"Making the Link: Sexual and Reproductive Health and Health Systems"

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Good morning!
We are addressing three themes in this meeting.

The Background papers and Andrew's presentation cover the first two in depth:

- Implications of health system design for SRH
- Implications of resource and financing reforms for SRH

Therefore, I'll focus largely on theme three:

- Advocacy, priority setting, accountability

What I have to say is derived from experience with exactly our task – linking SRH and health system development – in Bangladesh. Several of us here worked with the government, development partners, and civil society to design a national health and population sector program in the late 90's. We learned a lot and we still have more to learn.

Based on this and other experience, I will begin by laying out four premises for our dialogue – which I hope most people here already subscribe to. They were after all, established in the 1970's at the Alma Ata Conference that called for health for all.

The first is to recognize that the allocation of health resources, design of health systems, and definition of laws and regulations are profoundly political processes – especially in regard to SRHR.

- Our dialogue thus has to include the political dimensions of decision making – by individuals, families, communities, governments, and even the UN.

Second, morbidity and mortality associated with sexuality and reproduction are the product, not only of shortcomings in health services, but also of pervasive, significant inequalities between the sexes, commonly exacerbated by poverty.

- Thus, our conversation must encompass human rights, especially of girls and women, and
- Our task is to consider not only what is the most "efficient" or cost effective thing to do in economic and public health terms, but also what is the right thing to do.

Third, while some of what must be done to secure SRHR lies beyond the mandate and capacities of health systems, for their own effectiveness, health sector actors are going to have to work differently in two significant ways:

> Externally, by promoting the necessary social and behavioral changes and collaborating with the other sectors that will make these changes happen; and
> Internally, by greatly easing, if not breaking altogether, the traditional stranglehold of medical doctors, epidemiologists, and more recently health economists, over policy content and resources.

In each part of our agenda for the next three days, therefore, we should address these modes of work: intersectional collaboration, and diversification of the decision makers.

My fourth and final basic premise (at least for this meeting!) is the following:

> Given the first three premises, ensuring SRHR requires that those who design, fund and staff health systems,
> a) fully engage stakeholders – especially women – at every stage, and also

b) allow and respect mechanisms to hold the health system accountable for universal access to the best attainable standard of sexual and reproductive health information and care.

Here again, each segment of our work this week should examine how challenges can be met, and tasks completed by the health system in ways that fully engage the primary constituents of SRH. In turn, demands for services and information by informed constituents can help build the political will for health system financing, and for an enabling legal and regulatory environment for SRHR.

So much for premises –

As Andrew was very efficient and sent me slides in advance, I will not make the many important points I know he plans to cover. Let me address a few additional ones, however:

Some of us here today helped bring SRHR to the forefront of the world's agenda in the 1990's, first through the International Conference on Population and Development in 1994, and then, reinforced and extended in the Fourth World Conference on Women in 1995. I'll avoid boring you with detailed experiential evidence, and simply assert that achieving those, and subsequent, global agreements

was an extremely political process. SRHR was conceived, and ultimately agreements were achieved by the global women's health and rights movement – which had the good sense to engage their governments – including my own! – and to build broad alliances with other stakeholders, especially those who had for 25 years controlled ideas and resources in the population field. We now must do the same with those who control health resources.

The SRHR paradigm is "political" in many ways because it challenges fundamental aspects of the social and technical status quo. Three ways are particularly relevant for our discussion:

First the SRHR paradigm strikes at the heart of men's power over women – a phenomenon that characterizes every society, even those that are relatively gender "equal."

Second, it brings into the public sphere what is generally considered private and deeply taboo – namely sexuality, the most personal dimensions of our humanness, and the most intimate of our relationships.

Finally, the SRHR paradigm forged in the 1994 ICPD challenges the dominant health policy paradigm which assumes vertical, technical and pharamacological interventions will "fix" health

problems. The SRHR agenda is radically different from the "population control through family planning" paradigm that preceded it. It is also fundamentally different from today's HIV/AIDS control paradigm: condoms, ARVs, and vaccine development.

Since the ICPD in 1994, significant progress has been made toward SRH at national and international levels as we heard last night about Mozambique and China:

- In policy and program designs
- In experiments with alternative approaches to service delivery, integration of services, and innovations in subelements of reproductive health care.

But we have yet to see reduction in overall maternal mortality and morbidity in places where they are highest.

HIV/AIDS is literally rampaging freely.

Appropriate contraceptives are not accessible to all and supplies are in jeopardy.
Girls and women suffer the medical, emotional and social trauma of illegal unsafe abortion by the tens of millions each year.

And preventable cervical cancers kill thousands.

Nowhere – not even in the world's richest countries – do we have a fully functioning, accessible to all, comprehensive SRHR program – including not just health services, but also sexuality education, programs to prevent and manage sexual coercion and violence against girls and women, and legal and judicial systems that fully protect sexual and reproductive rights.

We have fallen far short of the millions – and now billions – of dollars required.

Further, SRHR are severely threatened by resurgent fundamentalisms, led by the Bush Administration, which would have us all adopt their sectarian ideology and moral values.

But at least as serious a challenge to the SRHR agenda is the current control of public health policy and resources by economists and epidemiologists focused primarily on <u>diseases</u> and <u>technical</u> fixes. (The big exception is tobacco use. It's not a disease and there is no technical fix. But I guess "just say no" is a "quick message fix." Too bad that message doesn't work for unsafe sex!)

So – what do we do about economists' and epidemiologists' myopia? I am a realist and a

pragmatist, so I'll leave you with three ideas for consideration over the next three days:

- First, look at the Millennium Development Goals framework as an important opportunity, not a flawed paradigm that dropped reproductive health.
- Second, design, test, monitor and invest in mechanisms to hold health systems accountable, especially in places where they are the weakest. Without such pressure on the health system, it will continue to be subject to the whims of politics and incompetence – to say nothing of vested interests – and SRHR will remain at the bottom of the priority list.
- Third, generate analyses to demonstrate to economists and epidemiologists that the nondisease elements of SRHR (contraception; abortion; pregnancy, delivery and neonatal care; sexual violence and coercion; infertility; cervical cancer) constitute a "global public good" and an investment in poverty reduction worthy of high priority in the competition for scarce health resources.

Finally, if all else fails, stand up for what is right!
(And now I'll sit down.)

Thank you.