- + Creation of linkages with other networks.
- + Continued exploration of mechanisms for enhanced cooperation.

APPENDIX I: Conference Recommendations

EuroNGOs calls for increased attention to sexual and reproductive health and rights (SRHR) at the General Assembly High-Level Plenary to Review Implementation of the MDGs:

EuroNGOs is inspired by the broad development agenda and welcomes the increased recognition of the need to include sexual and reproductive health (SRH) in the context of women's and girls empowerment; strengthening health systems at all levels; and reducing poverty in the report of the Millennium Project, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, and its Task Force Reports. It is clear that the MDGs increasingly determine donor priorities and funding rationales around the world. At the same time, EuroNGOs recognises that funding commitments made at the International Conference on Population and Development in Cairo (1994) are not being met. It also urges that the monitoring frameworks for the MDGs better reflect SRHR concerns, since they will determine future priorities.

EuroNGOs recognises the scientific value of the Millennium Project Reports and endorses their conclusions. It recognises that the 'Quick Win' actions identified by the Millennium Project can save and improve millions of lives at a modest cost and promote economic growth, particularly:

- + 'Expanding access to sexual and reproductive health information and services, including family planning and contraceptive information and services, and closing existing funding gaps for supplies and logistics';
- + 'Expanding the use of proven effective drug combinations for AIDS, tuberculosis, and malaria' including successfully completing the 3 by 5 initiative to bring antiretrovirals to 3 million people by the end of 2005; and
- + Launching campaigns to reduce violence against women.

EuroNGOs calls for:

- + Greater recognition of the gaps in SRH service provision in all countries and higher priority attention to SRHR;
- + The Maternal Mortality Goal (#5) to be universally understood to include an integrated approach to all core aspects of reproductive health;
- + Recognition of the link between SRH and HIV/AIDS and the importance of prevention in addressing the pandemic; and
- + Greater support for youth leadership and involvement in achieving the SRHR related MDGs.

EuroNGOs urges all concerned parties to collaborate in the months before the Millennium Summit in promoting SRHR as a priority within the broad multi-sectoral approach to poverty reduction within the MDGs, including in the development of an appropriate target and indicators.

Goal 3: Promote Gender Equality and Empower Women

EuroNGOs recognizes that gender equality is essential for achieving the MDGs and that gender considerations must be integrated into the other goals, targets and indicators.

EuroNGOs urges that:

- + The focus of Goal 3 be broadened to address critical aspects of women's lives and the range of inequalities they experience. This includes investment in quality and comprehensive SRH information and services, including safe abortion.
- + Interventions to prevent and eliminate violence against women and girls be fully integrated into SRH programmes.

Goal 5: Improve Maternal Health

The maternal health goal is essential for achieving the MDGs.

EuroNGOs urges that:

- + The recommended SRH target under Goal 5 of universal access to reproductive health services by 2015 through the primary health care system ensuring the same rate of progress or faster amongst the poor and other marginalised groups be adopted.
- + Political will be mobilized in support of saving women's lives and assuring resources for equitable access to quality maternal care and youth friendly services, giving special attention to the needs of young women and men's involvement.
- + The 'quick win' of expanding access to SRH information and services within the poverty reduction strategy process, including family planning and contraceptive information and services, and closing existing funding gaps for supplies and logistics and closely monitoring their delivery is strongly promoted.
- + Support be given to building functioning health systems from community up to national level including an integrated approach to all the core aspects of SRH; skilled attendants at all deliveries; access to emergency obstetric care for complications of pregnancy and unsafe abortion; and access to safe abortion services.

Goal 6: Combat HIV/AIDS

A human rights approach to HIV/AIDS is predicated on the realization of sexual and reproductive rights, the elimination of discrimination and stigma, and attention to the rights of specific populations, such as men who have sex with men, injection drug users, persons in detention, people in conflict and post-conflict settings, those engaged in transactional sex, and increasingly, women and girls.

EuroNGOs urges that:

- + There should be greater integration of SRH and HIV/AIDS services. This basic package of comprehensive services includes prevention, care and treatment of unintended pregnancy, HIV/AIDS, STIs, and unsafe abortion. Services should incorporate a rights-based approach that addresses gender-based violence and other expressions of gender inequality.
- + Legislative and policy frameworks related to HIV/AIDS at the country-level should incorporate human rights principles and standards that protect the sexual and reproductive rights of those living with or affected by HIV/AIDS.

- + User fees be eliminated as recommended by the Millennium Project, which would address the barrier of accessing services for women in resource poor settings.
- + Donor countries should invest in global research efforts aimed at the treatment, care and prevention of HIV, particularly new technologies aimed at protecting women.

APPENDIX II: What are the MDGs

THE MILLENNIUM DEVELOPMENT GOALS AND THEIR ASSOCIATED TARGETS

1. Eradicate extreme poverty and hunger	Reduce by half the proportion of people living on less than a dollar a day Reduce by half the proportion of people who suffer from hunger
2. Achieve universal primary education	Ensure that all boys and girls complete a full course of primary schooling
3. Promote gender equality and empower women	Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015
4. Reduce child mortality	Reduce by two thirds the mortality rate among children under five
5. Improve maternal health	Reduce by three quarters the maternal mortality ratio
6. Combat HIV/AIDS, malaria and other diseases	Halt and begin to reverse the spread of HIV/AIDS Halt and begin to reverse the incidence of malaria and other major diseases
7. Ensure environmental sustainability	Integrate the principles of sustainable development into country policies and programmes; reverse loss of environmental resources Reduce by half the proportion of people without sustainable access to safe drinking water Achieve significant improvement in lives of at least 100 million slum dwellers, by 2020
8. Develop a global partnership for development	Develop further an open trading and financial system that is rule-based, predictable and non-discriminatory. Includes a commitment to good governance, development and poverty reduction—nationally and internationally Address the least developed countries' special needs. This includes tariff- and quota-free access for their exports; enhanced debt relief for heavily indebted poor countries; cancellation of official bilateral debt; and more generous official development assistance for countries committed to poverty reduction Address the special needs of landlocked and small island developing States Deal comprehensively with developing countries' debt problems through national and international measures to make debt sustainable in the long term In cooperation with the developing countries, develop decent and productive work for youth In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries In cooperation with the private sector, make available the benefits of new technologies—especially information and communications technologies

EuroNGOs International Conference

Bedford Hotel – Rue du Midi 135-137 - Brussels
Hosted by Sensoa

Poverty, Politics and Sex: Will the Millennium Development Goals Deliver Sexual and Reproductive Health and Rights?

17 February 2005

08.00 – 09.00

Registration & coffee

09:00 – 10:30
Armstrong room

Introduction

Chairs: Susan Crane, EuroNGOs Chair, and Dirk Pyck, Executive Director, Sensoa

Key note speakers

- Hugo Schally, Head of Unit "Relations with the UN system, Member states and other OECD Donors", European Commission Directorate General for Development
- António Amado Vaz, Executive Director, Associação Santomense de Promoção Familiar

Discussion

10:30 – 11:00

Coffee break

11:00 – 12:30
Armstrong room

Presentations on the MDG Task Forces

Chairs: Gill Greer, Executive Director, FPA International Development and Henny Hansen, International Programme Coordinator, Sex og Samfund

Gender Equality

Sandra Kabir, Programme Advisor, International Council on Management of Population Programmes

Maternal Health

France Donnay, Chief Reproductive Health Branch, Technical Support Division, United Nations Population Fund

HIV/AIDS

Kevin Osborne, Senior Advisor on HIV/AIDS, International Planned Parenthood Federation

Question & Answer session

12:30 - 13:30

Lunch

13:30 - 14:00
Armstrong room

Presentation about the Millennium Project Report

Chairs: Victor Bernhardt, Programme Officer, Swedish Association for Sexuality Education and Joerg Maas, Executive Director, German Foundation for World Population

Stan Bernstein, Senior Sexual and Reproductive Health Policy Advisor, Millennium Project, UN Development Group,

14:00 - 15:00

Parallel Group Discussions

Armstrong room
Mezzanine

Gender Equality

- Resource person: Sandra Kabir, Programme Advisor, International Council on Management of Population Programmes
- Facilitator: Dominique Audouze, International Coordinator, Mouvement Français pour le Planning Familial

Armstrong room
Sidewing

Maternal Health

- Resource person: France Donnay, Chief Reproductive Health Branch, Technical Support Division, United Nations Population Fund
- Facilitator: Daniela Colombo, President, Italian Association of Women in Development

Gagarine room

HIV/AIDS

- Resource person: Kevin Osborne, Senior Advisor on HIV/AIDS, International Planned Parenthood Federation
- Facilitator: Chris Lambrechts, Executive Director, Sensoa

15:00 - 15:30

Coffee break

Presentation of Recommendations by Chairs of the Group

15:30 – 16:30
Armstrong room

Discussions

Chairs: Frans Baneke, Director, World Population Foundation, and Stan Bernstein, Senior Sexual and Reproductive Health Policy Advisor, Millennium Project, UN Development Group, UN Millennium Project

Key Note Speaker : Lieve Fransen, Head of Social and Human Development Unit, European Commission Directorate General for Development

16:30 – 18:00
Armstrong room

Panel Debate: SRH&R and the MDG Agenda - Progress and Challenges

Panelists (5 minute presentations and Q & A):

- Joana Almeida, Steering Committee Member of YouAct – European Youth network on Sexual and Reproductive Rights
- Lieve Fransen, Head of Social and Human Development Unit, European Commission Directorate General for Development
- Wendy Harcourt, Director of Programmes, Society for International Development, Chair of Network Women in Development Europe
- Stewart Tyson, Head of Profession, Health, UK Department For International Development
- Anne Van Lancker, Member of the European Parliament, Chair of the European Parliament Working Group on Population, Sustainable Development and Reproductive Health

Closing Remarks

Reception

18:00 – 19:30

APPENDIX IV: List of Participants

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APPENDIX V: Speeches and Presentations

1. The MDGs and the Monterrey Consensus: A Global Compact between Europe and the Developing World

Hugo-Maria Schally, Head of Unit 'Relations with the UN system Member states and other OECD Donors' Directorate General for Development, European Commission

ABSTRACT

The European Community has a strong role in helping developing countries to achieve the MDGs. The Barcelona and Monterrey commitments prove our will to provide additional resources; and right now, European Commission and Member States have started consultations on how to reach an agreement on "Barcelona II" type commitments.

However, one tends to forget that the Monterrey Consensus was a "global compact" that also committed developing countries to assume their responsibility; in particular, by creating the domestic "climate" – i.e. good governance, democratic and participatory decision-making, respect of human rights – that is needed to ensure that more ODA has a positive impact on the ground. Ownership is an essential principle for us – we expect that our partners formulate, on the basis of the MDGs, their poverty reduction strategies, taking into account their national priorities, and committing themselves to make the best possible use of ODA.

The empowerment of women has a crucial role in achieving the MDGs, both from a human rights and an economic and social development perspective. The global political climate, however, is currently unfavourable. For the promotion of gender equality, including women's and girls' right to sexual and reproductive health, the 1990's were a "golden era", but these achievements need to be defended and consolidated. The "Major Event" is a unique opportunity to prove that the outcomes of the Beijing and Cairo summits ten years ago are today essential inputs to, and integral parts of, the poverty reduction framework provided by the MDGs.

2. A Developing Country Perspective: the Case of São Tomé and Príncipe

Antonio Amado Vaz Dos Santos, Executive Director, Associação Santomense de Promoção Familiar (ASPF)

Ladies & Gentleman, Conference Participants

Greetings to all colleagues present. Your presence and participation shows your indispensable support for the promotion of sexual and reproductive health in our countries, as well as for human rights. I truly appreciate the presence and participation of all those invited. Each one of you supports this meeting in your own way.

I would like to thank the Portuguese FPA that has shown us great friendship and solidarity and has assisted us in the fight for a better life in our country, promoting ties and good relationships between Lusophone FPAs.

Ladies, Gentlemen, dear colleagues,

In São Tomé and Príncipe there are very few NGOs that have enough means for their programmes. The situation in the field is very difficult and needs everyone's support. Human resource capacities are limited so we need to improve management and train more national executives to support the work in the field. The economic situation of our country is very weak, with a high external debt, low cacao prices on the world markets and raising petrol prices. Moreover, there is a lack of means to manage the country's resources, which makes São Tomé and Príncipe a country with great difficulties.

The level of poverty of São Tomé and Príncipe, linked with socio-cultural problems, is responsible for the poor development situation in which we live. The maternal mortality rate in Africa is the highest in the world and is estimated at 870 deaths per 100.000 live births. This reflects the seriousness of the situation in many countries, especially the difference between rural and urban areas.

In our small country with a population of 140.000, the maternal mortality rate is 131 deaths per 100.000 live births. The overall fertility rate in Africa is about 5 to 6 children per women. In São Tomé and Príncipe this is 5.35. Unwanted pregnancies, especially among adolescents, often lead to unsafe abortion, which accounts for 20-40% of all maternal deaths. The maternal mortality rate is high, more than 20%. There is a referral system for cases that require more care. For instance, more than 60% deal with anaemia during pregnancy. Anaemia during pregnancy is even more serious when the patient also has malaria, which is the main cause of death. In general, service delivery is of poor quality, both for the prevention of obstetric fistula and for psycho-social rehabilitation for affected women.

The progress of the last decade is affected by the HIV/AIDS epidemic. Therefore it is of high importance to urgently introduce sexuality education into society in order to enable young people and adults to live their sexuality in a responsible way. In our country many adolescents engage in sexual activity as early as 12 or 13 years old, without having any notion of sexuality or contraception.

By the age of 15, 56% of young people have regular sexual relationships, often unprotected, which leads to unwanted pregnancies, unsafe abortions, sexually transmitted infections, HIV-infection and severe social problems due to early marriages and school drop-outs. This behaviour, which we consider high risk behaviour, will probably continue through their adult life.

Men are also exposed to sexual and reproductive health problems related to puberty, poor access to family planning services, abuse of toxic substances, sexual and domestic violence and having multiple sexual partners, which may lead to sexually transmitted infections and HIV-infection.

In sub-Saharan Africa people do not pay a lot of attention to menopause due to a lack of knowledge about the problems linked to menopause. Therefore it is necessary to take measures to treat these problems. On the other hand, female genital mutilation is still practiced in over 27 African countries. In certain countries at least 90% of women have been the victims of genital mutilation. It is estimated that at present about a hundred million women and girls in Africa have suffered some kind of genital mutilation. Apart from this, the rise of domestic violence and sexual abuse of women and girls poses a serious problem in most countries, especially for children living in difficult circumstances (street children). There is an urgent need to set up an interdisciplinary sensitising programme for sexual issues to prevent and eliminate these harmful practices and that focus on vulnerable children. It is also important to make sure that circumcision is practiced in hygienic circumstances.

The health problems mentioned above are aggravated by poor access or the lack of access to health services, the lack of financial means and by the poor performance of the health system.

Ladies and gentlemen, specific examples include:

- + The limited impact of existing programmes to reduce diseases linked to reproduction and sexuality;
- + The limited capacity of vertical programmes addressing issues of reproductive health - those that try to reach single women, men, young people and rural populations;
- + The lack of participation of users, especially women, in the planning and implementation of services, and the limited attention given to the needs of individuals throughout their lives.
- + The poor usage of existing technologies;
- + The lack of cooperation and investment from the government and services involved in reproductive health.

Therefore we have some guidelines that can strengthen the efficiency of the national reproductive health strategy. These guidelines were developed with the support of IPPF, WHO, UNFPA and other institutions working on this matter. They are:

- + Development and leadership of programmes by the country itself
- + Good quality programmes
- + Efficient cooperation between key NGOs as well as the informal sector and private commercial sector
- + Participation of all actors for the development of global first line services
- + Ethical considerations and taking into account the needs of local culture

It is necessary to improve a global partnership on SRH&R to implement and fulfil the 8 MDGs. The future of humanity depends on the way SRH is integrated into the MDGs. We need services, training, IEC material and strategies and good governance for sustainable programmes. The situation in the field is difficult and needs the support of everyone. The human resources and the technical capacity are weak, so it is necessary to improve the capacity and training of professionals to increase the interventions in the field. It is in the light of this situation that the São Tome FPA was founded in 1995, trying to contribute modestly to improve sexual and reproductive health, fighting several socio-cultural factors like illiteracy, some traditional practices and habits that pose obstacles to a healthy sexual and reproductive life, in a development context.

I would like to thank you for this opportunity and wish you a good conference.

3. The Work and Conclusions of the MDG Task Force 3 on Gender Equality

Sandra Kabir, Programme Advisor, Programme Adviser, International Council for Management of Population Programmes

Background

Goal 3 of the Millennium Development Goals is to promote gender equality and empower women. The indicators refer to primary, secondary and tertiary education of girls, women's literacy, women's wage employment and women in national parliament.

The UN Millennium Project was launched by the UN Secretary-General and UNDP Administrator, as a three-year project to identify the best strategies for meeting the Millennium Development Goals (MDGs). Ten task forces were created, two relating to gender. Membership of the Task Force on Education and Gender Equality and the Task Force on Primary Education includes people from NGOs, activist groups, academic scholars, parliamentary and government officials, directors of UN agencies and sectoral experts.

Analytical overview of work and conclusions

The task force on gender equality and women's empowerment takes the perspective that gender equality and women's empowerment are central to achievement of the MDGs. Each of the eight goals must take into consideration issues of gender and be designed to promote equality of women and men, as well as girls and boys. Women and men's social, economic and political power are determined by biological differences between women and men.

Three dimensions, each linked to the other, were adopted by the task force, being:

- + The capabilities domain, which refers to basic human abilities in health, education and nutrition;
- + The access to resources and opportunities domain, i.e. equality in the opportunity to use or apply capabilities by access to economic assets, resources and political opportunity;
- + The security domain, which is defined to mean reduced vulnerability to violence and conflict;

To be empowered women must have equal capabilities, equal access to resources and opportunities and they must have the agency to utilise those rights, capabilities, resources and opportunities.

The task force identified seven strategic priorities. These were:

- + Strengthen opportunities for post primary education for girls while simultaneously meeting commitments to universal primary education.
- + Guarantee sexual and reproductive health and rights.
- + Invest in infrastructure to reduce women's and girl's time burdens.
- + Guarantee women's and girl's property and inheritance rights;
- + Eliminate gender inequality in employment by decreasing women's reliance on informal employment, closer gender gaps in earnings, and reducing occupational segregation.
- + Increase women's share of seats in national parliaments and local governmental bodies.
- + Combat violence against girls and women.

Three particular groups of women were perceived as requiring special focus.

These were the: poor women in the poorest countries; adolescents in the poorest countries; and, women and girls in conflict and post conflict settings.

Strategic Priority 2: guarantee sexual and reproductive health and rights:

The task force deemed that gender equality and women's empowerment cannot be achieved without the guarantee of sexual and reproductive health and rights for girls and women. Without this women's ability to build their capabilities, take advantage of economic and political opportunities and control their destinies is not possible. Conversely, gender equality compromises women's sexual and reproductive autonomy.

Assessment of the current status of the goal:

The goal is to promote gender equality and empower women. However, in the context of sexual and reproductive health and rights, girls and women particularly in countries of the south, continue to be unacceptably disadvantaged.

This is evidenced by the following data for women:

- + Women in developing countries are 50 times at greater risk of dying from pregnancy-related complications.
- + In the Middle East and North Africa one-fifth of married women and one-quarter in Sub-Saharan Africa are unable to access the contraception they need.
- + Fifty to seventy percent of pregnant women in the south suffer from iron deficiency anaemia.
- + Almost fifty percent of HIV-infected adults worldwide are women and in Sub-Saharan Africa the proportion is 57%.

The facts and figures for adolescent girls are not better:

- + Seventy five percent of those aged 15 to 24 who are infected with HIV are females.
- + Many sexually active adolescents do not use contraception.
- + About 11% of the roughly 260 million women ages 15-19 worldwide, both married and unmarried, are sexually active and do not want to become pregnant but are not using a modern method of contraception.
- + Young women experience much higher levels of maternal illness and death than do women who bear children when they are older. This is due to lack of power, information and access to services and underdeveloped physiology, as well as limited negotiating power.

Disability Adjusted Life Years (DALY) and sexual and reproductive health:

SRH problems account for 18% of the global burden of disease and 32% of the burden among women ages 15-44 (WHO's 2001 estimates). On the other hand, all DALYS are 13% for neuro psychiatric conditions, 11% for respiratory illnesses and 10% for cardiovascular diseases.

Investing in SRH services is cost effective. This is demonstrated by an early study in Mexico. Every peso spent between 1972-1984 on family planning services, saved 9 pesos for treating complications of unsafe abortion and providing maternal and infant care. Additionally, prevention of illness and death, improvements in women's social position and increases in macroeconomic investment and growth also result in delivery of SRH services.

Interventions in the health sector are required for:

- + Sexual and reproductive health and rights, i.e. policies and quality services.
- + Family planning and safe abortion to meet the unmet need for contraception and fertility control.
- + Prevention and treatment of sexually transmitted infections and HIV/AIDS including counselling, prevention and treatment services, female-controlled method of prevention and investment in research.
- + Adolescents with services adapted to their needs.
- + Involvement of men as partners in reproductive health and support of men as agents of change.

Financing of interventions has been done through taxation and charging of user fees that has its drawbacks. The task force recommended abolishing user fees for basic SRH services.

Interventions outside the health sector include girl's education and sexuality education.

Interventions to build political consensus are required to create a conducive environment for sexual and reproductive health and rights.

Most serious obstacles for the UN, governments and civil society

All the above information has been gleaned from the report of the Task Force on Gender Equality. From the perspective of NGOs, particularly EuroNGO members, there are several major obstacles that must be overcome to promote gender equality and women's empowerment (Goal 3), particularly in the context of sexual and reproductive health and rights.

Reproductive health is being **held hostage** by the United States, some fundamentalist countries and supported by The Vatican. These anti choice elements always equate reproductive health with abortion (safe or otherwise) to mislead people and they oppose policies, programmes and funding for SRH. This opposition is done overtly and/or covertly by bringing political and economic pressure on governments, as well as by other means.

Fundamentalist elements in the G-77 are holding back reference to or inclusion of SRHR in MDG deliberations, i.e. the lead up to the September 2005 meeting. They are aided and abetted by the United States and The Vatican.

Individuals and organisations that battled so hard before, during and immediately after the ICPD process are **tired and jaded**. They are also having to spend increasing **time and energy on fund raising** instead of advocacy, programmes or research.

Sexual and reproductive health and rights is seen as **separate from 'main stream' development**. Agencies do not work in partnership but vertically, each one only focussing on their area of interest or specialisation.

The connection between sexual and reproductive health and rights and development has not, until recently, been clearly defined or promoted. Those who make policy and allocate resources at the international and national levels do not understand the necessity of good sexual and reproductive health for economic productivity and national well-being.

With the rampant spread of HIV/AIDS, **funds have been bifurcated** more towards the pandemic and increasingly less towards sexual and reproductive health. This distinct separation of funding for HIV/AIDS and sexual and reproductive health contributes towards duplication of effort and waste of precious funding.

There are ever changing **competitors for funding**. For example, in January 2005 there was a drop by one fifth of donations for Africa due to people donating to the Tsunami disaster relief and rehabilitation work.

To compound this, there is **donor fatigue and boredom** in continuing to fund the same sector of development over long periods of time.

Specific recommendations and strategies for integration of sexual and reproductive health and rights objectives into the goal:

More **political support** is required for sexual and reproductive health and rights.

A renewed vigour needs to be created and maintained for achieving the ICPD PoA and goal of universal access. To accomplish this, a sophisticated advocacy strategy, plan and resources are required. Clear, concise messages laying out the necessity of SRHR for economic growth and national well being require to be developed and used cleverly by and with the appropriate organisations/individuals.

EuroNGO members must be present and active in all development discussions and not only where SRHR is on the agenda. For instance, during negotiations and meetings of the other task forces of the MDGs, members or their allies on delegations should be at the table to push the gender equality, women's empowerment and sexual and reproductive health and rights agenda.

Allies in the south need to be identified and invited to join the EuroNGOs strategies for integration of sexual and reproductive health and rights objectives into goal 3.

Gender considerations should be integrated into the other goals so that the overall MDG process contributes to women's empowerment and the advancement of women's rights. Since sexual and reproductive health and rights is included in the report of the task force on gender equality and women's empowerment as a strategic priority, then it would automatically be included in the other goals.

Lateral vision and planning is required. Governments and development organisations (be they of the UN family, NGOs or civil society organisations) must understand, visualise, design, plan and implement policies and programmes that take into consideration the multifarious needs of people. Services for health, education, housing, water and sanitation, etc. should be provided seamlessly and effective referral systems designed, taking cognisance of gender disparities and needs. In the event of the above approach being accepted by the MDG project, then sexual and reproductive health and rights would be seen as an intrinsic element of development.

The linkage between HIV/AIDS and sexual and reproductive health is obvious, but unfortunately is not understood or accepted by all. Over the past couple of years meetings have been held on this topic and papers presented and published. The issue of making strategic linkages between HIV/AIDS and SRH needs to be widely shared and acted upon. The ICPD goal of universal access to a full range of reproductive health care and family planning services can intelligently be included in the MDG Goal on HIV.

Given competing issues and factors it would be more expedient to bring out the importance and connections between SRHR and development through parameters of the existing Millennium Development Goals and **not attempt to have a ninth goal created.**

The links between gender issues, the MDGs and sexual and reproductive health and rights must be more eloquently described, promoted and implemented at every opportunity, not only in the MDG process, but beyond.

To broaden the focus of goal 3 beyond education, employment and representation in elected office by incorporating other targets that address critical aspects of women's lives and the range of inequalities they experience. For instance, interventions that aim to improve women's well-being and capacity to participate fully in society, including investment in quality services and information to make essential health needs related to sexuality and reproduction available to all women and girls of appropriate age.

To address and combat all forms of violence against women. Gender-based violence remains, widespread and has clear links with many other factors, such as poverty, HIV/AIDS, and age. Interventions to reduce the rate of violence against women and give women and girls greater protection from sexual violence in particular are critical for the realisation of Goal 3 and all the MDGs.

4. 'Business as Usual' or 'Business with a Difference'? A brief analysis of the work and conclusions of the MDG Task Force 5 on HIV/AIDS

Kevin Osborne, Senior Advisor on HIV/AIDS, International Planned Parenthood Federation

Introduction

For over two decades we have been fighting a war. A war that claims- and is in deed claiming - more lives than we will ever be able to adequately quantify.

But it's a war in which we have over the past twenty plus painful years gained many lessons; learnt many truths and made some significant inroads. But the question that I pose before us all today is whether we are indeed applying these very lessons to the way in which we address the realities of the epidemic in 2005 and beyond. It should come as no surprise that despite groundbreaking scientific gains and breakthroughs, and the proliferation of declarations (and dare I say task forces!), as well as a gallant effort by many unsung heroes, it's a war that we are not winning at the pace we should. These sentiments – eloquently highlighted with some clear illustrative and regional specific examples – form a core part of the ethos conveyed in the Task Force report.

Good morning. Many thanks to the organisers for inviting me to address you today. At the outset I must admit that the task of attempting to provide a thorough review of the rather comprehensive 196 page report of the Task Force in 15 minutes is impossible. However from the sub-title of this presentation 'Business as Usual' or 'Business with a Difference'? I have purposefully decided to restrict my comments, observations and suggestions to the so-called 'bigger picture' ideas. For if this report and its recommendations are to form part of the basis of how nations and indeed the UN system should respond to the HIV/AIDS component of the MDGs, then it is critical that these are realistic, proactive and forward looking. For more of the same will simply not get us anywhere in the long term!

So how is the report structured and what does it say?

For the purposes of this presentation I am going to highlight 5 key areas in which this thorough Task Force report could be strengthened in order to maximise much of the content that is in fact presented.

1. Layout and Structure: At the outset I have to say that it is remarkable that while clear recommendations about PLWA involvement are emphasised throughout the report it is striking that the current task force doesn't include anybody openly living with HIV/AIDS.

In simple terms the report is both quite elaborate and, for those who have not read it, a rather absorbing read. The five chapters of the report (Epidemic and Response; Prevention; Treatment; OVC; Finance and Implementation) provide a comprehensive list of key issues facing the world today with regards to the HIV/AIDS epidemic. However it is precisely in the selection of these specific chapters where some of the missed opportunities lie. While the issue of human rights is at times woven throughout the report, it is the lack of a specific focus on the inherent connections between a comprehensive HIV/AIDS response and the very specifics of human rights issues and how these relate to prevention, treatment, and health seeking behaviours that could

have been strengthened. By realigning the report to reflect on both structural and political determinants that affect some of the issues that have been addressed would provide a catalyst to do things differently. Or at the very least think about things from a different perspective. At the very heart of this is the issue of human rights. And in this there is perhaps nothing new. We all collectively nod and agree that human rights are important. That it is a 'cross cutting' issue. That we follow a so-called 'rights- based approach' towards programming. But in terms of a clear focus with measurable outcomes and indicators, the report could have provided a much clearer and concise approach – for this would have strengthened the sum of its parts.

2. Goal and Targets: The Task Force recognised early on that part of the very problem with MDG goal for HIV/AIDS which is to 'combat HIV/AIDS, malaria and other diseases' and its target to 'have halted and begun to reverse the spread of HIV/AIDS by 2015' was that both lacked quantitative benchmarks that would in fact act on the lessons that have been learnt. By proposing two targets- carefully selected – to cover both key prevention and treatment interventions, the Task Force put into action the importance of ensuring that the indistinguishable links between prevention and treatment are real. This selection of targets provides a clearer framework from which to gauge action. While these two targets cleverly link prevention and care and provide much needed focus, the addition of a specific target to address the issues of human rights (broadly speaking) would have enhanced these two additional targets. Perhaps a target that could simultaneously address issues around:

- a) the legal frameworks. For example, to ensure better access for women with regard to property and inheritance rights and improve their access to ARV treatment and SRH services or to remove punitive policies relating to IDU, sex workers; and
- b) stigma reduction. The development of qualitative measures to gauge the reduction of stigma and discrimination would provide support to the prevention and treatment targets.

For if there is one thing that we know about this epidemic, is that intolerance is a mobile force. It attaches new fears to old forms. And this is exactly what makes it so hard to pin down and hard to resist with rational argument. HIV-discrimination attaches itself to pre-existing stigmas - to racial stereotypes or to stigma against sexual minorities or so called 'unacceptable' behaviours. An additional target of 'ensuring a supportive and enabling HIV/AIDS policy environment' may begin to address some of the supposedly cross-cutting issues I have just raised.

3. Political commitment: The 'simple dichotomy' used as a recurring theme in the report divides the epidemic and responses into two kinds. The first reflects on epidemics that are generalised- typified and, by the report's clear admission, largely focussed on Sub-Saharan Africa. (SSA). The second focuses on countries and regions with largely concentrated epidemics where the burden of disease is largely amongst key populations traditionally vulnerable to infection. On the face of it, this division assists in making the report both manageable, logical and persuasive. However, the focus of key responses highlights, for example, the strengthening of health systems as key to epidemics in Sub-Saharan Africa and the building of political commitment for countries with concentrated epidemics. And while this is true, the importance of a new era and brand of HIV political commitment for all countries (including those in SSA) should not be underestimated. The importance of political commitment as a necessary ingredient of a sustainable response to HIV/AIDS is emphasised but what is needed are invigorated indicators of political commitment that are refined, sharper, crisper, and nuanced to reflect the realities of a world that has not remained at the cutting edge of this epidemic.

No longer should commitment be measured in the mere recognition of AIDS as a global or national threat. It lies not in the allocation of national budget resources or the creation of a multi-sectoral AIDS Council or the involvement of people living with HIV/AIDS. In 2005 these should be mandatory and expected. These should be minimum standards rather than goals to be reached. The report could have been greatly strengthened by providing greater details or clarity on what the nature of political commitment for a post AIDS generation should be. In this way it could have opened the discussion into areas that otherwise remain silent and paved the way for greater accountability – an issue that is raised in the report with insufficient details of how to actually manage that accountability at both national and UN levels.

4. SRHR Entry Points: The lack of a specific MDG on SRHR issues has been the cause of much debate and it appears as if the Task Force has in its own way acknowledged that. For throughout the report the utilisation of SRH entry points as an opportunity to provide integrated prevention and treatment are emphasised. Yet the true test is the actual utilisation of these existing entry points to not only promote a renewed understanding of the inherent links between HIV/AIDS and SRH responses but how SRHR provides an under-utilised platform to address many of the constraints that are currently being faced with regard to scale up and coverage. Perhaps the report – in its recommendations – could have suggested concrete ways in which this could be achieved. For example, the Global Fund for AIDS, TB and Malaria could ensure that, as part of the criteria for proposal submission, various SRH entry points are expressly taken into consideration. Another way of addressing this cultural difference is for ICPD and the Programme of Action to be the instrument that facilitates those linkages and connections with HIV/AIDS communities. The impetus for this is coming from NGOs and community based organisations reacting to their own observations, rather than as the result of a structured framework presented to the sector through the ICPD and Programme of Action. This needs to change.

5. The Ten Imperatives: While the report tries at various places to be a true litmus of what proactive responses should be, it is clear that the devil is in the detail. And at times – despite the comprehensiveness of the report - the lack of specific detail means that a 'business as usual' approach is inadvertently being promulgated. While it is acknowledged that that 'ten imperatives' are not the sum total of the report, it's clear that they form the major thrust of the majority of the report's recommendations. And as any top ten, they are an eclectic check list of things that should be done; systems that should be put into place and approaches that should be adopted. Ranging from programmatic issues (including prevention, treatment, integration, OVC) to structural issues (health systems and addressing the root causes of the epidemic); from accountability to financing, the list of 'ten imperatives' does not pay sufficient attention to the building and strengthening of an HIV/AIDS competency and capacity on which many of the programmatic, structural and political imperatives actually depend. And while it can be argued that capacity development is an inherent part of the report, the lack of the measurable determinants clearly hampers how this will in fact be addressed.

I will highlight a few illustrative examples:

- + The issue of the role of the UN and the accountability of national governments are quite rightfully some of the key imperatives that are listed. The UN is encouraged to 'be far bolder in holding accountable member nations' – but it is precisely on the 'how' where clearer recommendations to achieve this should be forth coming.

Unless these broad brush strokes are given additional weighty recommendations, responses will not move as fast as they in fact could. And business is unlikely to operate any differently.

- + Similarly, the lack of mentioning the invaluable role that the NGO sector plays as one of the 'ten imperatives' is perhaps an oversight. Just as national governments are encouraged to be more accountable, so too the role of the NGO sector must be heard more clearly. The NGO Code of Good Practice on HIV/AIDS-'Renewing our Voices'- provides an excellent platform to showcase how NGO's with different niches and expertise can agree on a set of fundamental principles and actions.
- + One of the ever-present challenges is 'AIDS fatigue' that has the potential to derail the best planned initiatives. This weariness is not only present in the post-AIDS generation for whom the past battles have little if any meaning as they excitedly explore the realms of their sexuality, but it has an impact on the way in which communication and advocacy messages are developed for a world that is perhaps, despite some glimmers of hope, largely complacent about the epidemic.

Conclusion:

Our understanding of HIV/AIDS indicates the two of the most important concepts are those of justice and compassion. However, the history of this epidemic is still largely one of ignorance, prejudice and shame. Persons on deathbeds have been told – and let me tell you still are- that they deserve their condition, that it is God's punishment on their behaviours. Children have been barred from admission to schools and perhaps, more painfully, from play with other children. Public policy and private practice have both been forged from pure ignorance and ugly prejudice – and all too often increasingly based on particular political ideologies that threaten to strip away the very gains that have been made and lessons that have been learnt. And it is these issues that the Task Force in its recommendations should address head on.

The global fight against HIV will be won by a combination of increased political commitment, adequate resources, sound accountable policies and robust comprehensive health systems. This much we know and is emphasised in the Task Force report. But fundamentally however, the fight must be won at the personal level. When individuals – be they policy makers or the poor; presidents or patients– have the ability and skills to live, love and find the light that glows in the very shadows of this most human of epidemics. And it is these, all too frequently supposedly unquantifiable measures that should form a consolidated part - in measurable terms – of the report. If we are to win the war, it is abundantly clear that we need to strategise in a different way. We have the necessary arsenal and ingredients at our disposal – but the answer lies in how these are strategically marshalled to ensure success.

As the fight must be won at the personal level by individuals – what better way can I highlight and emphasise the importance of this than to hear from some of these women themselves. Comments such as these that we are about to hear, illustrate more clearly than I could the importance and the urgency of "doing business differently.

5. The Millennium Project Report. SRH and the MDGs: Process, Prospects and Priorities

Stan Bernstein, Senior Adviser, Sexual and Reproductive Health, Millennium Project

Following the Millennium Summit in 2000, eight Millennium Development Goals (MDGs) were developed which set out a mutual commitment between developed and developing countries to make sustained progress towards their achievement. The MDGs aim specifically to reduce poverty, reduce mortality, fight disease and hunger, get girls and boys in school, empower women and give people access to safe water. African countries, in particular, need to make most progress if they are to meet these Goals by the target date of 2015.

In 2002 the Secretary-General appointed Professor Jeffrey Sachs, his Special Advisor on the MDGs, as the Director of the Millennium Project, which is an independent technical advisory body tasked with proposing the best strategies for meeting the MDGs. Ten Task Forces were set up, bringing together over 240 experts, on poverty and economic development; hunger; education and gender equality; child health and maternal health; HIV/AIDS, malaria, TB and access to essential medicines; environmental sustainability; water and sanitation; improving the lives of slum dwellers; trade; and science, technology and innovation. Within this broad multi-sectoral development framework the challenge for those concerned with sexual and reproductive health and reproductive rights has been, and continues to be, how to ensure that these issues are fully integrated into the ongoing process.

There is still just enough time to meet the MDGs by 2015, even for countries that are now dismissed as being too poor or too off track, but it will require specific scaled-up actions. Immediate steps need to be taken, for example, to train enough doctors and engineers, strengthen service delivery capacity, and construct improved infrastructure. Several worldwide initiatives, which are included in the Report of the Millennium Project, are required, namely:

- + Identifying fast-track countries;
- + Preparing MDG-based poverty reduction strategies;
- + Launching a global human resource training effort;
- + Launching the Quick Win initiatives; and
- + Engaging middle-income countries in the challenge of meeting the MDGs.

Missing from the MDGs ...

Along with issues such as energy and transportation, reproductive health as a coherent concept is missing from the MDGs. Maternal health including mortality and morbidity is included as is HIV/AIDS. Gender is also included together with child health that includes neonatal health. Contraception and family planning are however included only as a misplaced indicator under the HIV/AIDS goal and while they are part of the ICPD agenda, there is no Goal for reproductive health. This has been a major concern not only to UNFPA but to the reproductive health NGO community as well. Some of these concerns have, however, been addressed in the Millennium Project Report. Yet we know – as many have concluded – that we cannot achieve the MDGs without achieving the ICPD Programme of Action.

An early champion of the cause of getting reproductive health on the MDG agenda was Dr Steve Sinding, Director-General of the International Planned Parenthood Federation. While initially calling for a 9th MDG which was a successful strategy in galvanising support for the inclusion of reproductive health, he has subsequently promoted and supported the concept, as included in the Millennium Project report, of the development of a target on access to reproductive health services and more appropriate specific indicators for their monitoring (see below).

Fast action – Quick Wins

While the list of Quick Wins included in the Millennium Project report is far from comprehensive, some of them could bring vital gains in well-being to millions of people. Quick Wins that are relevant to sexual and reproductive health include:

- Eliminating school and uniform fees to ensure that all children, especially girls, are not out of school because of their families' poverty;
- Training large numbers of village workers in health, farming, and infrastructure (in one-year programmes) to ensure basic expertise and services in rural communities;
- Eliminating user fees for basic health services in all developing countries, financed by increased domestic and donor resources for health;
- Expanding access to sexual and reproductive health information and services, including family planning and contraception information and services, and closing existing funding gaps for supplies and logistics;
- Expanding the use of proven effective drug combinations for AIDS, tuberculosis and malaria. For AIDS this includes successfully completing the 3 by 5 initiative to bring antiretrovirals to 3 million people by 2005; and
- Launching national campaigns to reduce violence against women.

Achieving the Quick Wins will not be easy – but they will be catalytic.

Necessary resources ...

The cost of implementing the MDGs, as calculated by the Millennium Project, is less than the 0.7 percent of GNP as pledged by world leaders at the Monterrey Financing for Development Conference in 2002, which would amount to almost \$200 billion today. The total development aid contributed in 2003 by the world's 22 richest countries was \$69 billion, a shortfall of \$130 billion from that pledged at Monterrey.

According to the Millennium Project, the cost of meeting the MDGs would require donors to increase ODA to 0.44 percent of GNP by 2006 (or \$135 billion) and to plan for a scale-up to 0.54 percent by 2015 (or \$195 billion). Therefore, of the approximately £30 trillion in the combined GNP of the rich countries, only an average of \$150 billion a year would be required to get the world on track to eliminate extreme poverty.

Key sexual and reproductive health recommendations in the Millennium Project reports

Task Force 3 on education and gender equality and Task Force 4 on maternal health and child health made strong recommendations on sexual and reproductive health in their respective reports. There is, for example, a strong recognition of the importance of ensuring access to sexual and reproductive health information and services, including voluntary family planning to achieving the MDGs. Gender equality which is essential for achieving the Goals cannot be achieved without guaranteeing women's and girls' sexual and reproductive health and rights.

There are strong links between rapid population growth, high fertility, ill-timed pregnancies and poverty, which creates a demographic-related poverty trap that also affects development prospects and also links between conflict, poverty and demography. Health systems, moreover, must be strengthened to ensure universal access to health services, with the full integration of sexual and reproductive health programmes. And, finally, partnerships need to be developed between government, donors, civil society organisations and the private sector.

Recommended target and indicators ...

A new target is recommended by Task Forces 3 and 4 Millennium Project, based on that originally defined in the ICPD Programme of Action of:

Universal access to reproductive health services by 2015 through the primary health system, ensuring the same rate of progress or faster amongst the poor and other marginalized groups.

The following indicators, some already included in the monitoring, are also recommended:

- Contraceptive prevalence rate (currently Goal 6, recommended to Goal 5)
- HIV prevalence among 15-24 year old women (Goal 6)
- Proportion of births attended by skilled birth attendants (Goal 5)
- Proportion of demand for family planning satisfied (Goals 3 and 5)
- Adolescent fertility rate (Goals 3 and 5)
- Availability of emergency obstetric care (Goal 5)

Changes are also recommended in other targets and indicators that will strengthen their technical rigor and provide guidance for their implementation: the slum dwellers target, for example, needs to be expressed in a way not tied to a specific (and low) number of people whose living conditions must be improved and an indicator of neo-natal mortality has been suggested to be added to the child mortality goal. The international community and international experts can act to make sure that the dominant development framework of our time is strong enough and inclusive enough to support the weight it has to bear.

APPENDIX VI: Information on Speakers

Joanna ALMEIDA

Joanna Almeida is a psychologist. After her studies she worked as a counsellor in a youth friendly health service of the Portuguese Youth Institute. She has also worked as a volunteer for the Portuguese FPA for many years and helped them recently in their activities on sex education and awareness-raising on Sexual and Reproductive Health and Rights issues in Portugal.

In July 2004 Joanna Almeida was accepted as a member of YouAct and was elected to the Steering Committee in August, as Internal Relations Officer. She represented YouAct on several occasions: the High Level Meeting on Sexual and Reproductive Health and Rights of the Dutch Ministry, the RHIYA youth Summit in Sri Lanka, the Youth Centre Study Session at the MDG Council of Europe.

Stan BERNSTEIN

Stan Bernstein is Policy Advisor to the UN Millennium Project with primary responsibilities of facilitating the incorporation of sexual and reproductive health concerns in Task Force analyses and recommendations, providing inputs to pilot country activities and for commissioning and producing other reports. Previously Stan was a Senior Research Adviser at the United Nations Population Fund where he researched and co-edited the annual State of World Population report over the last 10 years, addressing a variety of thematic concerns about population, reproductive health and development. He has participated in working groups related to the costing of population and reproductive health programs. While at the Fund he was also involved in strategy formulation and programming processes and served in the Secretariats of the International Conference on Population and Development, the Hague Forum, the General Assembly Special Session (ICPD+5) and the European Population Forum. Prior to his work with the Fund, he was a researcher at the School of Public Health at the University of Michigan from which he worked as a consultant for UNFPA and USAID, and helped run a Population and Development Training Program with financial support from USAID and the ILO.

France DONNAY

France Donnay, an Obstetrician/Gynaecologist from Belgium with a Masters in Public Health, currently holds the position of Chief, Reproductive Health, Technical Support Division at UNFPA. In that capacity, she coordinates the formulation of policies and programme interventions addressing issues of women's reproductive health, including family planning and maternal mortality, HIV prevention, and linkages between SRH and HIV.

She joined UNICEF in 1994, and was Adviser for Women's Health until 1999 when she moved to UNFPA. Prior to joining the UN system, she spent 20 years practicing obstetrics in Belgium, Chad and Cambodia and working in many countries throughout Africa, Asia and Eastern Europe as a consultant on reproductive health issues for WHO, UNFPA, The World Bank and Doctors Without Borders.

Lieve FRANSEN

Mrs Lieve Fransen is head of the Human and Social Development unit at the Directorate-General for Development of the European Commission.

She is a medical doctor and has a PhD in social medicine and public health.

After working as a general practitioner in Belgium, Mrs Lieve Fransen worked as a Public Health Advisor to the Ministry of Health in Mozambique. She was also the manager of research programmes related to sexual and reproductive health in both Rwanda and Kenya.

Mrs Lieve Fransen was the Founder and Executive Director of the AIDS Task Force set up in the framework of the European Commission's HIV/AIDS programme for developing countries. After that she stayed on at the EC but as the principal administrator at the Directorate for Development, in the Unit for Health, Family Planning and AIDS. A few years later she moved to the social development unit. Mrs Lieve Fransen received several distinctions, amongst which the National Order of the Lion of the Republic of Senegal for special merit in confronting AIDS in 1991 and the Jonathan Mann Award in 2001.

Wendy HARCOURT

Wendy Harcourt is currently Editor of the Development journal of the Society for International Development (an INGO founded in 1957) and Chairperson of Women in Development Europe (celebrating its 20th anniversary in 2005). Since 1988 she has contributed to the international development debate on population, gender, sexuality and reproductive rights and globalization from a civil society perspective with numerous publications, articles and reports dedicated to the issue as well as four edited books.

Sandra M. KABIR

Mrs Sandra Kabir is the Programme Adviser to the International Council on Management of Population Programmes. ICOMP is an international NGO based in Malaysia, but Mrs Kabir works from London, U.K. Her work there involves the promotion of south-south-north partnerships in sexual and reproductive health and rights; technical assistance to NGOs of the south in design and implementation of programmes spanning gender issues (including women's empowerment, violence against women, young people), health sector reform, governance issues; involvement in the International Initiative for Reproductive Health Supplies steering group and advocacy working group. Prior to that she worked for several years at Population Concern, also an UK based international NGO, first as the director of the International Programmes Department and later as the director of International Advocacy and Resources. Next to that she was on the Bangladesh government delegation to ICPD and the UK government delegation to ICPD+5. She also worked in the Preparatory Committees and conferences of ICPD and ICPD+5, the World Social Summit and the Fourth World Conference for Women. Mrs Kabir has a special interest in abortion, violence against women and health sector reform. In 1988 she was awarded with the international Stimezo Prize for her outstanding contribution to the reduction of abortion worldwide.

Kevin OSBORNE

Mr. Kevin Osborne is the senior HIV/AIDS advisor at IPPF. As a native South African with an extensive and varied experience in the HIV/AIDS field, he brings to the work of IPPF an understanding of the technical issues surrounding the importance of mainstreaming HIV/AIDS more fully into the SRHR agenda. His creative energy, passionate commitment to HIV/AIDS issues and numerous editorials on issues as diverse as the ABC approach and the role of integration have earned him a well-respected voice at community, national, and international levels. His ability to successfully work at all levels of policy and service intervention, coupled with his understanding of the complexities facing countries with explosive HIV/AIDS epidemics, evidence a unique skill used as an effective policy and services advocate. Prior to his joining IPPF, Mr. Osborne was the Director of HIV/AIDS at the Futures Group International in Washington DC where he worked extensively on the POLICY Project. He has also provided much needed technical support to regional programs around the globe to address HIV/AIDS policy issues. These have included initiatives focused on the development of local response initiatives through UNAIDS (Geneva) and the development of an advocacy agenda for the International PLWA Community. As part of the editorial team of the HIV/AIDS Review Group of the Cochrane Collaboration, he is aware of the value of evidence-based research and its impact on programme and policy decision-making.

Hugo-Maria SCHALLY

After graduating from law school at the University of Graz (Austria) he practiced law for a few years. He then did postgraduate studies at the Vienna Diplomatic Academy. In his further career he worked mainly on issues linked to sustainable development in the multilateral context holding jobs with the UNDP, the Austrian Ministry for Foreign Affairs and the Organisation for Security and Co-operation in Vienna. Since 1998 he has been a Head of Unit at the European Commission in Brussels. He is currently heading a unit dealing with multilateral matters at the Directorate General for Development. In the course of his career he has been closely involved with the negotiation and implementation of multilateral environmental agreements such as on the Ozone Layer, Climate Change, waste management etc as well as with major global Conferences such as UNCED, Monterrey and Johannesburg . He is currently closely involved in the preparations for the UN High Level Event scheduled for September 2005

Anne VAN LANCKER

Anne Van Lancker is a member of the European Parliament (sp.a - PES). She earned a Degree in sociology (1978) from the Catholic University of Louvain (KUL), a Postgraduate Degree in social legislation (1987) from the Free University of Brussels (VUB). She was an assistant at the faculty of sociology (1979-1984), Catholic University of Louvain (KUL). From 1984-1988, she was a Researcher at SEVI (Emile Vandervelde Institute Research and Documentation Centre). She became a Political Advisor for the Flemish parliamentary socialist group (1988-1989) and later Deputy Head of the office of the Flemish Minister of Employment (1989-1990). From 1992-1994, she was the Head of the office of the Flemish Minister of Employment and Social Affairs and is a member of the European Parliament since 1994. She is a member the Committee on Employment and Social Affairs, the Committee on Women's Rights and Gender Equality, and serves as a Substitute of the Committee on Development Affairs. She is also a member of the Delegation to the ACP-EU Joint Parliamentary Assembly, the Chair of the Working Group on Population, Sustainable Development and Reproductive health, and a former member of the PES

delegation to the Convention. She is a member of the bureau, Chairwoman of the Flemish Socialist Women ('zijkant').

António Amado VAZ DOS SANTOS

António Amado Vaz was born and raised in São Tomé, an island in the Gulf of Guinée, close to Gabon. He is a general medical doctor with a special interest in Tropical and Gynaeco-obstetrical diseases. Next to his general integral medicine courses, he did trainings on tropical medicine, AIDS and Malaria.

He lived in Cuba for 10 years, where he studied and worked as a doctor in several departments of different hospitals (obstetrical-gynaecology, paediatrics, tropical diseases, follow up of people living with HIV/AIDS, etc). After moving back to São Tomé he worked as a medical volunteer, a librarian manager and medical assistant in different hospitals. In 1998 he started working for the Family Planning Association of São Tomé (Associação Santomense de Promoção Familiar) where he is Executive Director and Programming Director. It is in this last capacity that he sees to it that the FPA addresses AIDS in particular.