

Sexual and Reproductive Health and Rights Advocacy Update: Europe and Beyond

**Report of the meeting of the European NGOs for Sexual and
Reproductive Health and Rights (EuroNGOs) Platform**

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EuroNGOs is a European network of non-governmental organizations working cooperatively in the fields of sexual and reproductive health and rights, population and development. The network seeks to translate the commitments of the International Conference on Population and Development (ICPD) into international cooperation programmes for sexual and reproductive health in low-income countries. EuroNGOs has 30 full members in 17 European Union Member States, Norway and Switzerland, and six associate members, including in Australia, New Zealand and Canada. The network is financially supported by its members and governed by the EuroNGOs Steering Committee, which is made up of five EuroNGOs members and observers from UNFPA and the IPPF European Network.

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Contents

Acronyms	4
1 Introduction	5
2 Global SRHR Advocacy	5
US SRH Policy Going Forward: Catching Up and Moving Ahead	5
The Decade-long Campaign to change Australia's 'Global Gag Rule'	8
Challenges in the South Asian Region and the Work of ICOMP	12
3 SRHR Advocacy in Europe	15
EuroMapping 2009: Mapping European Development Aid and Population Assistance	15
Countdown 2015 Europe	16
The Impact of the Lisbon Treaty on the SRHR Community	17
Annex 1 Meeting Programme	20
Annex 2 List of Participants	22
Annex 3 Speaker Index	24
Annex 4 Presentations and Other Resources	24

Acronyms

ACP	African, Caribbean and Pacific countries
AIDCO	EuropeAid Cooperation Office
AusAID	Australian Government's Overseas Aid Programme
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSW	Commission on the Status of Women
DG DEV	Directorate General for Development
DG ECHO	European Commission Humanitarian Aid Department
EDF	European Development Fund
EEAS	European External Action Service
EU	European Union
EuroNGOs	European NGOs for Sexual and Reproductive Health and Rights, Population and Development
GAERC	EU General Affairs and External Relations Council
GDP	Gross Domestic Product
GHI	Global Health Initiative
GNI	Gross National Income
ICOMP	International Council on Management of Population Programmes
MDGs	Millennium Development Goals
ODA	Official Development Assistance
PEPFAR	President's Emergency Plan for AIDS Relief
RHS	Reproductive Health Supplies
RTI	Reproductive Tract Infection
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VLP	Visionary Leadership Programme in Population and Development

1 Introduction

Members, partners and invited observers of the European NGOs for Sexual and Reproductive Health and Rights, Population and Development (EuroNGOs) network met in Riga, Latvia, on 8 September 2009 for an update on progress and challenges in relation to sexual and reproductive health and rights (SRHR) advocacy over the past year.

Speakers from Europe, North America, Asia–Pacific and South Asia presented progress reports and commentary on global and regional SRHR advocacy, including:

- Major political shifts (the election of Barack Obama in the US);
- Policy victories (rescinding Australia's 'global gag rule');
- Continuing SRHR challenges and opportunities in low- and middle-income regions (e.g. South Asia);
- Changes to Europe's governance and structure (the Lisbon Treaty); and
- Who gives what in terms of development aid to SRHR (EuroMapping 2009 and Countdown 2015 Europe).

2 Global SRHR Advocacy

US SRH Policy Going Forward: Catching Up and Moving Ahead

Susan Cohen, Alan Guttmacher Institute, USA

What a difference a year makes! Last year, just before the US elections, we talked about how things would not be so devastating if US Republican-party candidate John McCain was elected, because of the likelihood that the US Congress would have a majority of Democrats to rein him in. We also talked about how it still would not be easy to get all that we want – and certainly not as soon as we want – under an Obama administration, because, as the saying goes, 'only your friends can disappoint you.' I probably lied a little about the first statement, but the second one still applies.

What has been achieved

We have left behind the era of 'saving souls' (i.e. through, for example, abstinence-only policies based on religious or moral doctrine) and are getting serious again about saving lives. In other words: we have left the evidence-free zone. For example:

- The Global Gag Rule has gone (and we are working on making this permanent);
- The boycott of UNFPA is gone.
- Abstinence-only sex education – at home and abroad – is gone in the first case and is on its way out in the second.

In terms of financial support, the US is on a good trajectory to sharply increase its contribution to USAID's international family planning/reproductive health programme (although domestically the results are far less robust).

- In 2008, the US funded the overseas programme at US\$ 464 million (none to UNFPA).
- In 2009, once Obama came in, we pushed that up to US\$ 545 million, including US\$ 50 million for UNFPA.
- For the fiscal year that begins 1 October, Congress is on track to raise the level again substantially – maybe by as much as another US\$100 million. If that happens, in two short years the US will have managed a 40% increase in

financial support for family planning/reproductive health, which would be impressive, especially in this economic climate.

Since 2008, US NGOs have been making the case and waging a campaign for the US to increase spending on family planning/reproductive health to US\$1 billion, which would approximate the share that the US pledged in Cairo.

What is going on now

President Obama announced a new US **Global Health Initiative** (GHI) in May. The purpose is to give greater prominence to global health as a policy priority of this administration – a key component of the national security ‘smart power’ strategy. It is also to provide a framework for a more integrated approach and to emphasize proven, cost-effective approaches, and it is to position US programmes and policies towards achieving the Millennium Development Goals (MDGs). Its four key goals are to:

- *Prevent* millions of new HIV infections (note new emphasis);
- Reduce mortality of mothers and children under five;
- Avert millions of unintended pregnancies; and
- Eliminate neglected tropical diseases.

At the time of this writing, the initiative is still very much a work in progress. There have been many internal governmental meetings over the summer to flesh out the various pieces, including plotting out budget projections.

In 2009, funding for the PEPFAR/tuberculosis/malaria, maternal and child health, family planning/reproductive health and neglected tropical diseases altogether amounted to about \$8 billion. Under the GHI, the President has proposed that over the next five to six years it will commit a total of \$63 billion to global health. Congress will get its say too, and then the ‘devil will be in the details’ about how to allocate those funds among the key programmes.

The State Department is taking the lead in managing the negotiations among governmental agencies on all policy and budgetary pieces, and now it is reaching out to NGOs for input. Its goal is to wrap up this first key planning phase in the next few weeks.

In addition to the GHI, the US is in the midst of two other reviews – one conducted by the State Department and one by the White House National Security Council – to assess the US approach to development assistance in general. Neither of those processes is very transparent yet, but both reviews are supposed to be completed by the end of this calendar year.

On the horizon

Eventually, there will be new PEPFAR guidance reflecting the views of the Obama administration. (The recent one mostly was a continuation of the status quo.) We remain hopeful that the US will shift policy gears in a number of ways. For example:

- Support for comprehensive sex education: a policy that will no longer require that young people be sexually active already before they are entitled to accurate information about and access to condoms, for example.
- Linkages between family planning/reproductive health and PEPFAR programmes: referral and counselling for family planning within AIDS programmes are essential, and the linkages to family planning programmes “must be real”. Where no family planning programmes exist to be referred to, PEPFAR should be able to provide family planning services.

- Faith-based groups are still in the mix, but there must be at least a co-equal obligation to the patient/client. The aim will be to accommodate the religious views of providers where possible, but it is unconscionable to deny information to a discordant couple about condoms, for example, as this would represent an abandonment of care.

Global SRHR bill

As NGOs, we of course see our role as staying one step ahead of our leaders. Therefore we have decided that, while keeping up the pressure to dramatically increase the US financial commitment, it is time to push the policy agenda forward. We have drafted a bill designed to be an educational tool for grassroots groups to inform members of Congress (and the administration) and to give more of them something to do (co-sponsor, speak about the issues etc.) to make the connections between SRHR (not using those words necessarily) and all the MDGs. Operative provisions include:

- Assistance for programmes (family planning services and information, contraceptive supplies, prevention of sexually transmitted infection (STI)/reproductive tract infection (RTI), post-abortion care, harmful traditional practices);
- Assistance to prevent unsafe abortion and reduce its consequences;
- Assistance to provide SRH in emergency situations;
- Assistance to promote SRH to young people; and
- A strategy to link the various components of SRH with each other (maternal health and family planning, HIV and family planning etc.) and with other global health programmes as appropriate.

Now is the time reopen the discussion about critical political issues. Secretary of State Hillary Rodham-Clinton opened the door – particularly on the fact that safe abortion is integral to reproductive health care; we cannot pass on the chance to walk through.

President Obama is unapologetically pro-choice, but also in search of common ground. To that end, he has made clear he does not want to *do* anything about abortion; he wants to use it to do other things, like promote evidence-based sex education and more family planning and maternal health programmes. It remains to be seen over the coming months what this initiative will look like. We are impatient, because we have had so many years in the wilderness and because we know how short the window of opportunity may be open. With elections a little over a year from now, the Democratic majorities are likely to shrink. Indeed, the White House knows this too, which is why they are rightfully pushing so hard on health insurance reform right now. It is the anti-abortion groups and their cohorts who are not only fighting against allowing insurance coverage of abortion services under health care reform (almost all private insurance covers abortion now), but who are also charging that Obama's plan would mean 'death panels' and 'pulling the plug' on grandma. These are the same people who brought us arguments such as 'abortion is bad for the US economy because it eliminates future taxpayers' or 'contraception leads to more abortions because contraceptive availability leads to promiscuity.' Incredibly, they have made headway in shaking public support for health care reform. They have not gone away. We cannot be complacent.

The Decade-Long Campaign to Change Australia's 'Global Gag Rule'

Jane Singleton, Australian Reproductive Health Alliance and Parliamentary Group on Population and Development Secretariat

The Pacific and Southeast Asia region includes some of the most remote areas on Earth, with tiny islands and highly diverse populations. These are interesting and wonderful places – places that matter – but they are forgotten by most of the world.

For example, Timor Leste is one of the newest nations in the world (it was ten years old in August). It is a tiny, fragile state with little infrastructure and great challenges. Forty-five percent of its population is under the age of 15, and maternal mortality has doubled in recent years. But the world does not know this. According to UNFPA estimates, the birth rate in Timor Leste is 6.48 children per woman – the highest in the Pacific region and second highest in Asia. At maternal health clinics I have visited in Timor Leste, many women had eight or nine children, and some had as many as 24. A midwife told me that a few women used contraception after they had eight to ten children, but not before. Restrictive laws in the mainly Catholic country mean women cannot request elective abortion for any reason, including preserving their health or saving their lives. Also, "Forty per cent of all emergency obstetric care was managing and treating complications from early pregnancy losses, and doctors and midwives continued to be reluctant to speak with women about induced abortion."

Australia's aid programme (AusAID) is the largest donor of development aid in the Pacific and one of largest in Southeast Asia. Therefore, what the Australian government does matters, particularly in places like Timor Leste. So the fact that AusAID's Family Planning Guidelines mirrored the US Global Gag Rule is disturbing. The Guidelines have limited Australia's aid program and contributed to the deaths of thousands of women and their children in our region.

While the Guiding principles of the policy said that Australian funds can provide medical treatment support and counselling to women suffering from complications resulting from an unsafe abortion, this is the case only after an unsafe abortion occurs. According to a former Chair of the Parliamentary Group and a doctor of medicine: "Saving a woman after an abortion is all very well, but how much better to prevent the unsafe abortion to begin with, let alone provide family planning information, education and supplies." And of course if you 'saved' a woman from the physical complications of an illegal, unsafe abortion, there remain serious legal and social ramifications and consequences.

It took more than a decade to overturn the regulations, and success came only last week. There were many difficulties, false hopes and much disillusionment, but tenacity, a bit of brinkmanship and daring led to their abolition. The Australian Parliamentary Group on Population and Development along with the Australian Reproductive Health Alliance, of which I am CEO, led the campaign. The story of the campaign is important and achieving support within the community and government was complex and challenging. It proves the need for, and power of, strategic advocacy in our sector and an informed, committed and activist Parliamentary Group.

The story of the campaign

In a cynical move to achieve the support of a fundamentalist Christian Senator who held the balance of power in the Australian Parliament's upper house (legislation must successfully pass the Senate for it to be enacted), support for the privatization of the national telephone company, two pernicious policy and legislative changes were put in place.

One meant that medical abortion could not be provided in Australia despite the fact that surgical abortion was not only available but for most women legally and affordably available. This prohibition was overturned in a historic move by four women from the major political parties. These four women Parliamentarians, from the Australian Labor Party, The Australian Democrats, The Nationals and the Liberal Party came together despite their party political differences, to jointly allow the abortifacient RU486 (or mifepristone) to be used under medical supervision in Australia, putting us in line with other nations as diverse as the US, Russia, China, South Africa and most of Europe including Italy.

The second was the insertion of the 'AusAID Family Planning Guidelines' into Australian aid policy in 1996. The Guidelines prevented the full range of family planning services, education and information going to aid recipients in our region. The wording of the Guidelines may not be immediately disturbing: "Australian aid funds are not available for activities that involve abortion training or services, or research trials or activities which directly involve abortion drugs." But it has had both direct and indirect effects.

1. The direct effect is that funding is NOT available for activities that involve abortion training or services, or research trials or activities which directly involve abortion drugs. This not only affects the intended target (i.e. abortion), but other services as well. For example, one agency had to argue long, hard and in writing to include vacuum aspirators in a project on maternal health. They are commonly used to 'clean up ' after child birth, and are, by all measurements, an essential procedure. The concern was that they might be able to be used to procure abortion, not just clean up after birth.
2. The indirect effect is that the Guidelines created an atmosphere of fear or led to self-censorship. Agencies felt they could not press for funding for family planning services if there was a chance their work could be interpreted as supporting abortion – even education about safe abortion and even in those countries where abortion is legal. Additionally, the onerous accountabilities, detailed on the family planning check list, put too much strain on limited resources and capacity.

Given that in our region 13–45% of maternal deaths are due to unsafe abortion, this response is unrealistic, inhumane and counter-productive. The result of the policy was, indeed, far reaching. During the decade it was in force, general family planning funding from Australia to the Pacific and Southeast Asia region decreased by 84%. This information was revealed because of the work of members of the Australian Parliamentary Group on Population and Development (PGPD).

Gathering data about the impact of the Guidelines was difficult, not just because of the reluctance of the then-government, but because sexual and reproductive health and family planning funding was often hidden in other AusAID budgets. On the one hand, the lack of clarity access to the data made it more difficult for those who wished to protest about expenditure on family planning; but it also invited the argument that family planning funding was unnecessary since our aid programme appeared effective even without such expenditure.

The policy was not legislative in nature, which meant that no debate was required in Parliament, and thus the issue did not get a public hearing, and there was very little reportage. Essentially, it was all bit covert. What turned out to be a key piece of evidence in the fight against the Guidelines, however, was a roundtable convened by the Australian Reproductive Health Alliance and hosted by the Parliamentary Group on Population and Development on 'Sexual and Reproductive Health and Millennium Development Goals in the Australian Aid programme the Way Forward'.

The report of this meeting was a little green booklet ... but it earned its weight in gold as it was used again and again to brief bureaucrats, Parliamentarians and other agencies.

The key recommendations will not surprise you:

- Abolish the AusAID Family Planning Guidelines;
- Enhance integration of sexual and reproductive health and HIV/AIDS; and
- Strengthen systems support for sexual and reproductive health.

A long battle

But these recommendations were not enough to abolish the Guidelines. The government went through a number changes, including, at one point, giving control of our issue to a single Senator from a party called Family First, which is conservative, fundamentalist Christian and pro-life. His support was needed for any bill to get through and while the Guidelines did not come before the Parliament in any formal way, the Government was loathe to alienate this Senator, fearing they may have to trade off the Family Planning Guidelines for his support on other legislation. This was similar to what had happened more than a decade before when the Guidelines were created. Once again, a conservative Christian Australian Parliamentarian held hostage the reproductive health of women in our region.

Eventually, the Australian Reproductive Health Alliance and the Parliamentary Group produced advocacy packs and distributed them to parliamentarians, to international and national stakeholders and like-minded organisations. We briefed journalists and commentators as well; but everyone was too afraid to act openly for fear of making the situation worse. This is a common dilemma for those of us trying to decriminalize abortion or legalize condoms or get governments to support family planning.

When the Prime Minister took a leading role in the high-level conference on the MDGs at the UN in New York, we at last had a public hook we could hang our advocacy upon. We sent email letters to all international organizations and the Parliamentary Groups to make the case for the removal of the Guidelines as fundamental for the achievement of the MDGs. Similar letters were also sent to women's groups, human rights groups, health-related organizations, nurses' and doctors' representatives and unions in Australia, to encourage the Prime Minister to announce the removal of the Guidelines when he spoke at the United Nations. Letters to the editor were sent to the nation's newspapers: country, regional and metropolitan.

But despite the excellent contributions of Jeffrey Sachs on the MDGs and the internationally positive coverage of him and our issues, our Guidelines remained, and the window of opportunity presented by the meeting was firmly closed.

The members of the majority party in the Government, the Australian Labor Party, had agreed to work covertly on the issue so as not to inflame protest. However, without overt external pressure, those who could make the decision to remove the Guidelines seemed to feel safe in doing nothing. And because of the oft-touted, informal advice that the Minister would not be pushed and that in fact any public campaign would work against the removal, entrenching the Minister's caution and entrenching the Guidelines, the issue was largely out of the public gaze.

This made things very difficult, and presented real difficulties in the organization's relationship with its stakeholders and the rest of the sector. We could be seen to do nothing and activists were getting more and more frustrated.

Success at last

Time passed, and after women's day in March 2009, the Minister put out a media statement saying the Guidelines would change, that Australia's overseas development assistance program would 'support the same range of family planning services for women in developing countries as are supported for women in Australia, subject to the national laws of the relevant nation concerned.'

We sent out congratulatory media releases.... but the Guidelines remained, apparently part of AusAID aid policy, featuring on its website. Enquiries to both AusAID and the Minister's office elicited suggestions that the matter was waiting resolution in the other's office. There had been predictable attacks from senators aligned to the Right to Life (or 'Cherish Life' as it is now called). For example, Senator Boswell said the policy change could take aid funds away from programmes for maternal and child welfare, food and clean water. But beyond his cries, there had been no great opposition to the March announcements. However, the Guidelines remained.

Finally, I sought legal advice about international conventions to which the government was signatory that were being breached by the existence of the Guidelines, and the potential for taking the issue to the Hague. Last week, on Monday, six months after the announcement that the Guidelines were going, I let senior people in the government know I had sought such advice. I explained that I was going to be at important meetings in Europe and in Bangkok on the MDGs, ICPD and sexual and reproductive health and that I would be speaking on this issue. In summary, the Human Rights Law Resource Centre advised that the Guidelines constitute discrimination against women and therefore contravene Australia's legal obligations under international human rights law.

Human rights treaties, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) require the provision of development assistance and provide that such assistance must promote the equal enjoyment of human rights between men and women. By prohibiting funding for safe and legal reproductive health services that have been recognized as core components of the right to health, the Guidelines fall short of human rights standards. I explained that for a nation known to be keen to win a place on the Security Council these breaches would not look good and that international women's groups, population and development groups and sexual and reproductive health funders and advocates would be askance and active.

Late the next night, new Guidelines were signed by the Minister. They refer to Australia's commitment to the ICPD's goals of 'achieving universal access to family planning by 2015', and 'support the same range of family planning services for women in developing countries as are supported for women in Australia, subject to the national laws of the relevant nation concerned'. The Guidelines place a gestational term limit on abortion of up to 20 weeks, which is higher than in some parts of Australia. The Guidelines were ostensibly drafted back in March. In addition, funding for family planning will be identified with the insertion of the OECD DAC code 13030 Family Planning (Family planning services including counselling; information, education and communication (IEC) activities; delivery of contraceptives; capacity building and training).

Work with parliamentarians is essential

While many partners and supporters were essential to this success, the Alliance and the Parliamentary Group led the campaign and did the great bulk of the work. We need more parliamentarians who understand the implications of poor sexual and reproductive health. We need male and female parliamentarians. In 2008 the Centre for Democratic Institutions research indicated that in the Pacific, if you exclude the French and US Territories, only 4% of parliamentarians are women. In Australia it is almost 30%. Six Pacific nations have no women in their parliaments (Micronesia, Nauru, Northern Mariana Island, Palau, Solomon Islands and Tuvalu), and Papua New Guinea has only one.

Parliamentary Groups on Population and Development should be established in the Pacific nations. We are working with the newly formed Papua New Guinea Parliamentary Group, are working to establish one in Timor Leste, and hope to be able to do so in other Pacific nations and in Bougainville in future.

In our region, without the Parliamentary Group on Population and Development, the pernicious Family Planning Guidelines which mirrored the global gag rule and contributed to the deaths of thousands of women and their children in our region, might still be in force.

Challenges in the South Asian Region and the Work of ICOMP

Wasim Zaman, International Council on Management of Population Programmes (ICOMP), Malaysia

The International Council on Management of Population Programmes (ICOMP), based in Kuala Lumpur, was set up in 1973 upon the realization that people managing population programmes in most countries did not have adequate management training. In response, a group of people looked for a way to build management capacity so that population programmes could be more effective and efficient. ICOMP is an international NGO with considerable inter-governmental support from countries of Asia and the Pacific, Africa and Latin America. Substantively, ICOMP covers issues of Reproductive Health and the broader context of population and development, including population and environment. The primary focus is on improving management of programmes and enhancing efficiency of organizations involved in these focus areas.

Over the years ICOMP has been supported by various governments, the World Bank, UN Agencies such as UNFPA, UNAIDS, WHO, and private foundations such as Hewlett, Packard and Ford. ICOMP does not have an endowment and must raise money every year to fund its work.

The art of leadership

Leadership is not a vague term – it is a particular skill and quality that ICOMP focuses on in our training and other activities. For example, from 2002 to 2006 we led a Visionary Leadership Programme in Population and Development (VLP), with support from the David and Lucile Packard Foundation. In India – by a consortium of partners, the initiative built the capacity of 187 individuals from more than 150 organizations, including state and federal-level government bodies, the United Nations, donor and international development agencies, national NGOs, welfare organizations, academic institutions and the media. In addition to the 187 leaders. VLP led leaders through a programme of self-learning, an advanced leadership course, mentoring, on-the-job support, peer exchange and networking. Their

leadership capacity was further strengthened over time by opportunities to participate in task forces, drafting committees, advocacy networks, and so on.

In addition to initiatives like VLP, ICOMP has also produced a number of tools for promoting universal access to reproductive and NGO sustainability.

ICOMP is now looking forward, beyond the Cairo agenda, to determine the best way to build capacity and ensure universal access to reproductive health. For this, I welcome your wisdom and feedback.

Case Study: Family planning, SRHR and development in South Asia

While ICOMP works all over the world, we are based in Asia and have worked extensively in South Asia. This area is of particular interest to me, personally and professionally, and so I would like to outline some of the progress and the challenges of the region with regard to family planning and SRHR.

Linkages between RH and HIV and Aids programmes

In four countries of Sub Saharan Africa – Uganda, Tanzania, Ethiopia and Zambia -- ICOMP has worked with more than 30 NGOs for capacity building for linked response to Reproductive Health and HIV/AIDS. These projects focused on the needs of young people and thus worked both for counselling and referral to services for young people.

Progress and successes

South Asia comprises eight countries, with vastly different histories and stories. There have been great successes in the region, tremendous investments and achievements in social entrepreneurship. Three Nobel Laureates – one a poet and philosopher, the others focusing on gender, equality and injustice.

Family planning has also been a great success story in South Asia. Formal government family planning programmes started in the region 50 years ago, and fertility rates have come down dramatically in many places. For example, in Sri Lanka fertility rates are below replacement level. It is important to ask ourselves what the population of the region, and the world, would be if we did not have family planning programmes in South Asia. Gender has been placed squarely at the centre of family planning programmes in the region, and young people's needs have become a focus. In addition, the responsibilities of men are prominent, with SRHR programmes for male partners.

South Asia is at the cutting edge of innovation in many other ways as well. For instance, Bangladesh alone provides endless numbers of examples of what you can do despite poverty, illiteracy and other social challenges. Of course, one of the greatest success stories is the Grameen Bank and its founder, Muhammad Yunus, which received the 2006 Nobel Peace Prize. And Sri Lanka has seen unbelievable progress, despite its civil war, which hopefully is now coming to an end. Finally, Bhutan thrives by the notion that 'Gross Happiness Indicator', with a vision that it is important to look at more than income and wealth. Bhutan is serious about quality of life

Challenges remain

Despite the status of many South Asian countries as models of development and progress, approximately 70% of maternal deaths in the world occur in 10 countries, four of which are in South Asia: Nepal, Bangladesh, Pakistan and India. This is indicative of other dramatic differences among regions, populations and people, and of reversals of progress in South Asia. For example, Pakistan, for years, had an

impressively high rate of economic growth, but distribution and social progress have been slow. Pakistan, Afghanistan and Nepal are all troubled by a number of social, economic and security challenges.

While gender, including men's involvement, has become an important focus for many programmes in South Asia. There is still a monumental challenge with regard to establishing rights – rights to good health, not to die in pregnancy, and to access good quality health facilities, funding and services. There has been some progress in these areas, but it is not enough. India spends only 1% of its GDP on public health, in contrast, for example, to Iran, which spends 4.8%, and Bhutan, which spends 2.7%. Another area of unfinished business in India is illiteracy: it is estimated that, in 2010, almost half the children of India will remain illiterate.

There is a lot yet to be done on issues of poverty and injustice, and in terms of conflict. Former President Bill Clinton had said once that South Asia was the most dangerous part of world, and in Afghanistan and Pakistan this certainly is an issue, no matter which business you are in. This is further complicated because we have flawed democracy, and many corrupt people return to power over and over again.

South Asia's unfinished Agenda

I hear some donors say that it is time to exit South Asia and move on to Africa. This undermines South Asia's catch-22 situation: despite great progress, there is still much to do. Without a proper exit strategy adequately funded and timed, the unfinished business of South Asia would remain unfinished.

Discussion and Comments

US plans for the Commission on the Status of Women

A participant asked for clarification on the US administration's plans for the Commission on the Status of Women (CSW) and its celebration of Beijing+15. Susan Cohen explained that Hillary Clinton has created new ambassador for global women's issues, who is very experienced and leading efforts in preparation for the CSW. While no other details are available, there is optimism because we now have a high-level government appointee whose job is to deal with women's issues.

Morality a bigger problem than money in Timor

A participant from Portugal raised concern about the SRHR situation in East Timor – a former Portuguese colony – where religion and morality, rather than lack of money, appears to be the biggest problem. Jane Singleton explained that ARHA and the Australian population and development parliamentary group made their first visit to East Timor. She agreed that commitment to the church is very strong, with the most conservative interpretation of the Bible anywhere in the world. Fertility rates have only just fallen to seven children per woman. However, the leadership there depends on the Church, and they are making dangerous statements and have dangerous views, which is a huge problem. At some level funders can help to address the development problems there, and she hopes that economic pressure can have an impact.

3 SRHR Advocacy in Europe

EuroMapping 2009: Mapping European Development Aid and Population Assistance

Karen Hoehn, German Foundation for World Population (DSW) and Neil Datta, The European Parliamentary Forum on Population and Development (EPF)

DSW and the EPF released the 2009 edition of their *EuroMapping* report, an annual publication that provides comparative information about European official development assistance (ODA), official commitments to sexual and reproductive health and funding flows for population assistance. In addition to their annual research, they have also done a pocket guide, which was presented at the EuroNGOs conference. *Euromapping 2009* differs significantly from previous editions, featuring:

- General ODA trends;
- Health spending;
- Population Assistance spending;
- Contributions to major SRHR organizations;
- 38 donor profiles; and
- six case studies on budget support, division of labour and EU aid in Mozambique, Kenya, Nepal and Pakistan.

While EuroMapping includes a wide range of figures that are useful for SRHR advocacy, the following are some of the highlights.

Findings

The collective efforts of the EU have made it the single greatest donor of population assistance worldwide. In 2006 the EU spent nearly US\$ 3 billion on population programmes and activities, increasing its aid by US\$ 600 million. The US decreased its aid by nearly the same amount.

European ODA disbursements as a percentage of GNI

Even though the EU is performing below its overall commitment to ODA as a percentage of gross national income (GNI), the overall ODA trend in 2007–2008 was positive, with an overall increase among EU donors and worldwide, both as a percentage of GNI and in the volume of net disbursements. In addition, key EU donors, including Germany, the UK, France, the Netherlands, Sweden, and Italy, appear to have increased their 'real', rather than 'inflated' aid in nominal terms. This is a very positive trend leading up to the global economic/financial crisis, which is predicted to decrease real ODA in the coming years.

EU aid for health appears to have declined overall between 2006 and 2007. While the UK, Spain and Ireland increased their health ODA during that time period, the rest have decreased health ODA or maintained it at the same level. The EU contributes roughly 46% of overall global health aid.

The Good News

Global ODA increased over 10% in 2008, and almost all European donors increased their aid in 2008. The European Union (i.e. the European Commission and 27 Member States) accounted for 63% of all ODA in the world in 2008. The 'best performers' are European, with Denmark, Luxembourg, the Netherlands, Norway and Sweden all contributing above the UN target of 0.7% of GNI as ODA in 2008. The Nordic countries and Luxembourg remain the greatest per capita contributors, with

Norway providing the most. The UK has become the greatest health spender in absolute terms, with more than a two-fold increase from two years prior.

The Bad News

Although most new Member States have increased their efforts, they have not reached nor are likely to reach their interim target of 0.17% of GNI as ODA; Poland, Lithuania and Malta decreased their ODA in 2008. Austria was the only country of the former EU-15 where ODA declined in 2008, and the Italian government has indicated severe aid cuts will come. A significant percentage of European ODA remains 'inflated' with debt cancellation, student costs and refugee costs, without which Europe would spend 0.34% instead of 0.4% of their GNI on ODA. ODA spending on health decreased by \$124 million over the previous year, mainly due to a decrease in European health ODA.

Findings and Recommendations

Understanding the impact of the emerging aid environment requires extensive new research, and often information is available only through 'unofficial' sources, as parliamentarians and civil society in developing countries often are excluded from decision-making processes and procedures. Therefore:

- Civil society and parliaments need to be more involved in budget-setting and watchdog monitoring in developing countries.
- Increased transparency and accountability needed to assure ICPD gets sufficient funding – funds flows increasingly obscured by general budget support.
- The EU "division of labour" is increasing aid coordination at both the EU and developing country levels, with EU Member States actually delegating their authority by sector to manage aid in developing countries.

More information, graphic material and the *EuroMapping* study report in English, French and German are available online at www.euroresources.org/euomapping.

Countdown 2015 Europe

An Huybrechts, International Planned Parenthood Federation European Network (IPPF EN), Brussels

Countdown 2015 Europe is a group of European NGOs working on SRHR, with a special focus on reproductive health supplies (RHS). We work in 15 European countries to achieve increased support from European donors for RHS in developing countries. We also aim to improve European coordination and coherence to narrow the gaps between the needs, demand and availability of essential supplies.

At last year's EuroNGOs conference, Countdown 2015 Europe provided detail about its work; this year's presentation is a brief update on our research and publications, which are useful advocacy tools for European SRHR NGOs.

Tracking funding and policies on reproductive health supplies

We are tracking funding and policies on RHS in Europe. Last year we published a detailed report on tracking, and this year we have produced 15 country briefs, showing policies and funding for reproductive health and RHS in 15 European countries. These can be used by advocates throughout Europe to lobby for increased resources for RHS among European governments. The fact sheets are complementary to *EuroMapping*, providing a narrative analysis on specific funding and budgets as well as policies and commitments.

In addition to the country fact sheets, we are finalizing a brief on the European institutions policies and funding for RHS, and highlights and trends related to RHS in Europe. And we have engaged in research on the role of reproductive health and RHS in strengthening health systems. The report on this is almost finalized and will be available in October through our website.

Challenges in tracking funding

Our research did face some challenges. One is that earmarked funding for reproductive health and RHS is decreasing, and more is going to budget support and health systems strengthening. This makes tracking funding, and therefore advocacy for specific funding, very difficult.

For more information or copies of our research and publications, please visit www.countdown2015europe.org or email ahuybrechts@ippfen.org.

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The Impact of the Lisbon Treaty on the SRHR Community *Arben Fetaj and Astrid Poupez, Marie Stopes International, Brussels*

The Lisbon Treaty was signed on 13 December 2007 by the EU Heads of State and Government. Nearly all EU countries have ratified the Treaty, except Germany, the Czech Republic and Poland, where ratification is still in progress. Ireland rejected the Treaty by referendum vote in June 2008, and has a second referendum due to take place on 2 October 2009. It is expected that it will be approved in Ireland this time, since the European Council of June 2009 gave guarantees to Ireland that the Treaty will not affect Irish constitutional provisions on life, the family or education, EU taxation competence or Ireland's military neutrality.

The entry into force of the Lisbon Treaty will have significant implications for the competences and functioning of the EU institutions. This is particularly true in terms of the EU's organization into 'three pillars', or three institutions responsible for making policy and taking decisions. The Lisbon Treaty will merge the three EU pillars (European Community, Common Foreign and Security Policy, Police and Judicial Cooperation in Criminal Matters) into one legal entity.

The **Council of the EU (Council of Ministers)** now acts in a closed sphere. Under the Lisbon Treaty most of its elements will stay the same, but it will act in public when it deliberates legislative acts. This is where national advocacy is key for European decisions. Also in the Council, qualified majority voting and 'co-decision' will become the general rule after 2014.

The Lisbon Treaty also introduces the Ioannina Compromise to enable some governments to be able to protect their interests in the EU decision-making process – the thinking behind this is mainly related to sensitive areas such as agriculture, justice and home affairs. In terms of blocking procedure, anti-choice governments such as Poland, Ireland and Malta now need two large Member States to block a procedure. After 2014, with the application of the Ioannina Compromise, they could block a procedure with only one large Member State, such as Germany. After 2017, Poland and France alone could ask to review a decision! In light of this, advocacy needs to be stronger, because a small group of Member States will be able to block decisions. We also need to have strong national and international messages. It will be very important to work with anti-choice governments and with the largest Member States.

It is worth noting that as many as 8% of proposals made by the European Commission under the co-decision procedure are suggested by interest groups and NGOs. This shows that it is possible for NGOs to influence the EU agenda and that there are good opportunities for NGOs. Moreover, 'Conclusions' and other non-legislative acts are often adopted by the Council of the EU (GAERC) and the European Council ('Presidency conclusions'). They are reached by consensus, not by voting. This will not change with the Lisbon Treaty. Influencing them is important for SRHR because they define political guidelines for EU Institutions.

The powers of the **European Parliament** will be substantially extended under the Lisbon Treaty. The Parliament will share equal power with the Council of the EU in setting the EU budget, and co-decision will be extended to almost all policy fields. Politically, the Parliament's power will be extended as it becomes more involved with election of the President of the Commission; this is a new procedure which requires further consideration of the Parliament. The increase of the European Parliament's powers and political weight within the institutional triangle are factors for us to watch.

The **European Commission** now has 27 Commissioners – one per Member State. With the Lisbon Treaty, by 2014, there will be 18 commissioners who will be selected on a system of equal rotation among the Member States, established unanimously by the European Council. This means that some countries will lose their commissioners.

The European Council is relatively unstable because the presidency changes every six months. Under the Lisbon Treaty the president will be elected full time with a mandate of two-and-a-half years, renewable once, which will bring stability to the Council. The president will have no national function.

The Lisbon Treaty and the external action of the EU

Under the Lisbon Treaty, the fight against poverty is said to be at the heart of EU development policy, which is great for SRHR. The consistency requirement has been strengthened, and there is a move to ensure that EU development cooperation policy and the Member States' policies mutually reinforce each other (a 'Europeanization' of development cooperation). The Treaty does not make any mention to the 'specificity of cooperation with ACP countries', which enables the European Development Fund (EDF) to be included in the ordinary budget of the Union, voted in co-decision with the Council. The potential inclusion of the EDF in the general EU budget is an area of concern for us.

A High Representative of the Union for Foreign Affairs and Security Policy will be appointed by the European Council to enhance unity of EU external action. The High Representative will be supported by a new service called the European External Action Service (EEAS), which will be composed of officials of the Council, the Commission and seconded diplomats from Member States. The EU Delegations will be directed by the EEAS. However, the Lisbon Treaty does not define the EEAS's functioning, content and organization, which will be defined by a Council decision once the Treaty is in force.

European External Action Service and reform of the Commission

Under Lisbon, the EU Delegations will have a legal 'personality', enabling them to represent the EU, and they can '*contribute to the formulation*' of policies. The main challenges are to determine how the Commission and the Council will work together, as there might be opposition between the two entities. There is also a question about where the European Commission Humanitarian Aid Department (DG ECHO), Directorate General for Development (DG DEV), EuropeAid Cooperation Office (AIDCO) and others will be situated. If they are outside the EEAS, a single service

will be established within the Commission, embracing all EU development policies. Within such a Single Service there will be a need for clear separation in terms of how each area of policy is pursued. If they are located inside the EEAS, there is concern that development cooperation and humanitarian assistance will be submitted to a diplomatic agenda.

There will also be a specific legal base for humanitarian aid. The Union may conclude agreements with third countries and international organizations. There will also be the creation of a **European Voluntary Humanitarian Aid Corps** to provide a framework for joint contributions from young Europeans to the humanitarian aid operations of the Union'. The Union shall ensure the coordination and consistency of humanitarian aid operations. However, the Lisbon Treaty does not mention the principle of independence, therefore there are concerns that the humanitarian response will be subject to political objectives.

Opportunities for advocates

National Parliaments will have eight weeks after publication of an EU legislative proposal to vet that proposal and offer an opinion. Each National Parliament has two votes and review takes place if 18 votes are 'pro' (1/3 of the available votes). For our advocacy, it is important to work with other partners on SRHR to lobby the national parliaments. Nine countries veto a decision!

At least one million citizens, coming from a significant number of different Member States, may put forward a petition inviting the Commission to bring forward a proposal in any area which comes within the Union's sphere of responsibility. Arrangements for managing the citizens' initiative will need to be agreed after the Treaty comes into force.

Discussion and Comments

EU presidencies have been an important area for SRHR advocacy; how will our options change under the Lisbon Treaty?

Arben Fetaj commented that the Lisbon Treaty says nothing about council conclusions; because council conclusions are non-binding they are not affected and will remain the same. So it will be as difficult as it is now to work on council conclusions, because anti-choice governments will still be able to block the conclusions. We have to continue working as we have done in integrating SRHR.

According to Karen Hoehn, the Council has historically been a force for good with regard to the ICPD Programme of Action. In the past year to year and a half, in behind-the-scenes negotiations, many EU Member States that had been leaders on our agenda have been looking for common ground, so they are not continuing the fight. We must strengthen our Member States' commitments to lead on SRHR.

Annex 1 Meeting Programme

EuroNGOs AGM 2009

8 September 2009, Hotel Europa Royale, Riga, Latvia

- Program -

09.00-10.15 Beyond Europe

Chair: *Ms. Anne Quesney, Head of Advocacy, Marie Stopes International, UK*

The US Administration and SRHR

Ms. Susan Cohen, Director of Government Affairs, Alan Guttmacher Institute, USA

Australia's Global Gag Rule

How strategic parliamentary and media work can save the lives of thousands of women and their children

Ms. Jane Singleton, CEO, The Australian Reproductive Health Alliance (ARHA)

Challenges in the South Asian Region and the Work of ICOMP

Dr. Wasim Zaman, Executive Director, International Council on Management of Population Programmes (ICOMP), Malaysia

10.15-11.15 Europe

EuroMapping 2009

Latest Findings on European Development Aid and Population Assistance

Ms. Karen Hoehn, Vice Director, DSW, Brussels

Mr. Neil Datta, Secretary, EPF, Brussels

Countdown 2015 Europe

An Huybrechts, Coordinator, Countdown 2015 Europe/IPPF EN

The Impact of the Lisbon Treaty on the SRHR Community

Mr. Arben Fetaj, European Advocacy Officer, EPWG secretariat

Ms. Astrid Pouppez, Consultant, MSI

11.15-11.30 Coffee Break

- 11.30-13.00** **Parallel Sessions Dealing with Topics of Interest to the Network**
- Interactive Knowledge-sharing Session on Working with All-Party Parliamentarians Groups and Parliamentarians - to draw out lessons learned to record for our collective knowledge
Facilitator: Ms. Joanne Spratt, Family Planning International, New Zealand
- Opportunities for advocacy and networking in the light of the Spanish-Belgian-Hungarian presidency of the EU
Facilitators: Ms. Marta O'Kelly, GIE/SIG, Spain, Ms. Filomena Ruggiero, FPFE, Spain
- Reporting back from a Parliamentary Study Tour in Guinea-Bissau
Poster presentation and discussion about concrete result
Ms. Manuela Sampaio, President, APF, Portugal
- 13.00-14.00** **Lunch**
- 14.00-16.30** **Closed Session for Members Only**
- 16.30** **Closure**

Annex 2 List of Participants

		Surname	First Name	Organisation	Country
1	Ms	Apio	Christine	Care International	Uganda
2	Ms	Audouze	Dominique	MFPF	France
3	Ms	Bandere	Ilze	Papardes Zieds	Latvia
4	Mr	Behan	Niall	Irish Family Planning Association	Ireland
5	Ms	Bogaarts	Yvonne	WPF	Netherlands
6	Ms	Broomfield	Jane	Advocates for Action, Students Partnership Worldwide	UK
7	Ms	Carter	Anna	Advocates for Action, Students Partnership Worldwide	UK
8	Ms	Chimba	Chinyanta	Advocates for Action, Students Partnership Worldwide	UK
9	Mr	Chola	Gunston	African Youth Adolescent Network on Population and Development	Zambia
10	Mr	Christensen	Bjarne	Sex&Samfund	Denmark
11	Mr	Datta	Neil	EPF	Belgium
12	Ms	Dethlefsen	Tania	Sex&Samfund	Denmark
13	Ms	Doherty	Meghan	Irish Family Planning Association	Ireland
14	Ms	Duerr	Eva	OeGF	Austria
15	Mr	Etim	Emanuel	Centre for Development Action Intl.	Nigeria
16	Ms	Fenger	Pernille	UNFPA	Denmark
17	Ms	Ferris	Kristina	Share-Net	Netherlands
18	Mr	Fetai	Arben	Marie Stopes International	Belgium
19	Ms	Gabrieliute	Vilma	Family Planning and Sexual Health Association Lithuania	Lithuania
20	Mr	Gade	Nils	PSI Europe	Netherlands
21	Ms	Gonzales Rosa	Nirvana	Latin American and Caribbean Women's Health (LACWHN)	Puerto Rico
22	Ms	Harth	Elfriede	Catholics for Choice	USA
23	Ms	Haslegrave	Marianne	Commat	UK
24	Mrs	Hinz	Catherina	DSW	Germany
25	Ms	Hoehn	Karen	DSW	Belgium
26	Ms	Hurrynag	Kulvashi Devi	Development Indian Ocean Network (DION)	Mauritius
27	Ms	Huybrechts	An	IPPF EN	Belgium
28	Ms	Jamia Talebani	Lamia	Voice of Independent Women Organization	Iraq
29	Ms	Jaquesson	Kari	NSRR	Norwegian
30	Ms	Kelle	Iveta	Papardes Zieds	Latvia
31	Ms	Kjaerby	Ann Mette	UK All Party Parliamentary Group on Population, Development and Reproductive Health	UK
32	Ms	Knerr	Wendy	The Write Effect	UK
33	Mr	La Ramee	Pierre M.	International Planned Parenthood Federation	USA

		Surname	First Name	Organisation	Country
34	Ms	Leibnitz	Mirja	EuroNGOs	Brussels
35	Ms	Līdaka	Lāsma	Papardes Zieds	Latvia
36	Ms	Lupi	Natalia	AIDOS	Italy
37	Ms	Maldonado Posso	Viviana	ACDemocracia	Ecuador
38	Mr	Martin	Jacques Olivier	Planes	Switzerland
39	Ms	Mauget	Christine	MFPF	France
40	Ms	Mawhood	Kari	APPG on Population, Development and Reproductive Health	UK
41	Ms	Melne	Solvita	Papardes Zieds	Latvia
42	Ms	Melo Pinzon	Gladys	CFC	USA
43	Ms	Mīlgrāve	Beāta	Papardes Zieds	Latvia
44	Miss	Murphy	Fionnuala	Interact Worldwide	UK
45	Mr	Mwale	Amos	Youth Vision Zambia	Zambia
46	Ms	Nambatya	Diana	Partners in Population and Development Africa Regional Office	Uganda
47	Ms	Newman	Karen	Population and Sustainability Network	UK
48	Ms	Nortvedt	Lisbet	NSRR	Norwegian
49	Ms	O'Kelly Rasco	Marta	GIE	Spain
50	Ms	Otmakhova	Irina	Women's Global Network for Reproductive Rights	Philippines
51	Mr	Pavao	Andrew	DSW	Brussels
52	Ms	Poupez de Kettenis	Astrid	Marie Stopes International	Belgium
53	Mr	Pyck	Dirk	Sensoa	Belgium
54	Ms	Quesney	Anne	MSI	UK
55	Mr	Rabier	Serge	Equilibre & Populations	France
56	Ms	Regner	Asa	Swedish Association for Sexuality Education	Sweden
57	Ms	Ruggiero	Filomena	FPFE	Spain
58	Ms	Ryngbeck	Annica	Swedish Association for Sexuality Education	Sweden
59	Ms	Sakne	Odrija	Papardes Zieds	Latvia
60	Ms	Sampaio	Manuela	Portuguese Family Planning Association	Portugal
61	Ms	Samuels	Paula	Jamaican Network of Seropositive	Jamaica
62	Ms	Simkova-Iskakova	Jibek	EuroNGOs	Brussels
63	Mr	Simonyi	Gyula	BOCS Foundation	Hungary
64	Ms	Sines	Erin	Population and Reproductive Health MacArthur Foundation	USA
65	Ms	Singleton	Jane	Australian Reproductive Health Alliance	Australia
66	Ms	Stamenkova	Radosveta	BFPA	Bulgaria
67	Ms	Spratt	Joanna	Family Planning NZ	New Zealand
68	Ms	Stratmann	Johanna	DSW	Belgium

		Surname	First Name	Organisation	Country
69	Ms	Svensen	Ann	Swedish Association for Sexuality Education	Sweden
70	Ms	Takahashi	Nobuko	UNFPA New York	USA
71	Ms	Tapia Dominguez	Emiliana	GIE	Spain
72	Mr	Van de Voorde	Wim	Sensoa	Belgium
73	Ms	Varela	Alba	FPFE	Spain
74	Ms	Veldman	Dianda	Rutgers Nisso Groep (as representative) and World Population Foundation	The Netherlands
75	Ms	Vuorenmaa	Hilkka	EuroNGOs	Finland
76	Ms	Wetzer-Karlsson	Marina	Vaestoliitto	Finland
77	Ms	Wuyts	Eef	IPPF EN	Belgium
78	Dr.	Zaman	Wasim	International Council on Management of Population Programmes (ICOMP)	Malaysia

Annex 3 Speaker Index

An Huybrechts.....	13
Arben Fetai	14
Astrid Poupez.....	14
Jane Singleton	8, 11
Karen Hoehn.....	11
Neil Datta	11
Susan Cohen	5
Wasim Zaman.....	9

Annex 4 Presentations and Other Resources

Presentations and other materials from the EuroNGOs meeting in Riga are available at <http://www.eurongos.org/Default.aspx?ID=19709>.