7th International Dialogue on Population and Sustainable Development

Exploring Cultural Diversity and Gender Equality: towards universal access to sexual and reproductive health and rights

DSW

gtz Population Dynamics, Sexual and Reproductive Health and Rights

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IPPF International Planned Parenthood Federation

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7th International Dialogue on Population and Sustainable Development

Exploring Cultural Diversity and Gender Equality: towards universal access to sexual and reproductive health and rights

Panel Discussion
Wednesday, 15 October, 2008

Between freedom and suppression: Gender and sexuality in the 21st century

Conference Day, Thursday, 16 October, 2008

Exploring Cultural Diversity and Gender Equality: towards universal access to sexual and reproductive health and rights

Keynotes

Editorial

All over the world, culture is a pivotal element to development. The consideration of values, norms and taboos is crucial to the success of projects in development cooperation. Different cultures require different approaches. Therefore even programme with a similar focus, such as campaigns for the improvement of maternal health or the prevention of teenage pregnancies, cannot be realised the same way in every country. This basic assumption was embraced by the 7th International Dialogue, which was held under the heading 'Exploring Cultural Diversity and Gender Equality: Towards Universal Access to Sexual and Reproductive Health and Rights'. The issues addressed at the conference were specific. For example, the discussion focused on how to approach youths, how men can be better involved in particular programme, and what cultural traditions can be taken up to strengthen the rights of women and to improve women's and maternal health.

As the global market leader in the field of hormonal contraceptives, Bayer Schering Pharma is necessarily at the centre of this debate. About 200 million women worldwide have an unmet need for effective family planning methods. These women would use contraception if they had access to the required information and supplies. For decades, we have been supporting family planning programmes all over the world, especially in developing countries. As part of a global network and in cooperation with various partners, we supply our products without profit margins to international organisations for development such as the German KfW banking group, international family planning organisations, the United Nations Fund for Population Activities (UNFPA) and the International Planned Parenthood Federation (IPPF). Only recently did we agree to supply up to 110 million cycles of oral contraceptives yearly to John Snow, Inc. for family planning programmes in developing countries realised by the U.S. Agency for International Development (USAID). The cooperation allows more than eight million women to have access to modern and reliable hormonal contraception. Yet apart from the lack of access to reliable contraception, there is in fact a general need for education. Next to poverty, the

reasons for this are often to be found in social barriers. 'We have to understand and work with a community's views about what it signifies when a woman or a couple does not have any children, the effect of contraception on a woman's ability to conceive or on a man's view of what makes up his 'manhood' ', it says in this year's UNFPA report on the state of the world population. The UNFPA report, too, highlights the importance of culturally sensitive approaches, especially in conjunction with reproductive and sexual health and rights.

For the 7th International Dialogue, 200 experts on development cooperation came to Berlin to discuss how the joint goal of gender equality and, thus, a strengthening of the rights of women may be achieved in different social contexts. The experts generally agreed that cultural differences have to be considered, but not at the expense of human rights. Another conclusion was that men, also the younger men, should be involved. It is only this way that we can bring about sustainable changes and help reduce mortality and morbidity rates: More than half a million women worldwide die because of complications during pregnancy or childbirth, and an estimated 10 to 15 million women suffer injury or illness.

I feel the 7th International Dialogue was an important step towards attaining these goals. Hence I would like to seize the opportunity to thank all participants for attending the conference and for sharing their expertise and knowledge with us. Special thanks go to all those participants who traveled here from afar to let us take part in their experiences. Especially when we are addressing the issue of culturally sensitive approaches, we have to learn to turn towards one another and to understand each other. And this is best achieved through personal exchange.

Dr. Ulrich Köstlin

Member of the Bayer Schering Pharma AG Executive Board and the Bayer Healthcare Executive Committee

Panel Discussion
Wednesday, 15 October, 2008

Between freedom and suppression: Gender and sexuality in the 21st century

Welcome

Claudia Radeke
First Vice President
East and West Africa,
KfW Entwicklungsbank,
Frankfurt

We are, at present, only at the very start of the 21st century. For this reason, our discussion cannot be a stocktaking but will consider the possibilities and – if you will permit me to use the technical term – 'instruments' for implementing and improving sexual and reproductive health and rights. And we have to do so in a context that, depending on the country and region, is more or less characterised by freedom or suppression. Obviously, in gender equality the cultural differences are main determinants in realising universal access to sexual and reproductive health and rights. Access to health strongly influences, in turn, whether or not we can achieve the United Nations Millennium Development Goal Number 5 of improving women's health and cutting maternal mortality.

Sexual and reproductive health and rights encompass sensitive and controversial topics such as sexual self-determination, abortion and pre-marital sex among young people. Political values also embody judgements and views on what each gender may or must do. For example, these are manifested in legislation allowing, in varying degrees, women to decide themselves over their sexuality and their own desire to have children.

The use of the term family planning by the donors in political dialogue or the general wish to discuss the topic of population growth is often a political issue in a slightly different sense. There our high-ranking partners in particular are quick to react with accusations of neo-colonialism or interference in internal affairs. This is a great pity.

Nonetheless, population development and the implementation of the Millennium Development Goals by 2015 remain pressing concerns, and ones that have to be realised through improved access to sexual and

reproductive health, for instance, within a family planning framework. With German federal funding, the KfW Entwicklungsbank has been contributing for nearly thirty years to targeted aid supporting women's health in German development cooperation partner countries – for example, by supplying and marketing modern contraceptives to foster self-determined life planning, or making better care available in hospitals and health stations for women before and after childbirth, or promoting educational measures to improve young people's health, or by contributions to boys and girls' education to give them the knowledge to make correct decisions in life. We are very pleased to note that the Federal Ministry for Economic Cooperation and Development (BMZ) is continuously increasing the funding for these sectors and we continue to regard them as an important task in bilateral development aid – complementary to the main international multilateral efforts.

What is behind the term of sexual and reproductive rights? Of course, it also embraces family planning: 200 million people in developing countries still have no access to the modern contraceptives which would allow them to decide whether they have children and how many children they have. Experts estimate that this lack of access to contraceptives leads to 76 million unwanted pregnancies, bringing a series of consequences in their wake. Moreover, as you all know, far too many girls become pregnant far too young, and this leads to serious health problems for themselves and their children. In addition, amateur abortions are one of the most common causes of death among young women – abortions often carried out due to an unwanted pregnancy and often where pregnancy results from forced sexual intercourse. In this case, universal access to sexual and reproductive health and rights means, quite concretely, that these young women should be able to decide in a better and self-determined way how they want to shape their future life. Today, around half a billion young women between the ages of ten and nineteen - and around the same number of young men - live in the developing countries. Taken together, these young men and women amount to around one sixth of the world's population. At that age, they are starting to establish the foundations for their future. It is important for all of them to decide, and be allowed to decide, if and when they – the young women – become pregnant and how many children they have. This is what the 7th International Dialogue is calling for: the realisation of universal – and the emphasis is on the massive challenge of universal – access to sexual and reproductive health and rights.

For this reason, questions will be raised this evening, from a range of diverse perspectives, on gender equality and its implementation and I expect the answers will also be controversial. Here, the role of men will be just as much a topic as the role of the church and the political sphere. In addition, we will have the chance to see an interesting video by the pop group Culcha Candela.

I am sure we can now look forward to a very lively Panel Discussion. ■

Welcome

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

This year, the two days of the International Dialogue are dedicated to „Cultural Diversity and Gender Equality'. As with all of these conferences, the main emphasis is on universal access to sexual and reproductive health and rights. The focus this evening is specifically related to the potential conflicts inherent in the topic of 'Freedom and suppression - gender und sexuality'.

However, although this may sound slightly dry and theoretical – or, as one might say, a 'good' topic for discussion – this is far from being an academic debate. Instead, we are dealing with the quite concrete, everyday challenges faced by millions of people - first and foremost, women - day after day.

There is a very good reason why the United Nations has made improved maternal health one of the Millennium Development Goals (MDGs).

There are ten Millennium Development Goals in total, and three are directly or indirectly linked to concerns around sexual and reproductive health. The objectives are to:

- promote gender equity and women's empowerment
- improve maternal health, and
- cut child mortality rates

These goals are to be realised by 2015. Clearly, this means that today, in 2008, these goals have not yet been achieved.

However, these goals cannot be achieved by individuals' actions. Instead, what is required is cooperation between state, non-state and private sector actors.

Maternal health is the area where the biggest challenges have to be met worldwide. Half a million women continue to die every year from complications in pregnancy or childbirth, and the vast majority of these tra-

gic deaths occur south of the Sahara and in Asia. These deaths are also such a tragedy because we know there are ways to prevent them, for example, through better care provision for women during pregnancy and birth. One quarter of these deaths could be avoided just by preventing unplanned pregnancies.

For Bayer Schering Pharma, contraception and family planning is very much a main concern. Due to our expertise in women's health, we have long regarded the support of family planning in developing countries as a fixed plank in our involvement in social issues. As the market leader for hormonal contraception, we consider it our particular responsibility to be involved here, and we have been actively supporting family planning programmes for nearly 50 years.

We want to use our knowledge and skills to help find sustainable solutions for these health care tasks.

With our products, we help women to be able to decide on contraception and, hence, decide over a key aspect of their own lives. Nonetheless, we should not forget that many women and men still have no access to contraceptives. However, we also know that improved access to contraceptives alone cannot solve the problem. Access to health care has to be improved – and better access to health care has to include enhanced awareness and education. After all, poverty is only one reason for the lack of access to contraceptives. Cultural values and traditions also influence the implementation of family planning programmes.

At Bayer Schering Pharma, in realising development cooperation, we foster dialogue to promote an exchange on a partnership basis. We exchange views with policy makers, and governmental and non-governmental organisations to ensure there is a systematic transfer of knowledge and experience.

The very first International Dialogue took place in 2002 and was called: 'Reproductive Health – Stepchild of the International Community?'. It was attended by around 70 people, with most of the participants either experts in the reproductive health sector or from partner organisations.

Today we are meeting for the 7th Dialogue in this series and there are many more guests present. Apparently then, to judge by the reception of the Dialogues and the interest in them, this topic can no longer be regarded as a neglected step-child.

I am very glad about this development since the International Dialogue is a visible sign of our commitment and our belief in a need for alliances and concerted action. For that reason, I am very pleased to see so many of you gathered here for this meeting today.

I would just like to underline again how much we at Bayer Schering Pharma regard this debate as both interesting and important. At the end of the discussion, I would like to say 'lessons have been learned' – 'and we have gained in experience and ideas' – and at the end of the evening, I am certain this will be the case. ■

Gender equality, empowerment and women's rights – a country perspective

Esther Murugi Mathenge
Minister for Gender and Children Affairs, Kenya

HIV/Aids was declared a national disaster in Kenya due its high prevalence in the '90's. The government, with the support of its partners and stakeholders has put in place interventions to help reduce the prevalence of the disease that has caused untold suffering in the country and has drained a lot of resources. There are about 2.5 million orphans in Kenya and out of these; 1.4 million of them have been orphaned due to HIV/Aids.

Some of the initiatives and strategies that have been put in place have targeted led to the development of a slogan to promote sexual behavioral change. The slogan involves the ABC against HIV/Aids and calls for Abstinence, Being faithful to one's partner or if the above two fail, then using a condom. While the first two initiatives have received support especially the church, the use of condoms has been demonised. This is because they argue that it promotes sexual immorality in the society and this is what they preach against. They have therefore waged war against the use of condoms and urged their members to avoid the use of the condom.

The Catholic Church has come out strongly against the condom. This church has a very large following in the country. They promote abstinence and being faithful to ones partner. They believe that if you can't abstain, then the alternative is death.

Sex is a taboo subject in Africa and is therefore not discussed openly. The older generations often refer to it in parables and wise sayings. For this reason the promotion of condoms in Kenya is frowned upon by the whole society and the moral standards of the promoters are questioned. It parents also resist this promotion because they want to protect the morals standards of their children.

In the traditional African set up, the responsibility of teaching children about their sexuality was left to the grandparents and aunts. However, with modernisation, the extended family social structure has broken down and each parent has been left with that responsibility. Many are too shy to discuss this with their children and therefore can not tell them to use the condom. These children then learn about condoms and its myths from their peers and from the electronic and print media and the internet.

The use of condoms is more often than not associated with commercial sex workers and the promotion of the same earns the promoters that distinction. Even musicians who try to promote the use of condoms are never allowed to perform again.

It is therefore in line with this that married women would never imagine asking their husbands to use the condom. That would raise questions about her moral standards. It could in extreme cases even lead to divorce.

We have been trying to think of ways of how we could overcome this obstacle. We thought of involving the supermarkets, so that they would distribute it to their customers upon any purchases made. I was told that the supermarkets would not accept this as nobody wants to be associated with condoms. They fell they may lose their customers if such a move was made.

The use of condoms for us is still an option. We still have a long way to go before we reach a level where we can distribute condoms like you do. It is a long walk, and we are willing to walk it, even though it may be a very long walk, both from the traditional point of view and from the Christian point of view.

Some of the cultural practices that we embrace are said to have their roots from the Bible or the Quran. A practice like that of female genital mutilation was said to have been from the Quran. However the Imams have gone through the entire Quran and there is nowhere it says that women should be circumcised. We should take time to identify the good from the bad in religion and adopt only the good, not the bad.

In 1985, there was a big convention in Nairobi and we said we wanted women to be empowered. We sang the song of empowerment to women over and over again. Disappointingly, many years down the line, we are still exactly where we were in 1985. We need to evaluate ourselves so that we can identify our mistakes, and come up with sustainable solutions for the way forward. We need to strengthen ourselves. If we don't do that then we will be in danger of remaining stagnant many years to come and may not be able to achieve the MDGs by 2015.

We hope that we shall be able to achieve our vision 2030 which is Kenya's new development blue print aimed at making the country a 'newly industrialising' middle income country providing high quality life for all its citizens by the year 2030. We are working extremely hard to ensure that we will achieve the aspirations of this vision. ■

Men and gender equality

Douglas Mendoza Urrutia
Capacity and Alliance Building Officer,
Nicaragua and Centroamerica,
Fundaciòn Puntos de Encuentro

In Latin America the Catholic Church has a lot of power. For example, the last year, they influenced the parliament in order to remove therapeutic abortion. 100 years ago therapeutic abortion was legal. Now it is illegal. The Church was working together with the Sandinist people to promote this new law. In Nicaragua, the Catholic Church has a lot of power and influence to the national government.

Another example: representatives of Church think, that the promotion of usage of condoms and contraceptives as well as therapeutic abortion, is an idea of the feminist movement of European women. It is impossible to talk in the High School about sexuality because they think it is not a good idea. They only want abstinence beeing promoted. Last year parliamentariens started to promote equality of men and women in order to create equal opportunities. The Catholic Church opposed and argued, that this is not a good law, because equality of gender is only to promote lesbian homosexuality. These women don't have a value, they say.

Situation now slightly is changing to a better. In certain parts in Nicaragua it is possible to talk about the usage of condoms. But still there are so many regions, where people don't have information, for example, in rural communities in the mountains. These people don't have information. They have many, many children. Poverty is growing. Still the Catholic Church - no matter what is happening in this rural, real life - they only say abstinence is the best choice for daily life. It is difficult for the Catholic Church to change this idea. As already said, in Nicaragua, in this moment the Catholic Church has a war with the feminist movement, because they don't like this idea of gender equality. I think it should be possible to discuss all informa-

tion, even via TV, e.g. via ABC in order to discuss about abstinence, condoms, fidelity, so that young people and women can make their own decisions. It should be possible to deliver all information. But it is impossible. In certain High Schools, in certain cities in Nicaragua it is impossible to talk about the condom. The Church wants young people only to be abstain. On the other hand young people in high schools like to talk about sexuality. They want to talk about HIV prevention. But the teachers or families, they cannot talk about that. So they talk with their friends in the disco. They don't get good information. The result is, that they have early pregnancy or they are getting HIV or are sexually abused or whatever. Luckily there are some shows in the TV, where they are talking in different ways about condoms, because young people like to talk about that.

Information is also important for to change the machista cultural norm. It is crucial to change this idea. It is important to involve the men and boys and make them to participate in changing in order to promote gender equality. It is necessary to work with men, it is important to sensitise them. It is important to talk with men and boys about the importance to use the condom in order to prevent HIV, and that it is about to decide how many children they are going to have. It is important to involve the men and the boys for to create another reality. Because it is the man in Central America, the machismo, who is making the decision for the woman. It is important to involve the men in different activities, in different projects in order to sensitise them for the need of changing this mentality. ■

Religion, sexuality and reproduction

Friederike von Kirchbach
Provost of the German Protestant Church, Berlin-Brandenburg-schlesische Oberlausitz

The 21st century is the post-1989/90 century, the post-collapse of the world system century, the post-9/11 century. And in this century, the focus is not just on Africa but on the world in its entirety. The young generation has already learnt to think in global terms – in the context of the categories locating us all. 'Fundamentalism' is one of the main challenges in the 21st century. Fundamentalist developments are extremely dangerous, not only for the Protestant and Catholic Church, but also for Islam. But what is the solution?

As my fellow panel-member Itchyban has already said: the answer lies in talking to one another. And that means we need to talk to Muslims just as much as to Catholics.

Anyone looking in the Bible will discover that 'sexuality' is certainly not tabooed there. In fact, it deals remarkably openly with this issue, addressing it so directly that reading some passages aloud – especially from the Old Testament - is enough to leave you speechless. Down the centuries, the churches, including the Protestant Church after the Reformation, were the leading authority on rules, commandments, and ethical precepts and, naturally, they shaped a set of moral ideas. However, these ideas have altered over time. We are in a process of change now too – and in that process we are addressing 'sexuality', today closely linked to women's issues, in quite a different way. The changes in the Protestant Church on the question of women's rights have, in turn, transformed the way we deal with 'sexuality'. We are in a period of transition - and transition takes time. But we shouldn't throw everything from the past overboard. We need a set of ethical principles for life together. Faithfulness, love, commitment – the values that are important for the church are certainly not bad per

se. Rather, we need to question the rules on condoms, for example, or the clear disadvantaging of women. By the way, in my view, such problematic rules cannot simply be derived from the Bible, even if that was the claim for centuries.

At present, I am experiencing a church in the process of change. My hope is that there will also be some changes in the Catholic Church too. That is a hope I have had confirmed by many women who are Catholic. Here, the major challenges are little different from those facing other cultures or contexts. In general, there is still a lot that needs to be done for women in Germany. We have made considerable progress but are far from reaching the point, either in the Church, or in society, where we could stop.

This is not the place to list all the instances where women, especially those over 50, have a far more difficult time of it than men. Instead, I would just like to underline how pleased I am at the development and dynamism in this area. If anyone had told me in 1973 when I took my school-leaving exams in the former GDR that, in 20 or 30 years, I would be sitting in a panel discussion together with a Kenyan government minister, a member of the Bundestag, and two young men with a similarly global background, and that we would be discussing women in executive management and women's health issues – I would never have believed it possible. This is a miracle that even I, as a theologian, never thought could happen. My hopes for the future are based on the advances in the past. We have made substantial progress on women's rights – and it's an excellent start.

Now, we need to persevere with the same determination and energy.

Young and in love in a globalising world – young peoples' voices

Itchyban
Member of the music group
Culcha Candela

I'm quite happy to talk about condoms. This year, we performed at Rock am Ring, Europe's best known rock'n'roll festival. People, people, people – right to the horizon. Together with the Bavarian AIDSFoundation, we gave away 50,000 condoms during our set.

We believe that we are living in an enlightened society. But HIV infections are on the rise again – as they are in Germany too. It's common knowledge that Africa has a major problem with HIV/AIDS. But the new cases are also increasing in South-East Asia, Eastern Europe, Russia and in Poland – where I was born. And that's why we can't talk about condoms enough. Of course, I haven't got a magic bullet and the answer to all questions. But whether we shift the stone blocking the road to the side or climb over it – we simply have to try everything possible. I believe that, in the end, it's a question of the will to do it. In just a few days, it was possible to agree on an emergency aid package of nearly 500 billion to counter the effects of the financial crisis. It all happened really fast. HIV/AIDS has now been around for years. Why can't we get a similar sum to fight HIV/AIDS together just as quickly, from one day to the next? ■

Politics and policy making

Sibylle Pfeiffer
Member of the German Bundestag,
Chairwoman of DSW´s Parliamentary Advisory Committee

Strangely enough, we women always define ourselves by what we see in the mirror - as I do too. Before I came here, I also glanced in the mirror. Yet we have so much more to offer. We don't have to be fighting the battleof the sexes. We don't need to. Everyone is involved in doing something, in whichever area and whichever way suits them best. It's the results that matter.

„Empowerment' and the „empowerment of women' are crucial. And we have observed this in many aspects of our work, both practical and political. We sometimes act in cultural spheres where we cannot reach women at all, and cannot always directly address them. We have to take a roundabout route to speak to these women – a detour that runs through the men. In other words, we have to convince the men that is it important to empower their women. This is rather like trying to square the circle. Women know how important they are, central for their family, for feeding their family, and how much responsibility they bear for the agricultural development of their region and, in the case of the Kenyan Minister with us today, for her entire country. Now try explaining to a man why his wife suddenly ought to be allowed to have her own thoughts, decide over her own body, and - out of the blue - have the right to say yes or no to sex today. Can you imagine what happens then?

But we shouldn't delude ourselves. We can't simply assume that all this goes without saying here either. I don't intend to ask women participants today to answer a question such as: 'Would you please raise your hand if everything really runs without a hitch in your homes?' So let's not pretend that everything in Germany is perfect and runs smoothly. We can't go into the world, address other people and say: 'In our country, things are really going great and you just have to do this or

that to get it to work for you as well.' Unfortunately, things are not that simple. And that's why the road we are travelling on is so long. It also took a long time for things to change to here. Even 25 years ago, the word 'condom' was unmentionable. It took 25 years before we could get together like this and say that we are going to discuss sexual and reproductive health.

I have travelled widely in developing countries and become very much aware of the crucial role that women play in a country's development. Without women, it is simply impossible for a country to achieve social and economic development. In our experience, all the projects headed and run by women have proved a success. Unfortunately, though, in our view, there are not enough women taking on the tasks so relevant for the society in their own country and its development.
Just imagine for a moment that Germany did not enjoy the support of women in all areas - where would we be then?

Before I finish, I would just like to tell you about a little incident with my mother. My mother died last year - and right up until her death she could never get over the fact that, 25 years ago, Rita Süssmuth had first used the word 'condom' on German television. My mother would always say: 'That poor women – she had to say 'condom' right there in public.' As I said, that was 25 years ago. Over those 25 years, we've achieved a lot. And how have we achieved it? By taking our concerns into the public arena. Through politicians making things public. As a politician, that is one of my key tasks: Creating a public platform! Making the public aware of problems where a political solution needs to be found. But we can't do that if we don't have the broad support of society. In that sense, our main task is, for example, to use the word 'condom' - and gain a public platform for these issues. ■

Closing remarks

Hedwig Petry
Director Division Health, Education, Social Protection,
Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH

I am delighted to be here this evening and would like to welcome you all most warmly on behalf of GTZ. We have just seen a lively and results-driven discussion with interesting inputs from the worlds of politics, the church, civil society and youth. It were these different perspectives, both international and national, which have brought so much to this event. To sum up, I would just like to look briefly at three points and the key messages of the panel discussion. Let me start with the first point:

1. Sexual and reproductive health is a human right

Liberty and oppression were the focus of our panel discussion today, which has looked at various aspects of sexual and reproductive health. The discussion has shown once again that sexual and reproductive health is closely linked to the fundamental human rights of every individual worldwide – irrespective of their sex, age, religion, or their ethnic or social background.

These human rights include the following:

- The right to education
- The right to information (the opportunity to obtain information freely from generally accessible sources)
- The right to an adequate standard of living (including sufficient and healthy food, clean water and adequate housing)
- Access to health services
- The right to physical integrity
- The right to gender equality.

This last point in particular, the right to gender equality, has not yet been fully achieved in Germany either, as Federal President Horst Köhler underscored recently in the speech he gave on German Unity Day. There is still much to do.

Ladies and gentlemen, a state is responsible for respecting, protecting and guaranteeing the sexual and reproductive rights of its

citizens, male and female alike. If it fails to do so, this is deemed a violation of human rights and a failure to comply with international agreements. Reality shows, however, that in many countries rights related to sexual and reproductive health have not yet been adequately or fully translated into practice. For the individual this can be a very concrete and often extremely distressing experience, as has been vividly illustrated in our discussion:

- The feeling of being disadvantaged or marginalised (on the grounds of sexual orientation, age or sex)
- The fear of transmitting HIV to one's own child and of being stigmatised by society
- The fear of going to the doctor because one's partner refuses to use contraceptives or condoms
- The failure to use health services or counselling services because terminating an unwanted pregnancy and the medical care required constitute a criminal act.

And this brings me to the second point of my summary:

2. Sexual and reproductive health requires an enabling environment

If sexual and reproductive health is to become a reality, all of us, whether we come from the realms of politics, church or civil society, must adopt an attitude that fosters the rights of each individual. An enabling environment is needed – an environment which supports and strengthens people. This includes schools, families and friends. Each one of us can do a great deal here. What is also vital, is a culture of dialogue, which goes hand in hand with good governance and the rule of law.

So what does that really mean for us? Today we have heard a lot about values and norms, but also about taboos. Ladies and gentlemen, I believe that we must take into account the cultural dimension when we discuss these issues.

Which brings me to the third and last point, I would like to look at in my summary:

3. Culture is a crucially important factor – both a challenge and an opportunity for sustainable development

For some years now GTZ has been looking in depth at the cultural dimensions of development. Like UNESCO and the UNDP we take a broader view of culture, as being the world within which we live, which we have created by the way we live together, and which we are constantly redefining. Culture is not a static factor, but is subject to constant societal flux. Cultural aspects and diversity are taken very much into account in our work in partner countries of German development cooperation. A culture- and gender-sensitive approach is critical for the success of our work. In GTZ-assisted programmes this means entering into a participatory dialogue.

Ladies and gentlemen, culture and the realisation of human rights are not mutually exclusive; they are intimately linked. The extent to which we realise human rights around the world will depend in no small way on the extent to which we manage to enter into a genuine dialogue based on mutual respect with other cultures. Culture is, in the final analysis, the context within which universal human rights must become reality and gain importance. When we talk about the context, we mean something very precise in terms of our topics here today, as we saw in the panel discussion. For instance that a young woman in a Kenyan village receives support and has access to antenatal and obstetric care. And that young people, whether in Nicaragua, Uganda or Central Berlin are given access to information and health education. Cultural reservations, such as rejecting sex education, can be overcome if key actors within the culture in question advocate and initiate change. It has become very clear this evening that there are examples of this.

Let me sum up: Culture is a challenge and an opportunity at once. It is a challenge, because resistance exists, which must be taken into account and overcome. It is an opportunity, because change is possible within the framework of a dialogue and in a concrete environment.

Conclusion

Ladies and gentlemen, this evening's discussion has once again illustrated how vital it is that the various stakeholders involved work together – representatives of the worlds of politics, civil society, the churches, the academic community and practitioners. Young people have a pivotal part to play. For this reason I would like to thank all of you, in the audience and on the panel for your contributions.This event provides an important platform. It is a forum for dialogue, it encourages an exchange of views and strengthens partnerships. My thanks go to the organisers who have made this event possible with their exemplary cooperation – the German Foundation for World Population (DSW), the International Planned Parenthood Federation (IPPF), my colleagues at the KfW Entwicklungsbank and InWEnt, as well as Bayer Schering AG, not of course to forget the Federal Ministry for Economic Cooperation and Development – BMZ – which provides the development-policy framework within which we operate. I would also like to make special mention

of the GTZ sector project population dynamics, sexual and reproductive health, which prepared the technical ground for the event and provided invaluable organisational support. I am fully convinced that this event has given new impetus to the debate, and that it will continue to do so. We should harness this impetus in each of our countries and put it to the best possible use.

The subject of translating impetus into practical work brings me to the Cultural Forum exhibition, which I hereby officially open. The Cultural Forum presents experience gained in practical development work in more than twelve countries. It illustrates the wide spectrum of options available to us to promote sexual and reproductive health in various cultural contexts. I would like to invite you to take inspiration from these examples (from countries as diverse as Belgium, Indonesia, Kenya, Mali, Moldova, Morocco and Nicaragua). Make the most of this opportunity to engage in direct discussions with the relevant contact persons.

Once again my warmest thanks go to our facilitator Alexander Göbel (from the Deutsche Welle) and to you, our panel speakers for the illuminating discussion we have enjoyed this evening. I wish you all an interesting conference. ■

Cultural Forum - an Exhibition

The 7th International Dialogue 'Exploring Cultural Diversity and Gender Equality: towards universal access to sexual and reproductive health and rights' provided a platform for exchange and networking among national and international actors. Questions around culture and the promotion of sexual and reproductive rights were addressed. It offered an opportunity to 'meet the expert', exchange information and experience, and generate and share new knowledge.

The Cultural Forum presented numerous country examples, thereby providing an insight into the experiences and opportunities in promoting sexual and reproductive health and rights in diverse cultures. By presenting these case studies the conference covered a broad range of regional and context-specific experiences on culture, gender and sexual and reproductive health and rights.

These information were the basis for an in-depth expert discussion among participants, raising awareness about the influence of culture – both positive and negative - on efforts to promote gender equality and sexual and reproductive health and rights. The case studies provided an insight into strategies and approaches which are sensitive to culture and traditions, taking them as a starting point to moderate or induce a process of change.


BODILY KNOWLEDGE
AND
CONTRACEPTION

Poster Sessions presented

Belgium - International Planned Parenthood Federation – European Network
Joining forces: youth advocates for sexual and reproductive health and rights in development

Brazil – Population Media Center
Behaviour Change Communication 'Social Merchandising'

Ethiopia – German Foundation for World Population (DSW)
Prevention is the key – engaging in improving young girls' health

Germany - Berlin Model United Nations (BERMUN) 2008
Youth Assembly, HIV/AIDS Education and Learning Programme (H.E.L.P.)

Germany – Bundeszentrale für gesundheitliche Aufklärung (BzgA)
'Bodily Knowledge and Contraception' - health education for young people and adults of both sexes with migration background

Indonesia – Improvement of the District Health System in NTB and NTT
Reduction of Maternal & Neonatal Mortality in the villages of the Nusa Tenggara Provinces, Eastern part of Indonesia, using a gender sensitive approach

Ivory Coast – Agence Ivoirienne de Marketing Social (AIMAS)
Promoting sexual responsibility among youth and the sexual self-determination of women

Kenya – Gender Based Violence and Human Rights, Health Sector Programme
Intergenerational Dialogue (IGD) Kenya

Mali – Population Services International (PSI) Mali
Healthier lives through safer reproductive health practices in Mali

Moldavia – Gender Center
'Vagina Monologues' – education tool or sexual sensibility provocation

Morocco – Gender Mainstreaming in Economic and Social Development Policies
Integrating the gender perspective into Economic and Social Development Policies, Portrayal of the family code reforms through caricatures in rural contexts

Nicaragua – Fundación Puntos de Encuentro
'We're Different, We're Equal'

Uganda – Reproductive Health Uganda (RHU)
Making Money Work for Women: Enhancing Women's Access to Economic Resources and HIV&AIDS Services in Kabalore District

More information is available on our website www.dialogue-population-development.info

Conference Day, Thursday, 16 October, 2008

Exploring Cultural Diversity and Gender Equality: towards universal access to sexual and reproductive health and rights

Summary of the conference day

Rachel Lander
Writer/Editor, International Planned Parenthood Federation (IPPF), UK

1. Welcome

Claudia Radeke, First Vice President for East and West Africa, KfW Entwicklungsbank, began the day by welcoming all participants and setting the tone for what proved to be an inspiring day of learning and collaboration. Sexual and reproductive health and rights are difficult issues, she reminded us, and this is all the more reason why we need to talk openly about them and to share our own experiences and ideas.

There are many questions about condoms and about using them correctly, for example. But we are not so sure when or how is the most appropriate way to discuss this issue. Some people find it difficult to talk about condoms, and other sexual and reproductive health issues, but we have found that engaging in dialogue with partner countries has proved useful and has made it more acceptable.

Another urgent issue is the need to address inequity in maternal health between developing and developed countries. This is a very serious issue, affecting the lives of many many women.

There is still much work to be done to achieve the MDGs by 2015. Today we will look at some of the problems and together we will discuss some of the things that we need to do to accomplish them.

Klaus Brill, Vice President Corporate Commercial Relations, Bayer Schering Pharma AG, highlighted how sexual and reproductive health and rights are impacted by cultural diversity, within and across countries. Culture is represented by societal norms, attitudes and behaviours. We must look at this alongside the 'natural state' of humans.

Norms related to sex and reproduction are specific to different countries, to different regions. How can we reconcile culture and the universal right to health? This is a difficult topic, especially in low-resource settings where the health systems are weak, where many people live in poverty and where there is a lack of information.

To make progress we need to work with different people and at different levels. We can work with the United Nations, we can make strategic alliances and we can engage in dialogue to find solutions. In this spirit, everyone here should be able to contribute and benefit from the World Café this afternoon.

2. Opening address

All cultures are unique and valuable, representing the diversity of human life. The fact that there are profound links between culture and development, and particularly sexual and reproductive health, is a fact that resonated throughout Thoraya Obaid's speech. The Executive Director of the United Nations Population Fund (UNFPA) emphasised how cultural roots shape who we are and what we do, and highlighted some ways

that we can work through culture to achieve our goals.

Central to all people, our own individual identities, culture is a tool for development. People are critical agents of change, and therefore it is people who must work within their own communities to integrate principles related to women's rights, the right to health and equity.

And yet, the reality is that there is cultural divide. Sexual and reproductive health comes down to choices, the decisions that people can make to affect their own health and lives. Some cultural factors can manifest in people's inability to access services even when they are available. Discrimination, particularly against women, is ingrained in some contexts and can contribute to women's ill health.

The solution? Engage in dialogue, and make sure to use a culturally sensitive approach. Recognise sensitivities, laws, traditions, and deeply rooted behaviours. This approach should be based on mutual respect and seeks solutions that are based on societal knowledge and expertise. It means developing new strategic partnerships with people and organisations with which we don't normally work, but which nonetheless share our goals. This will strengthen our work and produce sustainable results.

It is better to understand culture and identify its positive elements to facilitate lasting change. This does not mean accepting violations of human rights, but fighting them within the cultural frame. To ensure that human rights are respected, we need to work with policy makers, with religious leaders and faith-based organisations, community gatekeepers and with other civil society actors. Engaging all stakeholders together often results in collective action to improve people's lives. Real country ownership is instrumental in promoting women's rights.

Culturally, there are many differences among us. We are not the same, but there are areas where we can work together. De-

veloping relationships and engaging in dialogue will enable us to reach all segments of society.

Culture is a matrix of infinite possibilities and choices. Here today, we are reaching out to partners around the globe to advance women's empowerment, gender equality and universal access to reproductive health. Together we can harness infinite possibilities to enable individuals to reach their potential.

3. Keynote speeches

Gita Sen made a thought-provoking presentation entitled 'Towards 'gendered' health systems – a new perspective on gender equity in health'. A professor at the Indian Institute of Management Bangalore, an adjunct professor at the Harvard School of Public Health and a Co-coordinator of the Knowledge Network and Gender Equity for the WHO Commission on Social Determinants of Health, Gita Sen is at the forefront of health system reform for equity and social justice.

Why hasn't the major paradigm change – embedded in ICPD Programme of Action – taken hold more strongly in policy, programmes and action? There are four principles reasons: firstly, an inertia of gender-bias throughout institutions; a diversion between Washington consensus economic policies and ICPD-friendly health system needs; the fact that funding has not reflected voiced priorities; and finally, the re-emergence of conservative agendas, with powerful backing. In recent years there has been new commitment to sexual and reproductive health, including the strengthening of civil society and new recognition of sexuality and sexual rights, embodied for example in the Yogyakarta Principles and the IPPF Declaration of Sexual Rights.

There are many things we can do to integrate sexual and reproductive health and sexual rights into health systems. While the actions of donors and governments will certainly impact progress, civil society – include lesbian, gay, bisexual and transgender (LGBT) groups and women's groups – also have a large role to play.

Knowledge network on woman and gender equity looked at why inequity persists between men and women, and what can be done to change this. Among its findings, a few of them stood out. The network found that gender inequity damages the health of women and of men, despite their power and control of resources. They also concluded that because of the magnitude of the problem and the number of people involved, actually taking action is one of the most powerful ways to reduce health inequity and ensure effective use of health resources. Finally, the knowledge network decided that deepening and consistently implementing human rights instruments is one of the most powerful mechanisms to motivate and mobilize all stakeholders.

There are seven specific, targeted actions we can take to build health systems that empower women and reduce health inequity. The first is to address the essential structural dimensions of gender inequality. Secondly, challenge gender stereotypes and adopt

multilevel strategies to change the norms and practices that directly harm women's health. Third, we should reduce the health risks of being women and men by tackling gendered exposures and vulnerabilities. We must also transform the gendered politics of health systems by improving their awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care, and making health systems more accountable to women. Next is to improve the evidence base for policies by changing gender imbalances in both the content and processes of health research. Another recommendation is that organisations at all levels must take action to mainstream gender equality and equity and to empower women for health by creating supporting structures, incentives and accountability mechanisms. The final recommendation is to support women's organisations. Women's organisations are critical to ensuring that women have voice and agency; they are often at the forefront of identifying problems and experimenting with innovative solutions. Women's organisations also prioritise demands for accountability from all actors, both public and private.

4. Human rights and maternal mortality

Paul Hunt, the UN Special Rapporteur on the right to the highest attainable standard of health and a professor at University of Essex, brought to the table a moving speech about maternal mortality — an inexcusable violation of human rights.

The right to the highest attainable standard of health is not an added benefit, an add-

on; it is a core human right which all states are legally bound to provide or ensure. The entitlement of people to health is enshrined in multiple human rights instruments, including the Universal Declaration of Human Rights, and over 100 national constitutions. While the ability of states to meet this duty is dictated, to some extent, by resources, they are bound to make all efforts possible to reach this goal.

Human rights shape policy, they shape measurable indicators, and they shape budgets. We now know what the highest attainable standard of health is, because of levels of health that have been reached in developed countries. The aim is to allow all people to access this standard of health.

To reach the highest attainable standard of health, health must be accessible in a culturally appropriate way. Health services must also be of good quality. There are a number of significant challenges to realise these goals. We must engage health workers, we must engage marginalised, disadvantaged groups. When you compare the violation of the right to health against violations such as domestic violence, freedom of speech, and democratic violations, the scale of maternal mortality is enormous.

To enable individuals to realise the right to health, we must strengthen health systems, and not use vertical funding mechanisms. Health systems are the only way to provide an effective, non-discriminatory health service to all. This means primary health care, an adequate of trained health personnel, good quality services and information about family planning. Health care must be based on principles of non-discrimination. To achieve the human right to health, we need tools to implement human rights and a way of measuring our progress. To see how effective we are in meeting the right to health for disadvantaged people especially, we need to disaggregate data to show equity and inequity across different groups. Maternal mortality is by definition a tragedy that happens only to women, and there is no comparable killer of men.

There has been progress, which is encouraging. Maternal mortality is increasingly being recognised as a human rights issue. We must take this further, take it to scale. Maternal mortality is a human right to health that is denied, it is the human right to bodily integrity that is denied. It is time to meet the needs and value the lives of women.

5. Promoting gender equity in global funding

Françoise Ndayishimiye, Senior Gender Adviser, Former Board Member, Communities delegation in the Global Fund To Fight AIDS, Tuberculosis and Malaria, Geneva, stated that gender equality and non-discrimination are fundamental to the right to health, and to health planning. Participation of disadvantages groups, including people living with HIV and AIDS, is crucial to ensure that health priorities and allocations reflect their needs.

Gender-sensitive planning is crucial to ensure that women and men can both fully develop their potential. Gender-sensitive planning is relevant to providing health both in health systems, in peaceful environments, and in conflict situations.

We must look to improve gender equality and reduce the discrimination that is perpetuated through cultural and religious practices. Many cultural practices do not support women adequately, and they do not support an inclusive environment for marginalised people. There is a lack of acceptance of sex and reproductive among people living with HIV and AIDS, for example, which prevents them from accessing family planning and other sexual and reproductive health services and information, and may also result in a poor quality of care. When we prioritise gender equality, however, and actively work to reduce stigma and discrimination, all people are empowered to improve their health and their lives.

One major problem that prevents women and others from accessing services and having their needs recognised is a lack of male involvement. Boys and men must be educated, they must be aware and play an active role and take responsibility for protecting themselves and their partners against sexually transmitted infections, including HIV.

Women and girls with HIV are increasingly vulnerable to criminalisation, in contexts where HIV is criminalised. Some African countries and others are developing and implementing policies that criminalise people who transmit the virus. This is counterproductive; it will result in increased discrepancies in health and access to services between men and women, and increased stigma and discrimination.

How can we achieve universal access? How can we ensure human rights to sexuality education, to reproductive, to family planning services, to voluntary HIV/Aids counseling and testing (VCT) and preventing mother –to- child transmission (PMTCT)?

We need to negotiate with the gatekeepers of culture and we need to create a cultural movement to eliminate myths surrounding HIV and AIDS. We need to demand and help implement gender-sensitive youth policies. We need to involve men throughout sexual and reproductive health programme (from beha-

viour change communication to education, to safe motherhood programme, etc). Men should also be involved in initiatives to counter gender-based violence and to support male circumcision as a method of HIV prevention. Culturally sensitive planning techniques and services will involve the community, including marginalised groups. All stakeholders must be involved.

The Global Fund to Fight AIDS, Tuberculosis and Malaria is developing a gender sensitive strategy which will be implemented throughout its work and ensure that the needs of women and girls are met. Gender must be reflected in global funding in order to achieve universal access to sexual and reproductive health.

6. Gender – culture - reproductive rights and health: a scope for action in German development cooperation

Erich Stather, State Secretary, Federal Ministry for Economic Cooperation and Development (BMZ), Germany, concluded the speakers panel by highlighting a few frequently overlooked issues of gender equality and addressing Germany's efforts towards this goal.

Sexual violence, particularly against women, is an issue that needs greater priority. It is relevant all around the world, in developed as well as developing countries, yet it is frequently left off the agenda.

The deadline we have set for the Millennium Development Goals is rapidly approaching, but our targets are far off. We owe it to women to realise them. It is women who feel the greatest impact of the violation of rights, of a lack of resources, and of sexual violence. We must address the inequity that is reflected in the state of maternal health around the world, which is in turn linked to wealth. Maternal health is a prerequisite for sustainable development. In addition, it is a determinant of all other MDGs.

Many cultural traditions are to the detriment of women's rights. They are in fact a violation of women's rights. Female genital mutilation is one example. It embodies the oppression of girls and women, it is a violation of girl's and women's physical and mental health, it prevents girls and women from participating fully in social and public life.

Germany is conducting many activities to increase gender equality around the world. 50 per cent of our funding supportes gender equality. We are actively working to end female genital mutilation (FGM). One project working to fight FGM in Benin has shown some success, it has demonstrated that deeply rooted support for the practice can be reversed.

If we are going to achieve the MDGs, we need to involve women substantively, at every level. With their participation, gender equality is possible.

7. 'World Café of opportunities'

In the afternoon session, participants engaged in a World Café to discuss some specific issues about health, human rights, gender and culture in small groups. Participants had the opportunity to rotate twice, participating in discussions on three of the four discussion questions. The four questions were:

- Human rights and culture: What is the interrelationship between human rights and culture?
- Gender equality, men engage and culture: 'How to promote gender equality (at all levels) and create opportunities to involve men?'
- Culture and tradition: 'What potentials do culture and traditions provide for the promotion of sexual and reproductive health and rights (SRHR) and gender equality?'
- Health systems, gender equity and cultural sensitivity: '50 ways to create health systems that meet SRH needs in view of cultural sensitivities and gender equity.'

After discussions, participants convened in a Town Hall Meeting to present the main discussion points. They are as follows.

Human rights and culture: What is the interrelationship between human rights and culture?

Human rights was identified as a means of empowerment for the most vulnerable groups, but participants acknowledged that at an operational level this does not always occur. They said that human rights needed to be translated by local actors, governmental and non-governmental, into culturally relevant, understandable concepts through local dialogue. They emphasised that culture must adapt to human right, and not the other way around. Advocates and governments must emphasise that human rights are universal, and especially that they are not a western idea. Culture can facilitate or be a barrier to human rights. Some traditions impede human rights, but in fact many aspects of cultures in developing countries and long-held traditions support human rights, and these must be championed. They can be highlighted in the public sphere and serve as a model to integrate human rights into other social institutions and practices. Participants discussing this question also pointed out that while all members of the community, especially the disadvantaged should be involved in creating culture, community leaders, including governmental figures and religious leaders, should be targeted early with plans to redefine and shape culture. They hold sway over large groups, who will be more inclined to respect human rights if their leaders are telling them it is the right thing to do. Some participants visualised a house, which is the dominant culture, within which human rights must be fostered. This involves learning and cooperation among all those within the house!

Gender equality, men engage and culture: 'How to promote gender equality (at all levels) and create opportunities to involve men?'

One aspect of gender equality that is frequently overlooked is in fact one half of the equation: men. In order to achieve gender equality men must be involved at every level, especially within the household and in decisions relating to sex and reproduction. Women, at the other end of the spectrum, must be empowered in education and be entrusted with decision-making roles. Thus, there must be some positive discrimination in order to overcome the usual social barri-

ers that prevent intelligent and qualified women from securing these positions. Gender equality and male involvement could be integrated further in culture by promoting these principles through peer education, through educator and health service provider training, and through dialogue with cultural and religious leaders. NGO involvement and community involvement, in addition, is crucial to sustain gender equity and make it a core value. Media has a role to play in this aspect also, for example through TV and radio programming. Role models, especially for young people and children, help promote positive attitudes and behaviours. Different approaches must also be used to address individual behaviour and attitude change, as opposed to collective change. We must develop affirmative action that includes time-bound goals.

Culture and tradition: 'What potentials do culture and traditions provide for the promotion of sexual and reproductive health and rights (SRHR) and gender equality?'

The power structures that exist within cultures were seen by most of the discussion groups as key 'actors' in promoting gender equity in the context of sexual and reproductive health and rights. Participants emphasised the need for inter-cultural, multi-religion dialogue and expression, including men and women, in order to identify and sensitise communities to the implications of both positive and negative traditions. Culture was seen as intrinsic to the self, shaping identities, behaviours and attitudes. These in turn create acceptability or not of ideas and priorities. As such, there is a need to use widely acceptable and position interventions, maternal health for instance, as a door into a more comprehensive sexual and reproductive health and rights agenda that includes more sensitive issues, including abortion and gay rights. Services and health providers should be made appropriate and acceptable for all different groups. Doctors should be women, minorities, people living with disabilities and HIV and AIDS, for example, and youth services should specifically address the needs of young people. Gender sensitisation training should be incorporated in medical school curricula. The discussions also highlighted the fact that political will is a great help to boosting cultural change, and hence the need to advocate with policy and decision makers.

Health systems, gender equity and cultural sensitivity: '50 ways to create health systems that meet SRH needs in view of cultural sensitivities and gender equity'.

While many more than 50 ways emerged as possible techniques to strengthen health systems to meet sexual and reproductive health needs in the context of cultural norms and gender equity, there were a few dominant ones which are highlighted here. Participants agreed that an effective health system should integrate both private and public providers, modern and traditional providers including traditional healers and trained birth attendants. They felt that civil society had a significant role to play, and said that as part of the health system, civil society organisations should be empowered to contribute and participate in health policy planning, implementation,

service delivery and evaluation, particularly with regard to gender equity interventions and processes. Primary health care providers and traditional healers should receive information, education and communication about gender and culture, and ideally they should be trained and evaluated according to gender equity principles, including, again, public and private facilities. Gender equity, in line with cultural sensitivities, should be an integral component of quality of care training, monitoring and evaluation, which already includes elements such as choice of provider, technical competence, interpersonal relations, adequate information on health problems and treatment options and choice of treatment(s). Other stakeholders, including patients/clients, community groups, women and disadvantaged groups should be involved in health planning, implementation and evaluation, in a meaningful way.

8. Wrap-up of the day and outlook

Gill Greer, Director-General, International Planned Parenthood Federation (IPPF), UK, brought the International Dialogue to a conclusion by reviewing the events of the past two days and offering her insight on the current and future climate of achieving gender equity and sexual and reproductive health and rights through culture.

Greer highlighted the changing reality of culture. Cultures are evolving and transforming, what once were cultural norms are now history, and behaviours which were once radical are acceptable. This presents incredible potential for gender equity and for human rights, especially sexual and reproductive rights. Human rights are for everyone, and it is the responsibility of all of us, governments, civil society, organisations and individuals, to enforce and observe them. Maternal mortality, the scale that it has reached, is a gross violation of women's rights that we simply cannot ignore. All people – men and women, and especially marginalised and disadvantaged groups, including people living with HIV, those whose rights are most commonly denied – must be involved in planning, budgeting, implementation and evaluation is we are going to succeed. We must engage in open and frank discussion about sex and reproductive health, with donors, governments and civil society and also unlikely partners such as religious leaders and pharmaceuticals. We must find the common ground where we can work together. Our efforts to achieve human rights must then be implemented at the operational level. We need to implement measurable monitoring and evaluation mechanisms; we must collect and analyse disaggregated data. We have some new tools, for instance new indicators and targets and advocacy tools such as declarations of sexual rights, and we must use them vigorously.

As Ban-ki Moon reminded us in a recent statement, Dr Greer said, development is the right of all. These two days, this International Dialogue, has been an opportunity to involve all stakeholders, to engage with each other and tell our stories, to cooperation and reach some shared targets of what we need to do to help millions to lead their lives in health, dignity and with purpose. ■

Welcome

Claudia Radeke
First Vice President East and West Africa,
KfW Entwicklungsbank, Frankfurt

The Dialogue's title clearly indicates the complexity of the issues we will be discussing here today. Sexuality, reproduction and rights are all very sensitive areas, and dealt with in very different ways in different cultures and subcultures. In this context, I always like to recall how one of our projects in Burkina Faso was able to include what was, even in my view, an extremely 'liberal' street theatre performance on the use of condoms and genital mutilation without incurring the disapproval of the audience.

The aim of the pivotal Cairo Conference in 1994 was – as you all know – to ensure 'universal access to reproductive health by 2015'. Now, seven years before the target date and fourteen years after Cairo, we are still far from achieving that goal, even though there have been many positive changes in the ensuing period.

For example, in the early 1990s, it was impossible to discuss sexuality at an international conference. Instead, we talked about 'population and development', important topics, and somewhat later we also discussed 'reproductive health'. But with the emergence, rapid growth and spread of the HIV/AIDS epidemic, we finally understood that we have to expand our own approaches and debates.

Now, we also know that we need to do far more for sexual and reproductive health, and also more for the rights connected with it. We had to come to acknowledge – and, unfortunately, still do – that too many men and women remain without access to reproductive health, whether due to the lack of requisite health services, for example, mother and child care, or due to political or cultural/religious convictions. Since then, a lot of research has been carried out and actions taken to improve this situation and

facilitate universal access to reproductive health. However, at least in some sub-Saharan African countries, there seems to be an analogy with the well-known Hare and Tortoise story, with the increasing dimensions of the problem continuing to overtake the increasing successes. In a recent study, the KfW Entwicklungsbank assessed how far the 8th Millennium Development Goal had been achieved so far. Sadly, the study confirmed that there was no genuinely clear and satisfactory improvement per person – and, above all, this could also be attributed to the continuing high rates of population growth in Africa. Unfortunately, though, for us as donor representatives, the question of high rates of population growth nearly always remains an absolute taboo subject in policy dialogue with high-ranking government representatives.

Cutting maternal mortality is one central plank of the Millennium Development Goals. As you no doubt know, we are still far removed from reducing maternal mortality by three quarters by 2015 – the goal agreed at the Millennium Summit in New York. In developing countries in 2006, the maternal mortality ratio was 440 women for every 100,000 live births; in an industrialised country, that ratio is 'only' 26 women per 100,000 births (and in sub-Saharan Africa the mortality rate is ten times as high).

The issue here is equality and balance, not only between the various regions and countries in the world, but also within the individual countries themselves. For example, women in countries where it is difficult to obtain any kind of medical care at all are, nonetheless, six times more likely to have proper childbirth care if they are rich than if they are poor.

Sexual and reproductive health and rights are intimately linked to power relations between the sexes. Here, one of the most important questions is how to involve men. In this regard, many approaches have been tried over the last fifteen years. They have given us insights and experiences that are both useful and necessary in achieving our goal. If men can be won over to support their own wives, female relatives and families in gaining access to reproductive health, then a crucial step has been taken in the right direction. We continue to have men too little 'on the radar'. The meeting yesterday evening has already given us some examples of how positively behaviour can be influenced across a range of cultures.

I would like to conclude my welcoming remarks with that thought and wish you all a very interesting and informative Dialogue. ■

Welcome

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

'Exploring Cultural Diversity and Gender Equality: towards universal access to sexual and reproductive health and rights: Cultural Diversity' is this year's focus to explore the themes and topics around reproductive and sexual health and rights. But why are we focusing on cultural diversity.

By culture, we understand everything created by people in contrast to the things produced by nature. Hence, rights, ethics and religion are all cultural products. Ever since humankind had a concept of civilization, human sexuality has been embedded in this triad of rights, ethics, and religion. And ever since civilisation has been discussed, records substantiate the human need for rules governing human relations and, thus, sexual relations as well. There never has been one set of rules for all humankind. They vary from region to region. Sometimes people talk explicitly about sexuality; sometimes it is totally tabooed. Moreover, people have not necessarily become more liberal as the centuries have rolled by!

But how do we deal with cultural diversity? What can we do when there are so many different rules – in so many different places? And first and foremost, how do we deal with cultural diversity in the era of Google, YouTube and mass tourism? This is a very significant issue for us as a company active on the global market. Marketing the contraceptive pill in Germany is a different process from making the same product in Africa available. In Germany, we have an established healthcare service and a functioning distribution system. We manufacture the contraceptive pill, sex education is provided for example by parents, doctors and teachers, the doctors prescribe the pill and women get the pill in pharmacies - which is the usual way things happen here. In many developing countries, though, the

route that the pill takes to the women who want to use it is a very different one. Women are often too poor to afford contraceptives. Often, they have no access to information about this contraceptive method, and in some cases they simply cannot read the information they are given. Tragically, as a result, over 500,000 women die annually from avoidable complications in pregnancy and birth, and every year around 14 million girls aged between 15 and 19 have a baby which may was unintended.

If we are manufacturing and market our product for the non-European market, we need to ask what strategies we should employ to ensure that, in particular, the poorest women have access to the pill and, moreover, understand how to take it correctly. For this reason, our products also come with an additional pictogram package leaflet in some countries. This is also why we are involved in projects by non-governmental organisations providing sex education to women and young people. We are working together with aid organisations committed to ensuring that the poor in the countries of the South also have access to family planning. For us at Bayer Schering Pharma, this cooperation is crucial. We can only provide effective help through joint efforts with the UN and non-governmental organisations, and with national governments and their aid implementing organisations.

And because alliances are important, and alliances require dialogue, we are very glad to see so many guests here at the 7th International Dialogue in the city of Berlin. I am especially pleased to welcome our many overseas guests. Nothing could be more embarrassing for an International Dialogue on cultural diversity than to issue invitations and then discover the discussion is solely from a German perspective. It is also a pleasure to have attracted so many top-flight speakers whose outstanding knowledge and expertise will undoubtedly guide us through this fascinating topic.

I am also particularly looking forward to the World Café session in the afternoon, and the impetus it provides for an exchange of views in small groups between all the experts gathered here. This year we have deliberately chosen the World Café method because the main focus should indeed be on a cross-regional and, in some cases, interdisciplinary exchange of experience. I am also looking forward to this conference providing a platform for a wealth of encounters and lively discussions on cultural diversity. I am curious to see what new insights we will gain together. I say 'gain' and not work towards – which seems to emphasise the effort involved. In my view, 'gaining insights' is a far more congenial term, especially since the phrase evokes the idea that each of us gains something from the exchange, and everyone benefits. I hope that after our exchange, we will all benefit from the new ideas and experience too – and I certainly hope that we will all benefit from the motivation to contribute to moving forward on realising the Millennium Development Goal of improving the situation of women and young girls by 2015, promoting women's empowerment, cutting child mortality rates and improving maternal health.

Opening address

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

It is my pleasure to join you in Berlin for the 7th International Dialogue on Population and Development. I have participated in several of these dialogues and appreciate the exchange of ideas and sharing of experiences that take place. I would like to thank the Federal Ministry for Economic Cooperation and Development, and in particular Minister Heidemarie Wieczorek-Zeul, as well as its partners, for organising this meeting and bringing us together.

I am honoured to address you because I have been asked to speak about a topic that I care deeply about. I will speak about the relationship between culture and development and how it relates to gender equality and the right to sexual and reproductive health.

As an Under-Secretary-General of the United Nations and as a person who has had the opportunity to traverse many cultures, I am adamant about cultural awareness and engagement as a vehicle to promote human rights and thus achieve development goals.

The great scholar and author, Amartya Sen, famous for his expansion of the term development to include the 'human' element, maintained in his treatise on 'Culture and Development' that cultural matters are integral parts of the lives we lead. 'If development can be seen as enhancement of our living standards,' he said, 'then efforts geared to development can hardly ignore the world of culture.'

The European Agenda for Culture in a Globalising World (2007) describes culture as lying at the heart of human development and civilisation. It says, 'Culture is what makes people hope and dream, by stimulating our senses and offering new ways of looking at reality. It is what brings people together, by stirring dialogue and arousing passions,

in a way that unites rather than divides.'

Yet we all know that our world is filled with perceived cultural divides and that some people believe that their culture is better than others.
The point that I would like to stress today is that while we may disagree with certain practices, all cultures are unique and valuable and represent the diversity of human life. People are both shaped by and actively shape their own cultures. And people in the same culture do not all think the same way. We also know that culture is not static; culture is dynamic and constantly changing.

In all cultures, people are critical agents of change and if we are serious about eradicating poverty, promoting the human rights of women, including the right to health, and in particular sexual and reproductive health, then we have to work with this range of agents of change and support cultural change from within.

This is simply a practical, common sense way to achieve greater progress in promoting the agenda of the International Conference on Population and Development, and achieving the Millennium Development Goals. All of us working in the field of population and development have been engaging with culture for years.

At UNFPA we have learned from nearly four decades of experience that population issues come down to the decisions that people can or cannot make. Whether it is a decision about using contraception, or sending a daughter to school, or seeking healthcare during pregnancy or childbirth, or packing up and moving to a city or another country, the decisions that people make, or cannot make, are deeply rooted in their specific cultural contexts.

Our data show that reproductive health eludes many of the world's poorest people. And this is due not only to a lack of health services, but also to cultural factors that manifest in an inability to access the services even when they are available, as well as inadequate levels of knowledge of sexual behaviour, social practices that discriminate

against women and girls, and the limited power many women and girls have over their sexual and reproductive lives.

We are aware that those who promote women's empowerment and the right to sexual and reproductive health often have to deal with criticism, suspicion and accusations of challenging either religion, culture or tradition – or all of them.

We also know that discriminatory attitudes towards women and harmful practices, such as child marriage, sex-selection/male preference, and female genital mutilation/cutting, are deeply rooted within cultural understandings and are often stronger than the laws that have been enacted to stop them.

Consequently, UNFPA has learned that to get to the root of these issues, it is necessary to use a 'cultural lens' - to ensure a culturally sensitive approach to facilitate change. Such an approach is based on the principle of mutual respect and grounded in a process of active listening and dialogue. It seeks solutions from within, based on knowledge, insights and expertise.

A culturally sensitive approach is one that takes into account, from the outset, the broad political, economic, and legal frameworks within which human behaviour and action take place. In other words, far from being an 'add-on' to development work, cultural sensitivity integrates a width of perspective, a depth of insight, and a deeply rooted outreach. Cultural sensitivity, effectively, refines and strengthens the way we do development.

I will argue today that this approach to actively engage cultures is vital not only for the promotion of a rights-based development, it is essential for aid to be appropriate, effective and facilitating sustainable results.
In today's world, we are challenged to increase our cultural 'fluency'. In this new aid environment, greater flexibility and innovation and the skills for relationship building, such as language and broader cultural understanding, are required more than ever. Internally, within our organisations, we have to adapt to dynamic and ever changing ways of doing our work, based on introspection and learning, partnership and mutual respect.

At UNFPA we have learned that it is better to understand culture and identify its positive elements to facilitate lasting change. This is not to say that violations of human rights should go unchallenged. On the contrary. The advantage of culturally sensitive approaches is that they provide insights on how to align cultural practices and human rights most effectively.

We have found this to be true in tackling such challenges as female genital mutilation and cutting, in addressing violence against women including domestic abuse and honour killings, and in working with partners to end prenatal sex selection in Asian countries where an estimated 100 million girls are missing due to a preference for sons.

In understanding the nexus of development, culture, gender and human rights, we are conscious of at least two levels: the national policy and governance level representing the

top-down promotion of human rights through legislation; and the popular level of civil society, where developing a 'culture of human rights' is evolving from the bottom-up.

To promote and protect human rights, both levels and kinds of partnerships are needed and neither is sufficient on its own. Whether it is to end female genital mutilation and cutting, or to counter son preference in families that may lead to eliminating the female fetus, or to combat the spread of HIV and AIDS, laws are important and necessary, but in and of themselves are not enough to generate changes in attitudes and behaviour.

The practice of female genital mutilation/cutting for instance, is deeply rooted and often considered by families, especially mothers, and community members to be essential for full entry into adulthood and membership in the community; women without it may be considered unfit for marriage, ugly and unclean.

Ending the practice involves taking all the different cultural meanings into account and finding meaningful alternatives in close cooperation and discussion with the community. In countries such as Senegal and Guinea Bissau, people are encouraged to talk about concerns in this area and to review problem-solving approaches. This process of engagement often culminates with a collective decision to abandon female genital mutilation. In some instances, such as in Kenya and Uganda, the symbolic value of the practice is maintained and celebrated as a rite of passage to adulthood, without the cutting.

I am pleased to announce that this year's State of World Report, which we will release on November 12th, focuses on many of these issues and is entitled, Reaching Common Ground: Culture, Gender and Human Rights. In the report, we show how some tensions often exist between universal standards of human rights and culturally specific norms and practices – particularly when it comes to the area of gender relations. Identifying those power structures that can play a role in either perpetuating the status quo or alternatively, supporting positive change, is strategic to promoting human rights and creating local ownership and agency.

Some of the most dramatic changes occur when the guardians of cultural norms and practices become advocates for change.

In Latin America, cultural agents of change, such as community, indigenous and church leaders are instrumental in bringing about important developments, which promote women's rights and equitable gender relations.

In Brazil, UNFPA has adopted a strategy of 'selective collaboration' with the Catholic Church, identifying and working together in those areas where objectives coincide, while respecting the boundaries inherent in each partner's mandate. Similarly, the passage of a groundbreaking new law in Guatemala that promotes better health for women and their families was the product of a year and a half of negotiations and consensus-building among a wide range of cultural and political stakeholders, facilitated by UNFPA. In Yemen, we are working with the Ministry

of Awqaf (religious endowment) and Religious Guidance, in helping to raise public awareness of reproductive health, including family planning, and the harmful effects of certain practices such as forced early marriage and female genital cutting. A Source Book on Reproductive Health, produced jointly by the Ministry of Health and the Ministry of Awqaf and Religious Guidance, guides muftis, imams and other religious leaders on handling sensitive topics among their followers. The Source Book relates family planning and reproductive health to the Quran, and stresses the Prophet's teachings on the equality of women and men.

In Uganda, UNFPA has successfully reached out to elders, kings, bishops and imams as opinion leaders in promoting healthier behaviours and the elimination of harmful practices. UNFPA's work in this country, which has successfully grappled with its HIV and AIDS epidemic, is a model for working within and among existing cultural dynamics.

In India, we found that to be effective in eliminating sex selection, legislation had to be complemented by an integrated broad-based awareness-raising campaign that involves opinion makers and custodians of culture. The campaign addresses the underlying cause of gender discrimination, in this case, a widespread preference for sons. The publication of research informed an understanding of prenatal sex-selection not only as a cultural issue, but one with social and economic and demographic dimensions. Given the imbalance in the sex ratio, men may face difficulties in finding wives, which may lead to increased levels of gender-based violence and human trafficking. In this case, we learned that confronting harmful practices that are national in scope can best be addressed through a broad coalition of actors, each of whom can bring forward their own expertise in creating awareness and corrective action.

In Cambodia, Buddhist monks are prominent in the struggle to combat HIV, and the nuns play a critical role in both prevention as well as in the healing necessary for those infected and affected by the disease. Since culture has a role to play in defining gender relations and sexual behaviour, both of which are factors in HIV transmission, and socialisation is an important dynamic in the spread of stigma, it follows that prevention and care require a culturally sensitive approach.

Based on our work in the field, we have found that faith-based organisations provide anywhere between 40 to 60 per cent of health-related services in some countries.

This is simultaneously a statement of vast outreach, capacity, and legitimacy. In other words, this is an undeniable form of power. UNFPA has a legacy of working with a number of these faith-based service providers for many years in several countries. Our recent mapping of such engagement across the developing world shows that we work with no less than 400 different faith-based organisations in over 100 countries.

Since 2002, we have sought to document, assess, and consolidate this range of partnerships with these strategic agents of change. In fact, after leaving this gathering, I will proceed to Istanbul to host UNFPA's first Global Forum of Faith-Based Organisations. This Forum is a consolidation of similar consultations in four regions where we listened to the diversity of experiences, challenges, and achievements of these organisations that work around our areas in maternal health, HIV prevention, women's empowerment, violence against women, and humanitarian assistance in times of conflict.

We heard their recommendations to enhance the partnership towards mutual goals of ensuring that every pregnancy is wanted, every birth is safe, every person is free of HIV and every girl and woman lives in dignity. Our goal is to establish a global interfaith network to work together with our other partners in government and civil society, for population and development issues.

In this age of advanced globalisation, we are building transnational and multi-stakeholder partnerships to advance development through a human rights'-based approach, founded on cultural sensitivity. These strategic partnerships will expand the domains of support in an age of growing religiosity and extremisms of all kinds.

All of us gathered here today believe in the values that all cultures hold in common: no woman should die in childbirth; nothing should condone rape, wife beating, human trafficking or other forms of gender-based violence; and no one should suffer and die of AIDS. With this in mind, we are reaching out to partners around the globe to advance women's empowerment, gender equality, and universal access to reproductive health. We are actively engaging men and boys as partners in equality. By reaching out to all segments of the population and society, we stand a better chance of meeting our goals and achieving success.

In closing, I would like to quote the great Nigerian writer and Nobel Laureate, Wole Soyinka. He said: 'Culture is a matrix of infinite possibilities and choices. From within the same cultural matrix we can extract arguments and strategies for the degradation and ennoblement of our species, for its enslavement or liberation, for the suppression of its productive potential or its enhancement'.

For those of us working in the field of development, basing our mission on human rights and human dignity, we must start from, and work within, this realm of 'infinite possibilities'. We can succeed if we keep close to our hearts the conviction that each human life is uniquely valuable, and the right to development is the right of all individuals to express the full measure of their potential and humanity. ■

Towards 'gendered' health systems – a new perspective on gender equity in health

Gita Sen
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I think the key question for us still is, why hasn't what was accepted as a major paradigm change in the ICPD programme of action taken hold more strongly in the intervening years of policies, programmes and action. I believe there are four reasons for this.

Rationale and Motivation

Four reasons:

- Inertia of gender bias that imbues institutions across the board, eg, absence of voice at the Millennium Summit
- Major divide between Washington Consensus based economic policies and ICPD-friendly health system needs
- Not enough walking the talk in terms of funding
- New energy provided to conservatism by super power backing

First is the gender bias that imbues institutions across the board. We saw this in the absence of feminist or women's advocates' voice at the Millennium Summit. It landed up with reproductive health practically dropping off in the Millennium Summit discussions and an enormous effort had then to be put in to bring back at least the target or the new target on reproductive health, involving many years and many hours of many people's labour. It really ought to have been there in the first place in a central way.

A second reason is the major divide, I believe, and I really do want to emphasise this very strongly, between the (now we can say pretty much dead but not quite gone) Washington Consensus-based economic policies and ICPD-friendly health system needs. I think during the intervening years since

1994, we have had major problems because what the macroeconomists kept doing to health systems and health policies would completely run counter to the creation of a positive, health-friendly environment that was essential for meeting the recommendations of the ICPD programme of action.

The third, which we all know well and which you certainly in this country face continuously on a day-to-day basis, is we all know there has not been enough of walking the talk in terms of funding in this area, and we see it particularly in today's world even in terms of the declining funding for something that everyone had accepted pre-ICPD, which is family planning itself, let alone many of the other essential elements of sexual and reproductive health and rights.

And the fourth, which we all also know quite well, is the new energy provided during this period, to religious conservatism by superpower backing. Those of us as feminist activists in the, ICPD plus 10 and Beijing plus 10 discussions had to see during the negotiations the most clever oppostion delegates who used to sit in the delegation of the Holy See now moving over and sitting in the delegation of the United States. This was an entirely different political environment within which we had to ensure that the ICPD programme of action did not sort of slip entirely and fall off the table.

For me, the setting up the WHO Commission on Social Determinants of Health and the creation of its Knowledge Network on Women and Gender Equity provided an opportunity to address some of these issues from a broader perspective. And in today's remarks, I am really going to be speaking about that broader perspective.

Another opportunity in addition to the WHO Commission is, I think, provided by forward movement on accepting the idea of sexual rights in the face of many of the cultural barriers and boundaries that Thoraya spoke about earlier. We have seen enormous forward movement in this area during these intervening years, fuelled by a strengthening of civil society movements. This includes the presence of sexual rights at the new Human Rights Council, which is one of the most NGO and civil society-friendly sites in today's international negotiations. It's also been enshrined in the Yogyakarta Principles, which basically apply international human rights law to sexual orientation and gender identity and which were put together by a group of highly distinguished human rights advocates including some who are on this panel today.

The Yogyakarta Principles affirm 29 key rights, many of which have implications for health. They affirm the primary obligations of states to guarantee these rights. Principle 17, for instance, reinforces the right to the highest attainable standards of health for all persons regardless of sexual orientation or gender identity; Principle 18 affirms the right to protection from medical abuses, which particularly for those who do not belong to hetero- normative groups is a major source of abuse in many situations in many different countries.

In addition to that, IPPF's recent Sexual Rights Declaration, which specifically de-

scribes itself as „human rights applied in the area of sexuality', through its seven principles and 10 key articles, provides us with another very important tool. Much more needs to be done to integrate sexual rights into what, after ICPD and because we could not get sexual rights explicitly affirmed in ICPD, we began calling the agenda of sexual and reproductive health and reproductive rights without being able to formally mention sexual rights. Much more needs to be done, but such tools as the Yogyakarta Principles and the IPPF declaration provide us with important guidelines and ways in which this can move forward.

More crucial, I believe, will be the ability of civil society, especially the LGBTI and the women's movements, to build strong alliances and work through tensions such as those around the recognition of the feminisation of HIV and of funding. And hopefully during the day we may have some possibilities of this discussion; many complex cultural but also economic and other issues are involved. Now, let me go on from there.

Why specifically, as in the WHO Commission, should one look at gender inequality and inequity in health? Because it makes it possible to see how key social determinants of health, economic inequality, gender inequality and injustice and other social inequalities interact. This, I believe, has been recognised increasingly since ICPD as a very important set of interactions to pay attention to, because these interactions affect health status, health outcomes and health care access and affordability, as well as health norms and perceptions. And therefore, if we are not able to grapple with these larger sets of interactions, it will be very difficult for us to move the agenda of ICPD forward in terms of actual implementation.

Our work in the Knowledge Network on Women and Gender Equity allowed us to see how culture, gender and human rights interact with key economic forces including globalisation to affect health. The Knowledge Network was established in 2006. It has a number of members. And it did a lot of outreach globally before coming up with its report, and nine background review papers, which have come out in a recent issue of the journal, Global Public Health.

The key messages of the knowledge network were three. First, gender inequality damages the physical and mental health, as we know, of millions of girls and women across the globe; but also of boys and men, despite the many tangible benefits it gives

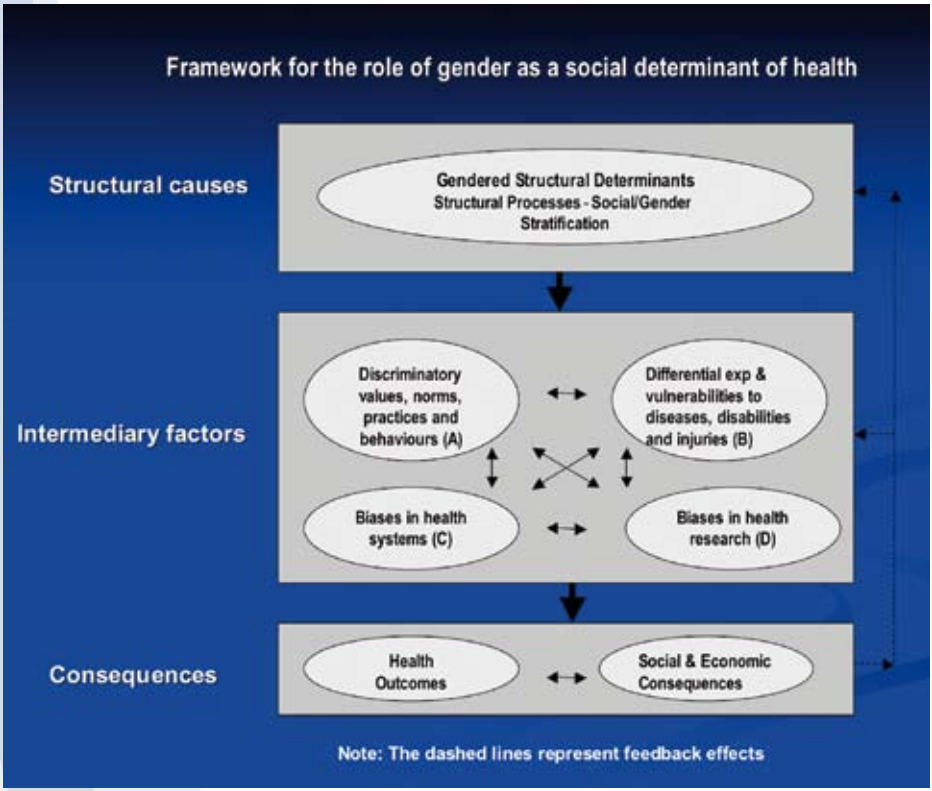
men through resources, power, authority and control. Despite that, men's health is damaged by gender inequality itself. And the more that men's groups and boys' groups recognise this and work with this, the more we can see a transformation in gender relations, which I think is absolutely essential to affirming and fulfilling the ICPD agenda.

The second key message is that because of the numbers of people involved, practically the entire human race one might say, and the magnitude of the problems, taking action to improve gender equity and health and to address women's rights to health in particular is one of the most direct and potent ways to reduce health inequities and to ensure effective ways of using health resources.

I say this because in much of my own work in this area, one of the windmills that we have to keep tilting against is the assertion that, if you deal with poverty, you will deal with the problem of inequality. Well, what do I say (I do in my work on maternal mortality on the ground in a very poor area near where I live) when I find a perfectly well-off, 17-year-old girl from a well-off household dying because her preeclampsia was simply not acknowledged, recognised and dealt with. There is no economic reason why that young woman should die and yet she did die. And we have cases like this all of the time. Dealing with poverty by itself, without addressing the problem of gender inequality as a specific issue interacting with poverty, is simply not sufficient.

The third key message is that deepening and consistently implementing human rights instruments can be a powerful mechanism to motivate and mobilise governments, people and especially women themselves. And I would say that in the area particularly that we are concerned with, in the area of culture, as we work on the ground we know perfectly well that it is not possible to ignore culture. We cannot deal with the problem of the 17-year-old woman if we ignore the cultural roots that led to her death. But as much as we say that, we also recognise that the strongest and most important way in which we empower women is to show them ways to affirm their rights as part of the universal standards, so that they don't fall off the table of universal standards and norms, even as we recognise that working with culture is important.

In the Knowledge Network, we developed a simple framework to talk about the different factors at work. We placed structural



causes at the top, then the intermediary factors, and then the outcomes. We identified four critical intermediary factors. One of them is the discriminatory values, norms, practices and behaviour, or what in today's discussion we have been calling culture. But three others are absolutely crucial in interacting with these: differential, gender-based, exposures and vulnerabilities to diseases, disabilities and injuries; biases in health systems; and biases in health research. Women don't get cardiac arrests or have cardiac problems to the same extent than men do. And that is due to a biological reason. But women tend to die because the system is not geared up to ensure that when a woman starts showing the symptoms of a cardiac problem, it is recognised and treated. Women get treated much later; they get treated much worse and less adequately than men do. And this is the way in which even when you don't have a biological vulnerability to the same extent that men do, your social vulnerability ends up with an adverse outcome. Biases in health systems therefore are a central part of the problem. And biases in health research are important too. In our own work, we were greatly amused to find out how badly WHO performs in terms of the composition of its committees, its task forces and so on when you put them through a gender lens. Furthermore, the European regional WHO organisation and European governments also don't do well in this regard. So this is not to point a finger only at Southern countries, it is a problem everywhere.

Let me put forward before you the seven priority areas that we identified for work. On the left hand side of the slide is the evidence that we pulled together and on the right side, what we put forward is the action priorities.

Priority (1) - Address the essential structural dimensions of gender inequality

Evidence:

- **unequal access to and control over property, economic assets and inheritance;**
- **strongly defined gender-based divisions of labour within and outside the home;**
- **unequal participation in political institutions from village to international levels.**

Action priority:

- **Expand women's opportunities and capabilities including both education and income earning and control;**
- **Ensure that access, affordability and availability of health services are not damaged during economic reforms, with particular focus on women's health;**
- **Cushion the 'shock absorbers' through resources, infrastructure and policieskey structural reforms;**
- **Support women's voice and agency including through support for women's organisations.**

The first priority is to address the essential structural dimensions of gender inequality. Here, we identified three broad actions, the first of which has to do with the continuing problem in the economics area: control over property, economic assets and inheritance. The second is very strongly gender-based definitions of divisions of labour within and outside the home, and the third is continued unequal participation in political institutions.

On the right hand side are the action priorities, and we identified four in this area: expanding women's opportunities and capabilities including yet beyond education. That 17-year-old girl who died in our example was actually fairly well educated. She had been married early and she was sort of expected to manage things. There was enough help at home to support her with housework and domestic work. But she died anyway.

Priority (2) - Challenge gender stereotypes and adopt multilevel strategies to change the norms and practices that directly harm women's health

Evidence:

- **unequal decision making in households; unequal restrictions on physical mobility, reproduction and sexuality; sanctioned violation of women's and girls' bodily integrity; and accepted codes of social conduct that condone and even reward violence against women.**

Action priority:

- **Create, implement and enforce formal international and regional agreements, codes and laws to change norms that violate women's rights to health.**
- **Transform and deepen the normative framework for women's human rights and ensure effective implementation of laws.**
- **Work with boys and men through innovative programmes for the transformation of harmful masculinist norms, high risk behaviours, and violent practices.**

The second priority is to recognise the importance of implementing formal and international, regional agreements, codes and laws, transforming and deepening the normative framework for women's human rights and working with men and boys through innovative programmes for transformation.

Priority (3) - Reduce the health risks of being women and men by tackling gendered exposures and vulnerabilities

Evidence:

- **Differential exposures and vulnerability of women and men across a range of health problems, and these differences are poorly recognised.**

Action priority:

- **Address women's and men's differential health needs including SRH but also beyond reproduction.**
- **Tackle social biases that generate differentials in health related risks and outcomes. Social insurance systems must cover workers in informal occupations and key SRH needs.**
- **Strategies that aim at changing health damaging life-styles at the level of the individual should be combined with measures that aim at changing the negative social and economic circumstances in which the health damaging life-styles are embedded.**

The third priority is reducing the health risks of being women and men by explicitly tackling gendered exposures and vulnerabilities. These affect both women and men because the men suffer from their own violence and risk-taking behaviours. But those violent and risk-taking behaviours affect not only the girls and women and young boys in their households; they affect their own health. And so you have men dying in traffic accidents because of idiotic masculine norms about driving. We have men dying out of violence in poor communities because violence is so much part of those masculine norms. So it is bad for men as it is bad for women. And the transformation of gender power relations would be good for the health of both.

Priority (4) - Transform the gendered politics of health systems by improving their awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care, and making health systems more accountable to women

Evidence:

- **Biases in health systems that affect women as both providers and consumers of health care and services. Women, through work within families and at lower levels shore up Failing health systems but receive inadequate support, recognition and remuneration.**

Action priority:

- **Provide comprehensive and essential health care, universally accessible to all in an acceptable and affordable way and with the participation of women.**
- **Develop skills, capacities and capabilities among health professionals at all levels to understand and apply gender perspectives in their work.**
- **Recognise women's contributions to the health sector, not just in formal, but also through informal care (home-based and outside).**
- **Strengthen accountability of health policy makers and health care providers; clinical audits and other quality of care measures must incorporate gender.**

Fourth, health systems need to ensure that comprehensive and essential health care, universally accessible to all in an acceptable and affordable way and with the participation of women. It is very important for us to recognise this now as a right, because non-recognition has been part of the damage caused by the Washington Consensus. It is essential to recognise women's contributions to the health care sector, particularly at the informal levels where they are expected to do everything for poor or no pay and simply not supported adequately.

Priority (5) - Take action to improve the evidence base for policies by changing gender imbalances in both the content and the processes of health research

Evidence:

- **Gender imbalances in research content: e.g. slow recognition of health problems; misdirected or partial approaches; poor recognition of interactive pathways.**
- **Gender imbalances in the research process: e.g. non-collection of sex-disaggregated data in individual research projects or larger data systems, inadequate protocols and trials, insufficient resources, and gender imbalance in ethical committees, and in research funding and advisory bodies.**

Action priority:

- **Collection of data disaggregated by sex and other social stratifiers and gender analysis of such data.**
- **Include women in clinical trials and other health studies in appropriate numbers.**
- **Funding bodies should promote research that broadens the scope of health research and links biomedical and social dimensions, including gender considerations.**
- **Strengthen women's role in health research. Redress the gender imbalances in research committees, funding, publication and advisory bodies.**

The fifth priority is to take action to improve the evidence base for policies by changing gender imbalances in both the content and the processes of health research.

Priority (6) - Take action to make organisations at all levels function more effectively to mainstream gender equality and equity and empower women for health by creating supportive structures, incentives, and accountability mechanisms

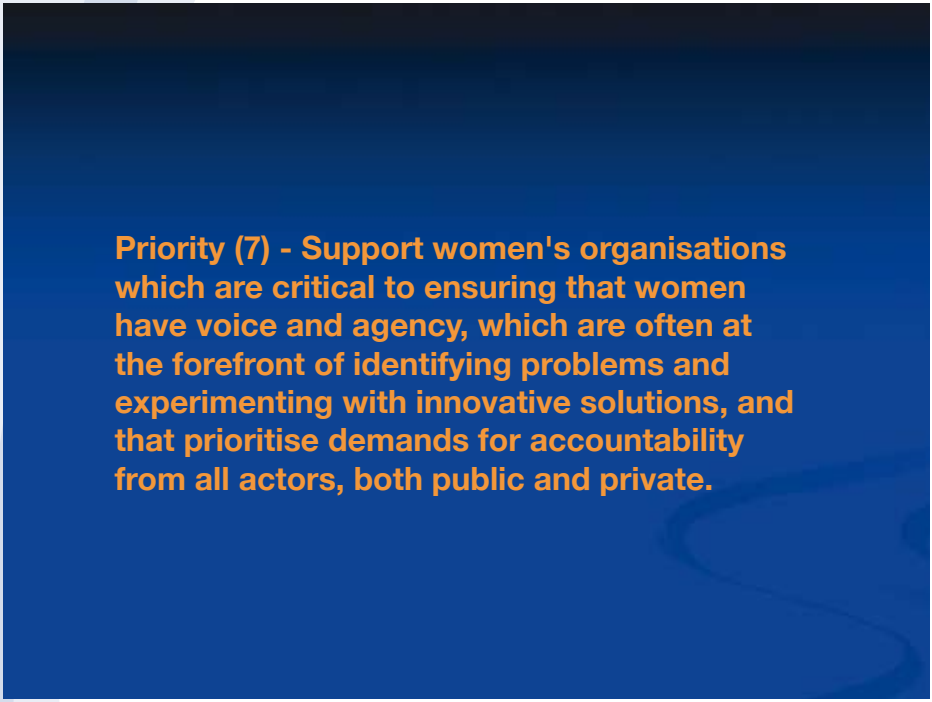
Evidence:

- **Gender discrimination, bias, and inequality permeate the organisational structures of governments and international organisations, and the mechanisms through which strategies and policies are designed and implemented.**
- **Long-standing male dominated power structures and patriarchal social capital (old boys' networks) in many organisations.**

Action priority:

- **Gender mainstreaming in government and non-government organisations has to be owned institutionally, funded adequately, and implemented effectively. It needs to be supported by an action-oriented gender unit with strong positioning and authority, and civil society linkages to ensure effectiveness and accountability.**
- **Empower women's organisations so that they can collectively press for greater accountability for gender equality and equity.**

Sixth, it is necessary to take action to make organisations more accountable for ensuring gender equity and equality. We all talk about gender mainstreaming in this area and we know there is a huge debate whether and how gender mainstreaming works or doesn't. We believe, and in this report we strongly emphasise that gender mainstreaming hasn't worked well because of three reasons: It's not led effectively and owned institutionally, it's not funded adequately, and it's not implemented effectively. And in the work that I am now doing with the Pan American Health Organisation's task force on gender equality, to mainstream gender in all of PAHO's work, I hope we can provide real, clear ways and guidelines for how it's possible to move this agenda forward.



And seventh, and this is my last slide, a priority is to support women's organisations that are critical to ensuring that women have voice and agency, that are often at the forefront of identifying problems and experimenting with innovative solutions and that prioritise demands for accountability from all actors both public and private. ■


7th International Dialogue
on Population and Sustainable
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Human rights and maternal mortality

Paul Hunt
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The right to the highest attainable standard of health does not provide magic solutions to complex health issues, any more than do ethics or economics. Nonetheless, this human right has a crucial, constructive role to play. Health policy makers and practitioners who ignore this fundamental human right are failing to use a powerful resource that could help to realise their professional objectives.[1]

At the international level, the right to health was first articulated in the Constitution of the World Health Organisation in 1946. Subsequently, it was enshrined in several legally binding international human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights, as well as many national constitutions.[2]

However, the vital challenge is implementation: how can we together deliver these international and national right-to-health commitments?

Although first articulated long ago, the right to health remained little more than a slogan for more than 50 years. Not until 2000 did an authoritative understanding of the right emerge when the UN Committee on Economic, Social and Cultural Rights, in close collaboration with WHO and many others, adopted General Comment 14.[3]
This substantive instrument confirms that the right to health not only includes access to medical care, but also the underlying determinants of health, such as safe water, adequate sanitation, a healthy environment,

1_ For the sources and content of the right to the highest attainable standard of health, see E/CN.4/2003/58 (13 February 2003). The full formulation of the right is the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. Here, for convenience, I will use the shorthand 'right to the highest attainable standard of health' or 'right to health'.
2_ See E. D. Kinney and B. A. Clark, 'Provisions for Health and Health Care in the Constitutions of the World', 37 Cornell International Law Journal 285, 2004.
3_ General Comment 14, E/C.12/200/4 (11 August 2000).

health-related information (including on sexual and reproductive health), and freedom from discrimination. The right has a pre-occupation with disadvantaged groups, participation and accountability. It demands that health-related services be evidence-based, respectful of cultural difference, and of good quality. Moreover, it places a responsibility on high-income countries to help developing countries deliver the right to health to their people.[4]

Importantly, the international right to the highest attainable standard of health is subject to progressive realisation and resource availability. It does not impose the absurd demand that the right to health be realised immediately, overnight.[5] Nor does it expect Malawi and Zambia in 2008 to be doing as well as Germany and the United Kingdom; obviously, today Malawi and Zambia have fewer resources than the UK and Germany. Rather, international human rights law requires that a State move as expeditiously and effectively as possible towards the realization of the right to the highest attainable standard of health, with particular regard to those living in poverty and other disadvantaged groups and individuals. These steps must be deliberate, concrete and targeted. And they must, of course, take into account the resources - national and international - at the State's disposal.[6]

In my experience, many countries are most definitely not doing all they reasonably can, within their available resources, to progressively realise the right to the highest attainable standard of health, especially for those living in poverty. It is imperative that they be held to account for these shortcomings - more on accountability later.

Although General Comment 14 leaves numerous questions unanswered, it remains groundbreaking and marks the moment when the right to health ceased to be a slogan and became an important tool for all health policy makers and practitioners.

While UN Special Rapporteur on the right to the highest attainable standard of health between 2002 and a few weeks ago, I tried to make the right to health - and General Comment 14 - more specific, accessible, practical and operational. Informed by numerous consultations with a wide range of health workers, my numerous reports - all of which are public - focus on poverty, discrimination and the right to health.[7] Some reports look at the right to health in particular countries, such as Uganda, Mozambique, Peru, Romania and Sweden. Some focus on special situations, such as Guantanamo Bay, as well as the war in Lebanon and Israel during mid-2006.[8] One focuses on the World Trade Organisation. Several address broad right-to-health issues, such as maternal mortality, mental disability, access to medicines, sexual and reproductive

4_ For an accessible guide, designed for non-governmental organisations, to the right to health, see J. Asher, *The Right to Health: A Resource Manual for NGOs*, Commat/AAAS, 2004.

5_ However, the right to health gives rise to some obligations of immediate effect that are not subject to progressive realisation and resource availability. For example, a State has an immediate obligation to ensure that its health-related laws, policies, programmes and projects are non-discriminatory.

6_ See General Comment 14, from paragraph 30.

7_ For all my reports and press releases, see the Right to Health Unit at the University of Essex, http://www2.essex.ac.uk/human_rights_centre/rth/.

8_ Both reports were co-authored with other UN independent human rights experts.

health rights, and the skills drain of health professionals - a perverse subsidy from the poor to the rich that undermines the right to health of those living in sending countries, including Malawi and Zambia. My last thematic report to the UN Human Rights Council identifies the key right-to-health features of a health system,[9] while my last report to the UN General Assembly sets out *Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines*.[10]

All these reports and interventions look at issues through the right-to-health lens. In this way, they develop an analytical framework for 'unpacking' the right to health. This framework deepens understanding of complex health issues and helps to identify practical policy and programmatic responses, including measures that are meaningful to disadvantaged communities and individuals.

New skills and techniques

One of the most pressing challenges is the integration of the right to health in all national and international health-related policies.

After all, if the right to health is neither an established feature of domestic law, nor integrated into national health-related policies, what useful purpose is it really serving?
Thus, the right to health should be integrated into those policies that are designed to realise the Millennium Development Goals, as well as other poverty reduction and development policies.

After a long process of consultation, the UN Office of the High Commissioner for Human Rights has recently published guidelines to help States integrate human rights into their poverty reduction strategies.[11]

To achieve this integration, the traditional human rights methods and techniques - 'naming and shaming', letter-writing campaigns, taking test cases, slogans, and so on – are not enough.

If I visit a Minister of Health and talk in slogans and threaten test cases and letter-writing campaigns, obviously the Minister will show me the door. And rightly so. These traditional human rights methods are sometimes still needed, but new techniques and skills are also required, such as indicators, benchmarks, impact assessments and budgetary analysis. Moreover, these new methods are taking shape, reflecting the growing maturity of the health and human rights movement.[12]

Today, for example, it is widely recognised that a system of indicators and benchmarks is essential if we are to measure the progressive realisation of the right to health. Several specialised agencies, civil society organisations, academics and others are contributing to the development of appropriate indicators and benchmarks in the specific context of the right to health and other human rights.[13] One of my recent reports

9_ A/HRC/7/11 (dated 21 January 2008).
10_ A/63/263 (11 August 2008).

11_ *Principles and Guidelines for a Human Rights Approach to Poverty Reduction Strategies*, OHCHR, available on the website of OHCHR.
12_ For a discussion of some of these issues, see A. Yamin, 'The Future in the Mirror', 27(4) *Human Rights Quarterly* 2005.

sets out a human rights-based approach to health indicators.[14]

Also, a range of actors are now developing human rights - and right-to-health - impact assessments.[15] If the right to health is to be integrated into policies, a methodology is needed to help policy makers anticipate the likely impact of a projected policy on the enjoyment of the right to health, so that, if necessary, adjustments can be made to the proposed policy. I have co-authored a UNESCO-funded paper that introduces some of the growing literature on this topic and sets out, for discussion, a draft methodology for right-to-health impact assessments.[16]

The health and human rights movement is grappling with other difficult issues and questions, for example: when formulating health policies, which trade-offs are permissible and impermissible from the perspective of the right to health? Given finite budgets, how should Ministers of Health prioritise, in a manner that is respectful of the right to health, among competing objectives?[17] The health and human rights movement is developing the techniques and skills that will enable it to make a constructive contribution to these important, complex discussions.

In short, there is a new maturity about the health and human rights movement. 'Naming and shaming', test cases and slogans all have a vital role to play in the promotion and protection of the right to health, but so do indicators, benchmarks, impact assessments, budgetary analysis, and the ability to take tough policy choices in a manner that is respectful of international human rights law and practice.

13_ For example, the Office of the High Commissioner for Human Rights; also, World Health Organisation, http://www.who.int/whosis/en/index.html viewed 14 August 2007.

14_ UN Commission on Human Rights, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, (3 March 2006), E/CN.4/2006/48.

15_ For example, Norwegian Agency for Development Cooperation, *Handbook in Human Rights Assessment: State Obligations, Awareness & Empowerment* (2001); Rights and Democracy, *Human Rights Impact Assessments for Foreign Investment Projects* (2007); Humanist Committee for Human Rights (HOM), *Health Rights of Women Assessment Instrument* (2006).

16_ G. MacNaughton and P. Hunt, *Impact Assessments, Poverty and Human Rights: A Case Study Using the Right to the Highest Attainable Standard of Health* (2006), available at http://www2.essex.ac.uk/human_rights_centre/rth/ viewed 14 August 2007.

17_ For a preliminary discussion, see the report (dated 8 August 2007) to the General Assembly of the UN Special Rapporteur on the right to the highest attainable standard of health, A/62/214, chapter II.

Unfortunately, some States, international organisations, civil society groups and commentators seem oblivious to these new, encouraging developments.

Is the international right to health merely aspirational? Is it too vague to be implemented?

Some argue that the right to the highest attainable standard of health is only aspirational. They usually add that it is too vague – too imprecise – to be taken seriously.

Let us be clear: the international right to the highest attainable standard of health gives rise to legally binding obligations on States. Whether or not the relevant treaty is incorporated into domestic law, it places legally binding responsibilities on the State authorities.

As for the charge of vagueness, in fact, the right to health is as precise (if not more so) as concepts like reasonableness, fairness, justice, democracy and freedom – all of which routinely shape policy. Some of these concepts regularly come before the courts for adjudication.

Moreover, how precise are the well-established civil and political rights? How precise is freedom of expression, with its complex array of lawful limitations? How precise is the right to privacy? As for the prohibition against torture, one tribunal says torture means one thing, and another overturns that interpretation and asserts another. If civil and political rights are precise, how is it that there are so many cases – at the national, regional and international levels – exploring, clarifying and confirming exactly what they mean?

Of course there are grey areas in our understanding of the right to health. The right gives rise to difficult concepts that require further elucidation. But the same can be said for many well-established human rights.

In my view, the right to health is the victim of a double standard. A higher standard of 'precision' is demanded of the right to health than a number of other human rights and legal concepts.

It seems to me that the charge of imprecision is often an excuse for inaction. Some States, and others, say: 'Sorry, we would like to implement the right to health - but it is so vague that we cannot.'

Ten years ago that argument had some legitimacy. But our understanding of the right to health has come a long way in recent years and its so-called vagueness can no longer be permitted as an excuse for inaction - neither by States, nor international organisations, nor civil society, nor anybody else.

Uganda, neglected diseases and the right to health

In 2005, I was pleased to accept an invitation from the Government of Uganda to visit and prepare a report on neglected diseases.[18]

By neglected diseases I refer to those illnesses that are mainly suffered by poor people in poor countries. They are also known as 'poverty-related' or 'tropical' diseases. In

18_ The report is E/CN.4/2006/48/Add.2, dated 19 January 2006.

Uganda they include river blindness, sleeping sickness and lymphatic filariasis.

Neglected diseases are an enormous problem – and not just in Uganda. According to WHO, the global 'health impact of … neglected diseases is measured by severe and permanent disabilities and deformities in almost 1 billion people'.[19] Despite the astonishing scale of this suffering, these terrible diseases have historically attracted little health research and development. Why? Because those afflicted invariably have negligible purchasing power. The record shows that, hitherto, the market has failed them.[20]

Neglected diseases mainly afflict neglected communities. Importantly, it was the right to health analysis – and its preoccupation with disadvantage – that led, in the first place, to the identification of this neglected issue as a serious right to health problem demanding much greater attention.

Examining Uganda's neglected diseases through the lens of the right to health underlined the importance of a number of policy responses.

For example, it underlined the imperative of developing an *integrated* health system responsive to local priorities. Vertical health interventions that focus on only one particular disease can actually weaken the broader health system. An integrated system is essential.

In Uganda, village health teams are urgently needed to identify local health priorities. Where such teams already exist, they need strengthening. Village health teams often know the neglected diseases afflicting their villages much better than a health official in the regional or national capital.

Of course, if Uganda is to tackle neglected diseases, more health workers are essential. Additionally, however, incentives are needed to ensure that health workers are willing to serve the remote neglected communities especially afflicted by neglected diseases.

There are myths and misconceptions about the causes of neglected diseases – these can be dispelled by accessible public information campaigns.

Some of those suffering from neglected diseases are stigmatised and discriminated against – this too can be tackled by evidence-based information and education.

The international community and pharmaceutical companies also have responsibilities to provide needs-based research and development on neglected diseases, as well as other assistance.

The right to health requires that effective monitoring and accountability devices be established, not with a view to blame and punishment, but with a view to identifying what works (so it can be repeated) and what

19_ M. Kindhauser, (ed) *Communicable diseases 2002: Global defence against infectious disease threat*, Geneva, WHO, 2003 (WHO/CDS/2003.15).

20_ In recent years, the amount of research and development on neglected diseases has increased, see M. Moran and others, *The New Landscape of Neglected Disease Drug Development*, The Wellcome Trust, 2005.

does not (so it can be revised). This 'constructive accountability' is one of the most important features of the right to health – and I will come back to it later in relation to the Millennium Development Goals.[21]

In Uganda, existing parliamentary and judicial accountability mechanisms are not working in relation to neglected diseases. In my report I suggest that one way of enhancing accountability would be for the Ugandan Human Rights Commission to establish a Unit responsible for monitoring initiatives relating to these diseases. I also recommend that the Unit should go beyond monitoring and hold all actors to account. Adopting an evidence-based approach, it should endeavour to assess which initiatives are working and which are not – and if not, why not. Using the right to health as a yardstick, the Unit should consider the acts and omissions of all actors bearing on neglected diseases in Uganda, and report annually to Parliament. Significantly, the Unit should monitor and hold to account both national and international actors in both the public and private sectors.

The issues I was confronted with in Uganda were symbolised by a girl I met in a camp for internally displaced people where she lived in squalid conditions. She was suffering from disfiguring lymphatic filariasis. At school, she was mocked, bullied and unsupported. She could not stand the abuse and left school. This young woman was the victim of multiple human rights violations. As my report tries to show, the right to health signals the policies that could and should address her desperate injustice.

A few months ago, I returned to Uganda to see whether or not the recommendations set out in my earlier report had been implemented. I found that the Ministry of Health was adopting a much more integrated approach in relation to neglected diseases. Also, the Ugandan Human Rights Commission had established a Unit to monitor neglected diseases and the right to health.[22]

For present purposes, however, my point is that the right to health has something precise, practical and constructive to contribute to serious, complex health issues, such as neglected diseases. Of course, you could identify these policy proposals for neglected diseases without reference to the right to health – just as you could construct a good court system without reference to the right to a fair trial. But the right to health can help to identify good proposals and, where they already exist, the right can reinforce them.

The same applies in relation to policies that are designed to achieve the Millennium Development Goals (MDGs).

Millennium Development Goals

The Millennium Development Goals represent one of the most important strategies in the United Nations. So far as I am aware, no other set of international commitments

21_ See L. P. Freedman, 'Human rights, constructive accountability and maternal mortality in the Dominican Republic', *International Journal of Gynaecology and Obstetrics*, vol. 82, 2003, pp. 111-114.

22_ See A/HRC/4/28/Add.3 dated 21 March 2007.

and policy objectives has attracted such strategic, systemic and sustained attention since the foundation of the world organisation. The Goals have much to offer human rights, just as human rights have much to offer the Goals.

Although the MDGs have generated a great deal of literature, human rights receive relatively slight attention in this rich material.[23] This is especially surprising given the close correspondence between the Goals and a number of human rights, including the right to the highest attainable standard of health. As Kofi Annan, the former UN Secretary-General, put it: 'economic, social and cultural rights are at the heart of all the millennium development goals'.[24]

Health-related Millennium Development Goals

One of the most striking features of the MDGs is the prominence they give to health. Of the eight MDGs, four are directly related to health: Goal 4 (to reduce child mortality); Goal 5 (to improve maternal health); Goal 6 (to combat HIV/AIDS, malaria and other diseases); and Goal 7 (to ensure environmental sustainability, including reducing by half the proportion of people without sustainable access to safe drinking water).

Two other MDGs are closely related to health: Goal 1 (to eradicate extreme poverty and hunger); and Goal 8 (to develop a global partnership for development).[25] Both of the remaining goals (achieving universal primary education and empowering women - Goals 2 and 3) have a direct impact on health. It is well documented that educated girls and women provide better care and nutrition for themselves and their children.

23_ There are some notable exceptions eg Interim Report of Task Force 4 on Child Health and Maternal Health, 19 April, 2004; Ethical Globalization Initiative, Comments on Interim Report of Task Force 5 Working Group on HIV/AIDS; Grow Up Free from Poverty Coalition, 80 Million Lives, 2003; Philip Alston, 'Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen Through the Lens of the Millennium Development Goals', *Human Rights Quarterly*, vol. 27.3 (2005), pp. 755-829.

24_ A/56/326, dated 6 September 2001, para. 202.

25_ For example, one of the MDG 8 targets is to provide affordable essential drugs in developing countries.

Health is central to the MDGs because it is central to poverty reduction and development. Good health is not just an outcome of poverty reduction and development: it is a way of achieving them. But it is also more than that. As we have seen, international law - and numerous national constitutions - recognises the human right to the highest attainable standard of physical and mental health.

What does the right to health bring to the Millennium Development Goals?

The answer to this question has been signalled by the previous comments on a right-to-health approach to neglected diseases. A right-to-health approach to the Goals resonates with the right-to-health approach to neglected diseases. But the question 'What does the right to health bring to the Millennium Development Goals?' also demands some additional responses.

Helping to deliver the Millennium Development Goals to the disadvantaged and marginal

The health-related Goals are framed in terms of societal averages, for instance, to reduce the maternal mortality ratio by three-quarters (Goal 5). But the average condition of the whole population can be misleading: improvements in average health indicators can mask a decline for some disadvantaged groups. Human rights require that, so far as practical, all relevant data are disaggregated on the prohibited grounds of discrimination.[26] In this way it becomes possible to monitor the situation of marginal groups - women living in poverty, indigenous peoples, minorities and so on - and design policies that specifically address their disadvantage.[27]

This is one of the areas in which the right to health has a particular contribution to make to the achievement of the health-related Goals. Because of the special attention that it has devoted to these issues over many years, the international human rights system has a wealth of experience on non-discrimination and equality that can help to identify policies that will deliver the health-related Goals to all individuals and groups, including those that are most disadvantaged.

Enhancing participation

Participation is an integral feature of the right to health. The right to participate me-

26_ The twin principles of non-discrimination and equality are among the most fundamental elements of international human rights, including the right to health. Both principles are enumerated and elaborated in numerous international instruments.

27_ Country-level situational analyses may identify marginal groups that are not expressly included in the grounds of discrimination prohibited under international human rights law but which nonetheless demand particular attention.

ans more than free and fair elections. It also extends to the active and informed participation of individuals and communities in decision-making that affects them, including decisions that relate to health. In other words, the right to health attaches great importance to the processes by which health-related objectives are achieved, as well as to the objectives themselves.

While strategies for development and poverty reduction must be country-driven, country ownership should not be understood narrowly to mean ownership on the part of the Government alone. The strategy has to be owned by a wide range of stakeholders, including those living in poverty. Of course, this is not easy to achieve and takes time. Innovative arrangements are needed to facilitate the participation of those who are usually left out of policy making. Moreover, these arrangements must respect existing local and national democratic structures.

While the MDG initiative is highly commendable, it exhibits some of the features of the old-style, top-down, non-participatory approach to development. A greater recognition of the right to health will reduce these technocratic tendencies, enhance the participation of disadvantaged individuals and communities, and thereby improve the chances of achieving the health-related Goals for all.

Ensuring vertical interventions strengthen health systems

The right to health requires the development of effective, inclusive health systems of good quality. For the most part, the health-related MDGs are disease - specific or based on health status - malaria, tuberculosis, HIV/AIDS, maternal health and child health - and they will probably generate narrow vertical health interventions. Specific interventions of this type are not the most suitable building blocks for the long-term development of health systems. By drawing off resources and overloading fragile capacity, vertical inventions may even jeopardize progress towards the long-term goal of an effective, inclusive health system. A proper consideration of the right to health, with its focus on effective health systems, can help to ensure that vertical health interventions are designed to contribute to the strengthening of good quality health systems available to all.

More attention to health workers

Health workers - doctors, nurses, midwives, technicians, administrators, and so on - have an indispensable role to play in relation to the health-related MDGs. However, human resources are in crisis in many health systems. Unless the plight of health workers is given the most serious attention, it is hard to imagine how the health-related MDGs will be achieved in many countries. The difficult situation of health workers bears closely upon the right to health. For example, fair terms and conditions of employment for health workers is a right to health issue. As already observed, the skills drain of health professionals from South to North is also a right to health issue, as is the rural-to-urban migration of health professionals within a country. The South to North skills drain is inconsistent with Goal 8 (a global partnership for development) because here we have northern policies draining the pool

of health professionals away from developing countries. The right to health can help to ensure that these complex issues concerning health professionals, that impact directly upon the achievement of the health-related MDGs, receive the careful attention they deserve.

Sexual and reproductive health

The MDGs encompass sexual and reproductive health issues, such as maternal health, child health and HIV/AIDS. In 2005, universal access to reproductive health for all by 2015 became a new target under Goal 5.

According to the United Nations, 'sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[28] In 2004, I explored the scope of the rights to sexual and reproductive health in the context of the Cairo and Beijing world conferences of the 1990s.[29] I will not repeat that analysis here, but confine myself to three issues.

First, the right to health includes women and men having the freedom to decide if and when to reproduce. This encompasses the right to be informed about, and to have access to, safe, effective, affordable, acceptable and comprehensive methods of family planning of their choice, as well as the right to go safely through pregnancy and childbirth.

Second, adolescents and young people under 25 years of age are especially vulnerable to sexual and reproductive ill-health. In many countries, adolescents lack access to essential and relevant information and health services. Yet, as the global data confirm, their needs are acute. An estimated 16 per cent of all new HIV infections occur among those under 15, while 42 per cent of new infections occur among those aged 15-24. Every year there are 100 million new, largely curable, reported cases of sexually transmitted infections among adolescents.

The right to health places an obligation on a State to make sexual and reproductive health information available and accessible to adolescents.

Third, the global scale of maternal mortality is catastrophic. Every minute a woman dies in childbirth or from complications of pregnancy. That means well over 500,000 women each year.[30]

These deaths reveal chronic, entrenched global health inequalities. The burden of maternal mortality is borne disproportionately by developing countries: 95 per cent of these deaths occur in Africa and Asia.[31] In Sub-Saharan Africa, 1 in 16 die in pregnancy or childbirth, compared with 1 in almost 30,000 in Sweden.[32]

28_ E/CN.4/2003/RES/2003/28, dated 22 April 2003.
29_ E/CN.4/2004/49, dated 16 February 2004.

30_ A 'maternal death' is defined, according to the Tenth International Classification of Diseases, as 'the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.'
31_ UNFPA web site, http://www.unfpa.org/mothers/statistics.htm, viewed 14 August 2007.
32_ C. Ronsmans, et al. 'Maternal Mortality: Who, When, Where and Why', *The Lancet* [on line] www.thelancet.com, viewed 14 August 2007, pp.2.

Crucially, most maternal deaths are preventable.[33]

For every woman who dies from obstetric complications, approximately 30 more suffer injuries, infections and disabilities, often leading to stigma, discrimination and deepening poverty.[34]

33_Unsafe Abortion: Global and Regional Estimates of Incidence of Unsafe Abortion and Associated Mortality in 2000, WHO, 2004.

34_ UNICEF statistics, 2003, reported in S. Bernstein, Public Choices, Private Decisions: Sexual and Reproductive Health and MDGs, Millennium Project, 2006.

Pregnant women survive where they are able to access safe reproductive and maternity health care services around the clock. But eliminating preventable maternal mortality is not just a question of access to medical care. Women's health is shaped by a wide-range of factors that lie beyond the health sector, including gender equality and access to education. Maternal mortality demands collaboration across a wide-range of sectors and ministries.

There are several human rights that bear closely upon maternal mortality, most obvi-

ously the rights to health and life, as well as non-discrimination, equality, and international assistance and cooperation.[35]

We have to grasp that maternal mortality is not just a personal tragedy. It is not just a development, humanitarian and health issue. Maternal mortality is a human rights issue.

This is the central idea driving the International Initiative on Maternal Mortality and Human Rights, a civil society initiative launched by Thoraya Obaid, Mary Robinson and others at the Women Deliver conference in October 2007.[36]

The scale of maternal mortality is larger than some of the human rights issues that, for many years, have attracted much of the attention of well-established human rights non-governmental organisations. For example, several of these organisations campaign against the death penalty. Amnesty International reports that in 2006 about 1,600 people under sentence of death were executed.[37] This is almost certainly an underestimate, so let's assume this figure should be multiplied tenfold to 16,000.

In the same period, how many maternal deaths were there? About 500,000. And most of them were preventable.

The death penalty is an extremely serious human rights issue that fully deserves the human rights attention it receives. But maternal mortality is also an extremely serious human rights problem and yet it has not received the attention it deserves from the human rights community.

The time has come for established human rights non-governmental organisations to recognise that maternal mortality is a human rights catastrophe on a massive scale. It is time for them to campaign against maternal mortality just as vigorously as they have campaigned against the death penalty, disappearances, extra-judicial executions, torture, arbitrary detention, and prisoners of conscience.

Some will ask: if a preventable maternal mortality might be a violation of the right to health, who is the alleged violator? The international community for failing to do all it promised to help the State in question? The State for failing to formulate and implement the most effective maternal health policies within available resources? The health facility for alleged mismanagement or corruption? The local community for in-

35_ Those who have written on maternal mortality and human rights include: L.P. Freedman, 'Human Rights, Constructive Accountability and Maternal Mortality in the Dominican Republic: A Commentary', *International Journal of Gynaecology and Obstetrics*, Volume 82, 2003, 111-114; R. J. Cook, M.B. Dickens, et al, *Advancing Safe Motherhood Through Human Rights*, Geneva, World Health Organisation, 2001; A. Yamin and D. Maine, 'Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations', *Human Rights Quarterly*, Volume 21, Issue 3, 1999, 563-607; J. Bueno de Mesquita and P. Hunt, *Reducing Maternal Mortality: the Contribution of the Right to the Highest Attainable Standard of Health*, UNFPA/University of Essex, 2007. Apart from those contributing to a deepening human rights analysis of maternal mortality, many others have contributed in other congruent ways e.g. the political analysis in J. Shiffmann and A. Valle, 'Political History and Disparities in Safe Motherhood Between Guatemala and Honduras', *Population and Development Review* 32(1): 53-80 (March 2006).

36_ For more information contact mstoffregen@reprorights.org

37_ Amnesty International, *Facts and Figures on the Death Penalty*. http://web.amnesty.org/pages/deathpenalty-facts-eng viewed 14 August 2007.

adequate timely support for the woman who died? Or perhaps a combination of these – and other – factors.

The straight answer is that we do not always know, at first sight, who is responsible for a preventable maternal death. But that does not stop it from being a profoundly important human rights issue that must be investigated *precisely to determine where responsibility lies*, and so as to better ensure that the appropriate policy and other changes are introduced as a matter of urgency.

Of course, if there has been a breach of human rights then formally the State will be responsible. But an investigation could and should go beyond this formal, legal position and shed light on where *operational* responsibility lies. This is akin to what is sometimes needed in relation to alleged violations of civil and political rights, such as systemic, widespread 'disappearances'.

In conclusion, recognising maternal mortality for what it is - a human rights catastrophe on a massive scale - is not going to solve a complex health problem. The contribution of human rights must never be exaggerated. But neither must it be ignored.

Reinforcing Goal 8: a global partnership for development

As already suggested, developed states have some responsibilities towards the realisation of the right to health in developing countries. These responsibilities arise from the provisions relating to international assistance and cooperation in international human rights law. Importantly, international assistance and cooperation should not be understood as meaning only financial and technical assistance: it also includes the responsibility of developed states to work actively towards an international order that is conducive to the elimination of poverty and the realisation of the right to health in developing countries.

Like some other human rights and responsibilities, the parameters of international assistance and cooperation are not yet clearly drawn. However, in principle, international assistance and cooperation requires that all those in a position to assist should, first, refrain from acts that make it more difficult for the poor to realise their right to health and, second, take measures to remove obstacles that impede the poor's realisation of the right to health.[38]

The human rights concept of international assistance and cooperation resonates strongly with Goal 8, as well as the principles of global equity and shared responsibility that animate the Millennium Declaration. However, in addition, because it is enshrined in binding international human rights law, the human rights concept of international assistance and cooperation provides *legal reinforcement* to Goal 8, as well as the Declaration's principles of global equity and shared responsibility.

Shortly, I will return to the vital issue of developed states' accountability in relation to Goal 8.

38_ For a detailed consideration of a high-income country's human rights responsibility of international assistance and cooperation in health, see 5 March 2008, A/HRC/7/11/Add.2, regarding the policies of the Swedish International Development Cooperation Agency in relation to Uganda, the World Bank and IMF.

Strengthening accountability

International human rights empower individuals and communities by granting them entitlements and placing legal obligations on others. Critically, rights and obligations demand accountability: unless supported by a system of accountability they can become no more than window-dressing. Accordingly, a human rights – or right to health – approach emphasizes obligations and requires that all duty-holders be held to account for their conduct.[39]

All too often, 'accountability' is used to mean blame and punishment.[40] But this narrow understanding of the term is much too limited. A right to health accountability mechanism establishes which health policies and institutions are working, which are not, and why, with the objective of improving the realisation of the right to health for all. Such an accountability device has to be effective, transparent and accessible.

Accountability comes in many forms. At the international level, human rights treaty bodies provide an embryonic form of accountability, while at the national level a health commissioner or ombudsman may provide a degree of accountability. A democratically elected local health council is another type of accountability mechanism. Administrative arrangements, such as publicly available health impact assessments, may also enhance accountability. In relation to a human right as complex as the right to health, a range of accountability mechanisms is required and the form and mix of devices will vary from one State to another.

We have to be frank and recognise that the accountability mechanisms in relation to the Goals are weak. Human rights, including the right to health, can strengthen this accountability. Existing human rights accountability mechanisms can consider the adequacy of what States are doing to achieve the Goals. At the country level, a national human rights institution - or other independent body depending on the country context - could establish an MDG monitoring and accountability unit. At the international level, the examination by a human rights treaty body of a State's periodic report could consider those MDGs falling within the treaty body's mandate. On country mission, special rapporteurs could explore those Goals falling within their mandates.

Human rights do not provide a neat standard-form accountability mechanism that can be applied to the MDGs. More thought needs to be given to devising appropriate, effective, transparent and accessible accountability mechanisms in relation to the MDGs. If such mechanisms are not devised, the Goals will lack an indispensable feature of human rights - and, more importantly, the chances of achieving the MDGs will be seriously diminished.

Strengthening accountability for Goal 8

While the accountability mechanisms in relation to all the MDGs are weak, they are especially feeble in relation to Goal 8 (a global partnership for development). Some developed states have published reports

39_ H. Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, University of Essex, 2008.
40_ Freedman, 2003.

on their progress towards Goal 8 and such self-monitoring is very welcome. It does not, however, constitute an adequate form of accountability.

There is a long-standing perception among developing countries that accountability arrangements are imbalanced and mainly applicable to them, while developed countries escape accountability when failing to fulfil their international pledges and commitments that are of particular importance to developing countries.[41] Unfortunately, the Millennium Development initiative tends to confirm this perception. The burden of MDG reporting falls mainly upon low- and middle-income countries. This imbalance is inconsistent with the principles of reciprocity, shared responsibility and mutual accountability upon which the United Nations Millennium Declaration and its Goals are based.

This imbalance is especially regrettable because of the crucial importance of Goal 8 to developing countries, many of which suffer from acute impoverishment on a national scale. For them it is not a matter of greater efficiencies or fairer distribution among their citizens (although these considerations are often important), it is a question of an alarming shortage of resources

41_ UNDP, Bureau for Development Policy, 'Is MDG 8 on track as a global deal for human development?', prepared by J. Vandenmoortele, K. Malhotra and J. A. Lim (New York, 2003), pp.2.

and grossly inadequate budgets. In other words, Goal 8 is absolutely vital for developing countries.

From the point of view of human rights, including the right to health, it is imperative that the accountability arrangements in relation to Goal 8 be strengthened. If the international community is not able to agree on effective, transparent and accessible accountability mechanisms regarding Goal 8, developing countries may wish to establish their own independent accountability mechanism regarding the discharge of developed states' commitments under Goal 8.

I attach particular importance to accountability in relation to Goal 8 because, for many developing countries, achieving the health-related MDGs depends to a large degree upon developed states honouring their commitments under Goal 8.

While, to their credit, many developed states are endeavouring to deliver their Goal 8 commitments, this does not diminish the need for effective, transparent and accessible accountability mechanisms in relation to these vital commitments.

For their part, developed states are right to call for greater accountability in developing states. But this is a two-way street. Greater accountability is also urgently needed in relation to developed countries' international pledges and commitments that are so vital to those living in poverty in low and middle-income states.

Conclusion: the complementary relationship between health and human rights

I have not considered all the issues where human rights and the Millennium Development Goals intersect and reinforce each other.

Human rights, for example, have a crucial role to play in relation to Goal 6 – halting and reversing the spread of HIV/AIDS. Stigma and discrimination are critical factors in the spread of HIV/AIDS because they undermine prevention, treatment and care. Women and girls are especially vulnerable to HIV/AIDS when they lack control over their bodies and sexual lives – in other words, when their human rights are denied. On public health and human rights grounds, it is imperative that prevention, treatment and care strategies target at-risk populations, including commercial sex workers and their clients, and men who have sex with men. It is wrong on public health, human rights and humanitarian grounds when hospitals refuse to treat people living with HIV/AIDS. Human rights can help States achieve the HIV/AIDS Millennium Development Goal,

just as they have a contribution to make in the struggle against neglected diseases and maternal mortality.

Obviously, the right to health depends upon health workers who enhance public health and deliver medical care. Equally, the classic, traditional objectives of the health professions can benefit from the new, dynamic discipline of human rights. Health workers can use the right to health to help them devise equitable policies and programmes that benefit the most disadvantaged; strengthen health systems; place important health issues higher up national and international agendas; secure better coordination across health-related sectors; raise more funds from the Treasury; leverage more funds from developed to developing countries; in some countries, improve the terms and conditions of those working in the health sector; and so on. In short, the right to the highest attainable standard of health is an asset and ally, which is at the disposal of all health workers.[42]

I urge health and human rights workers to recognise their common ground and to collaborate together in our collective struggle to achieve all the Millennium Development Goals and the elimination of that human rights catastrophe – preventable maternal mortality. ■

42_ See BMA, *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, BMA/Zed Books, 2001.

Promoting gender equity in global funding

Françoise Ndayishimiye
Senior Gender Adviser, Former Board Member, Communities delegation in the The Global Fund To Fight AIDS, Tuberculosis and Malaria, Geneva

I. Why should we promote gender sensitive planning?

- Gender sensitive planning attempt to redress existing gender inequalities
- Gender inequalities are a strong driver of the HIV/AIDS, TB and malaria epidemics and close attention needs to be paid to how such inequalities fuel the spread of disease and affect the ability of women and girls, men and boys to access health-care services equally.
- Gender inequality and stigma / discrimination of women and girls especially those living with HIV, of sexual minorities have a very adverse impact on the spread of HIV.

- The needs of people living with HIV/AIDS (PLWA) in sexual and reproductive health are ignored especially for young couple and their rights are not recognised or respected.
- The lack of engagement of men is also a causing the failure of many prevention programmes like Prevention of Mother to Child Transmission (PMTCT) programme, Family Planning (FP)
- The fight against gender inequality constitute a cornerstone of effective prevention of HIV, tuberculosis and malaria

Gender inequalities and discrimination persisted because of:

- Cultural and religious belief and practices to the disadvantage of women, girls and discrimination sexual minorities,
- Lack of social acceptance of sexual and reproductive rights for people living with HIV;
- Non-involvement of men in the reproductive health;
- Lack of access to support services for women (fear of stigma, fear of their husbands, long distance in the absence of means for transport);
- Lack of access to information or erroneous messages that criminalise women and girls behaviours, especially those living with HIV/AIDS.
- Practices of sexual exploitation of girls in-

cluding female circumcision of girls that are culturally accepted;
- Sexual abuse made against women and girls especially in situations of armed conflict;
- Gender inequalities in the occupation of decision-making positions.

II. Universal access to sexual and reproductive health and rights

For better universal access to sexual and reproductive health and rights, we need to respect and recognise the needs of sexual and reproductive health of people living with HIV taking in account all determinants based on cultural and social issues.
- Right to sexual education,
- Right to reproduction,
- Right to family planning services,
- Right to Voluntary Testing and Counselling,
- Right to Prevention of Mother To Child Transmission (PMTCT) services,
- Need of men engagement in the sexual and reproductive health programmes;

III. Gender equality and male engagement
- Men need to be targeted during all the interventions aiming sexual and reproductive health including:
- Behaviour change promotion,
- Sexual and reproduction education,
- Antenatal consultation,
- PMTCT programmes,
- Family planning,
- Better information on and strong fight of young girls and women abuse;
- Better information on the male circumcision as one of the way of HIV Prevention
- The male engagement is especially necessary when one or both in the couple is HIV positive, in other to ensure primary protection or to avoid multiple infection by using condoms.

IV. How to promote gender equity in global funding?
- There is no standard or normative gender sensitive planning because of Cultural diversity that influence taking in account the gender dimension.
- The gender sensitive planning must involve the communities with emphasise on the concerned persons: women, young girls, young boys, sexual minorities and men; especially, those living with HIV.
- The programmes' designers should:
- Engage, involve at all level and empower women and young girls and especially those already infected;
- Ensure a participatory planning specific to each country is developed to propose durable solutions;
- Ensure that the link between fighting for human rights, gender equality and fighting against sexual minorities' discrimination is better defined;
- Consider the specific gender issues in different communities while developing policies and programmes on gender.

V. What global funding processes can contribute to?

The global funding processes can contribute in different manners:
- Supporting countries to take the gender dimension of their epidemic into account through;

- Situation analysis within countries and better planning;
- Support the advocacy related with gender equality;
- Support experience exchanges of what has worked in similar situations;
- Ensure that the grants financed, appropriately cover equal and equitable access for all on different prevention, treatment and care services and that the gender dimension is well taken in account;
- Ensure there is a coordination at different level and with main participating partners;
- The partnership will take in account also:
- Technical assistance,
- Normative guidance and capture of what works,
- Support advocacy in program development, governance and implementation,
- Co-financing of interventions that address gender inequalities,
- Developing operational research on what works for sharing,
- Developing new technologies with particulars focus on gender.

VI. How the Global Fund to fight Aids, Tuberculosis and Malaria (GFATM) is engaging in this?

The GFATM is developing a Gender Strategy to ensure gender equality in the response to HIV/AIDS, tuberculosis and malaria. This strategy is aiming to ensure the GF grants support services and intervention that meet the needs of most vulnerable and marginalised, including women, girls and sexual minorities. The GFATM will play a catalytic role by supporting countries to take the gender dimension of their epidemic into account. It will work in partnership with other key stakeholders for more efficiency in this work.

Conclusion

We have to promote gender equity in global funding to achieve universal access to sexual and reproductive health and rights; the

process should begin by specific situation analysis for better planning, it should involve the stakeholders especially the communities in addition of others stakeholders. But the involvement is not enough; it should be strengthened by the empowerment of women, young girls and sexual minorities and by promoting the engagement of men. ■

Gender – culture – reproductive rights and health: a scope for action in German development cooperation

Erich Stather
Federal Ministry for Economic Cooperation and Development (BMZ), Germany

Introduction

This year, gynaecologist Monika Hauser was awarded the 'Alternative Nobel Prize' – which I was personally very pleased about. She was honoured for 'her tireless commitment to working with women who have experienced the most horrific sexual violence in some of the most dangerous countries in the world'. For all too long, rape in crises and conflicts was regarded as 'collateral damage'. It is thanks to people such as Monika Hauser that the UN Security Council ratified a resolution this summer which stated in clear and unequivocal terms: rape is a war crime! Fourteen years after the International Conference on Population and Development (ICPD) in Cairo in 1994, we have to note with concern that, in many parts of the world, progress in the area of sexual and reproductive health is far behind the goals we set ourselves. Moreover, we are lagging behind in realising the Millennium Development Goals (MDGs) on gender equality and maternal health. We cannot allow there to be any 'forgotten MDGs'!

Consequently, we need to increase our efforts! We do not only owe it to the women of this world but to everyone. After all, women are decisive in achieving the Millennium Development Goals!

I No development without gender equality

The world reveals a grim picture of women's rights and chances.

All around the globe, in comparison to men, women are disadvantaged. The face of the following is female:

- extreme poverty (worldwide 70 per cent of women)

- lack of property (women own 1 per cent of assets worldwide)
- illiteracy (worldwide 60 per cent of women)
- the global 130 million victims of genital mutilation, with three million more added every year.

Or take maternal mortality as another example. It is totally unacceptable that the risk of dying in pregnancy or childbirth is 300 times higher in Africa than in industrialised countries.
In no other area of health care is the contrast between rich and poor as shocking as in maternal health.

Discriminating against women and disadvantaging them is not only deeply inhumane and unfair, it is also totally irrational in economic terms! Studies by the World Bank show that gender equality generates economic growth. Gender equality is a basic requirement for sustainable development and the realisation of all MDGs.

II Seeing culture as a chance
Cultural sensitivity is just as important as the sensitivity to gender issues.

Culture has a decisive influence on a society's capabilities. It is a source of creativity and innovation - and that is why we have to learn to understand cultural, traditional and religious convictions. After all, people regard changes to their cultural surround as a threat, and as an attack on their identity.

For example, Afghanistan: 43 per cent of Afghans, both men and women, believe the presence of foreign troops is threatening local customs and Islamic values. However, culture is not a value in itself – traditions can also hamper human development. Maintaining customs can become an end in itself or serve as a pretext for suppression. We must tolerate cultural differences but should not be afraid of openly debating those differences when human rights are at stake – discussing them not only with our partners, but also with donors and international organisations.

For example, India: In the space of twenty years, deliberately aborting girls in India has probably led to around 10 million women too few. It is an archaic image of women that says girls are worth less than boys. Here, a critical dialogue has to be conducted to support universal human rights.

This has nothing to do with western arrogance. Quite the contrary. Where 'cultural correctness' is misunderstood, it is always at the cost of the victims – and that means at the cost of women in particular.

My attitude is unequivocal - zero tolerance for violence against women. Even when it appears in the guise of cultural differences.
Women's rights are human rights. Every person has the right to physical integrity. Female genital mutilation violates this right. It takes away a small part of the girls and women's bodies – and a large part of their dignity.

Genital mutilation is not a culture, it is not a religion – the Koran does not prescribe it

and the highest Islamic scholars say: Genital mutilation is a crime against the creator! Genital mutilation is a serious human rights violation and a form of suppression. We cannot shut our eyes to it. We have to speak out against those who defend genital mutilation on the grounds of other 'cultures'.

III German development policy contribution

Gender equality is a question of our credibility and, hence, an explicit goal of German development policy and a task integrated into all our projects!

50 per cent of German development cooperation funds flow into projects promoting gender equality. Roughly 25 per cent of funds flow directly into strengthening women's rights and roles.

I am focusing on the question: What can we do concretely to strengthen reproductive and sexual health?

1. Make health care policy gender equitable

International health care policy has to take the needs of both genders into account. We consider it a major success that the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) has developed a gender strategy. We have been expressly calling for this. Francoise Ndayishimiye, the previous speaker, is designated Champion for Gender Equality in the Global Fund – and I am very pleased that you are able to be here.

2. Promoting sexual and reproductive health, combating HIV

Half a million women die every year from complications in pregnancy or childbirth – and 99 per cent of them in developing countries! Universal access to reproductive health is one particular target set by the Millennium Development Goals – and that put us under an obligation to achieve successes here by 2015. The HIV infection rate among women is rising over-proportionally. 61 per cent of those infected in sub-Saharan Africa are women. More than 200 million women worldwide have no chance to use contraceptives and protect themselves against HIV/AIDS.

- Our contribution: From 2008 on, providing around Euro 500 million annually for the global fight against HIV/AIDS, tuberculosis and malaria.
- A Social Marketing Programme for condoms in over 34 countries - not only providing condoms but the requisite information as well.
- Bilateral programmes in over 40 countries. Health is a main focus in 14 of our partner countries: strengthening health systems, promoting social security systems and supporting prevention campaigns.

3. Using the chances that culture offers but also speaking out against human rights violations disguised as culture.

For example, Cameroon: 4000 young single mothers received training in a communicator role as so-called 'aunties'. This model builds on the traditional role of aunts in their nieces' sex education. This has a positive effect in two ways: as 'aunties', marginalised young women enjoy a new respect and over 50,000 young women can receive counselling, attention and information. And not only for their concerns with sexual and

reproductive health.
For example, combating HIV/AIDS: In countries coined by Islamic beliefs, Islamic values are incorporated into the programmes combating HIV/AIDS. We work together with Muslim players and dignitaries.

For example, Benin: In 2003, Benin legally banned female genital mutilation after it had existed there for centuries as a deeply rooted and unquestioned tradition. It was not only prohibited but there was also a national ceremony to end the practice. Today, 93 per cent of women and 95 per cent of men in Benin are against genital mutilation!

That goes to show that if one seriously makes the effort, supposedly deep-seated traditions can be overcome within a single generation.

That is a heartening development and gives me hope for the worldwide abolition of genital mutilation!

Concluding remarks
At the General Assembly of the United Nations in New York September 2008, the international community of states underlined its determination to strengthen involvement.

We have to reduce worldwide poverty, strengthen equal rights, cut maternal mortality, and create universal access to reproductive health by 2015.

We cannot allow ourselves to slacken our efforts – no country in the world can afford not to fully use the potential its women citizens offer. I am totally convinced that we need the power, courage and potential of women to achieve the MDGs. If we give women the same chances to participate, they will build the future! For a ministry, gender issues and cultural and value issues are key integrated tasks which we need to prepare for in organisational terms. Culturally sensitive approaches are needed – but cultural sensitivity should never be allowed to disguise human rights violations! We cannot revert to 'cultural correctness'. We have to make unequivocally clear, without ifs, ands, or buts, that women's rights are human rights. I hope that, in this spirit, this Conference will provide an impetus forwards! ■

'World Café of opportunities'

Impressions

During the World Café session, conference participants met around small tables in a relaxed, 'café-style' atmosphere. Under the guidance of moderator Dr. Sibyl Dümchen, the participants were soon interactively discussing the overarching questions of the conference. These were:

- What can examples of experience teach us about the way culture, gender and SRHR are interrelated?
- How can fostering gender equality and a culturally sensitive approach play a part in achieving universal access to sexual and reproductive health?
- What are key cultural and gender-specific factors influencing the success of programmes and campaigns?

These questions were further broken down into particular aspects for the groups to debate:

1 The 'Culture Lens': culture and tradition
'Culture has always been relevant to development. Culture is a right – and, moreover, an equal right. Diversity and the varied experiences it brings should be honoured and understood. This is fundamental to every people's 'right to development'.'

2 Health systems: gender equity and cultural sensitivity

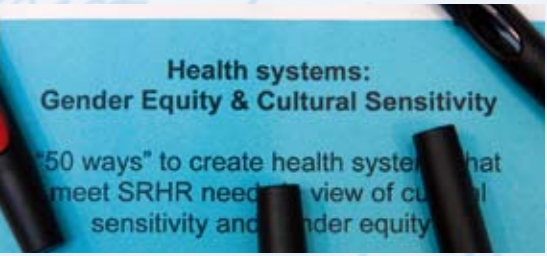
'50 ways' to create health systems that meet / match the SRHR needs of people. Please list your recommendations on health systems, cultural sensitivity and gender equity.

3 Human rights and culture
Human development, including advances on the MDGs (MDG 5 in particular), depends on a realisation of human rights that is only possible when engaging with and respecting cultures, and translating human rights into cultural concepts, meanings and contexts.

4 Gender equality, 'men engage' and culture
The integration of boys and men in promoting SRHR is essential for the SRHR of all. It is important to ensure that boys and men in predominantly patriarchal societies understand their own SRHR and promote the SRHR of girls and women and young people. How can gender equality be promoted (at all levels) and create opportunities to involve men?

The participants were free to choose their preferred focus for discussion. The table cloths were different colours to allow the discussion groups to be easily identified. The tables were also equipped with large sheets of white paper for the participants to jot down their statements during the discussions.

In addition to these overarching issues, each group was asked to discuss a set of concrete questions:



Group 1
- How can German development cooperation work together with positive cultures and traditions to promote SRHR?
- What role does reproduction and sexuality play in people's traditions and culture?
- What different traditions and cultures most influence/affect SRHR?
- Why are culture and traditions so important in promoting SRHR?
- Youth and culture - What role can/must they play?
- What importance does culture have for young people and how does this affect SRHR?

Group 2
- Young people's rights – given evolving capacities, how can access to information and services be improved?
- What can be done to improve access to health supplies?
- What are the roles of the various national level agencies involved in achieving young people's SRR? (Government, private sector, youth movement, civil society, etc.)
- What can international donors do to link strengthening of the health system and access to SRH services?
- What can German development cooperation do to improve health systems?

Group 3
- Where does respect for cultural diversity end and the need for the protection of hu man rights start?
- Are culture and cultural sensitivity opposed to human rights? Relativism versus univer-

salism? Are these two values incompatible and at opposite ends of the spectrum?
- Young people are frequently a lightning rod for SRHR issues, yet many people feel uneasy about trusting them to make decisions on their sexuality and rights. Do young people have a right to sexual pleasure?
- Where is the line between the right to protection and the right to autonomy for
- young people and their sexual behaviour? Should the age of consent be the same for young men and women in all cultures?
- How can German development cooperation find a compromise between respecting cultural diversity and safeguarding human rights?

Group 4
- What culturally sensitive approaches to tackle discrimination, stigma and violence should be promoted and why?
- What is the role of men in SRHR; why and how can and should they be involved?
- How can culture support young people's evolving capacity to understand their sexual identity? Does this vary by gender? Should gay and lesbian young people have the same rights in all cultures as straight young people?
- How can German development cooperation support the involvement of men in promoting SRHR?

At a 'Town hall meeting', the main results were then presented and discussed in plenary .

Wrap-up of the day and outlook

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

I want to start by just reading you part of a recent statement from Ban Ki-moon. He said: 'Passing the midpoint to the 2015 deadline for the Millennium Development Goals, we face a development emergency. Millions of people are still trapped in structural poverty and go hungry every day. As we celebrate the 60th anniversary of the Universal Declaration of Human Rights, let us remember that development should not be a privilege of the few but the right for all.' And so with that in our minds, I would like firstly to thank the minister and the ministry, and all of the organisations that have organised today and all of you making it such a rich, challenging and interesting day, and for giving us, I think, many ideas that we will follow in a variety of ways.

I don't have to ask you about the process, you have already responded to that. But hopefully that did help to build the networking. We have seen and we have discussed dialogue among people of different genders, cultures, traditions and languages. We have actually walked the talk today. We have people here from government, from civil society including NGOs and from the private sector, we have the young and the not so young, we have men and women. And this in fact has demonstrated exactly what this is all about. The importance of collaboration, the importance of finding the common ground of a shared vision, of finding ways to move forward. As someone said at a table when I went past, 'well I actually don't think people want women to die', and I imagine that should be the ultimate bottom line.

What I am going to do is run through some of what we said today and then give you what I have heard as the recommendations. You probably have an entirely separate list. The day really did bring up a lot of ideas about what we need to do if we are going to achieve a brighter better world for the largest generation of young people the world

has ever seen, if we are going to eliminate the massive gender injustice of maternal mortality and morbidity. As the German minister of development said recently at a side meeting at a recent UN high level event, and I will say it again today: 'Maternal mortality only happens to women, it cannot happen to men.' She was talking about the deaths that come so needlessly every minute as part of the preventable pandemic of maternal mortality.

It has also been a very paradoxical discussion. We have heard some things that are in some ways directly contradictory of each other. This morning we began with Claudia Radeke reminding us about the taboos that sometimes prevent people from even speaking about sexual and reproductive health. As a side comment, it seems we have reached the point now in the United States where we cannot even talk family planning, because people start to think that we actually mean abortion. Now, how illogical is that? If there is one thing that can help to prevent the need for abortion then surely it is family planning. And it always amazes me that those who are opposed to abortion are equally opposed to sex education and contraception — often the very things that could prevent it. She went on to remind us about the growth in inequity that exists between countries and within countries. And it is not just a North-South divide. We know within all countries, even in the poorest countries, there are some who are rich, that access to family planning, to contraception, to safe abortion is something they can access, but we also know even within Europe, the number of countries that subsidise family planning has decreased hugely. But in particular of course we are concerned about the developing world, where the chronically poor become poorer.

Klaus Brill highlighted the regional differences also, but emphasised that we do need to find ways to bridge cultural differences and to recognise human rights and bring together rights and culture. Whether it is at the UN level or as individuals working in communities, everyone, all of us, has a role to play if we are to improve maternal health and increase gender equity. And I have a couple of more questions. I come from the Pacific and when you say to a Pacific parliamentarian whom I know, and she is actually a princess, and you say to her 'What do you think about culture? What do you think about your traditional culture?' She says to me, „Which culture? If I go back before Christianity and colonialism, women had status in the Pacific. Today, we have very little. We no longer sit of the head of the table; we no longer have a special place. If you talk to me about culture, take me back before the missionaries and then let us talk about my culture.'And I want to ask you too, when we talk gender, what do we mean? Are we using it as synonym, as a word that means the same as 'women' because for so long at the UN we could not talk about women's rights, so we had to talk about gender? Or are we talking about a continuum of men, women and the fact that there are many and various points along that continuum. In some countries like Indonesia, Thailand, and many other countries, a man who considers himself to be entirely heterosexual and straight might have sex with another man to earn money or for

some kind of sexual relief. Who knows? But if you say to him: 'Are you gay?' He may well look at you in horror and say: 'No, I am absolutely straight.' That man will go back to his wife or his girlfriend. So do we think then, when we talk about gender of what has become known as 'sexual minorities', or are we really just talking about women or, as I think today has been about, are we talking about men and women?

I watched, I think, the world's first transgender member of parliament stand up in our House of Parliament back in New Zealand, before I came to England, and it was the last day of the debate about the decriminalisation of sex work, a highly controversial subject. It was introduced for two reasons, public health and human rights. She stood up and she said: 'I think I am the only person in this House who has ever been a sex worker, and I am sure I am the only person in this House who has ever been a transgender sex worker.' And she continued: 'I am here to tell you and the people of this country that I had no rights, no one could protect me if my client beat me, no one could protect me if my employer beat me. I could not go for health care, I could not admit what I did, I had no rights.' She was a nonperson. That is what I mean about gender and rights. They passed that bill by one vote only. But I think it is worth thinking about that absolute denial of the basic human rights, which many of us here are fortunate enough to take for granted.

Thoraya Obaid reminded us that culture is central to our lives and central to development, that we must all be agents of change and that we must work from within, not dictate from the outside. She talked about the importance of local community, which is the key to developing societies that are more sensitive. It is not so long ago since the English would have had this table cloth right down to the floor because no legs were allowed to be seen, not even table legs. And certainly not human legs or women's legs. That was part of English culture. I guess the most dramatic demonstration of cultural change that some of us could think, of course, is the situation in China where women's feet are no longer bound. What brought that change about? How did that happen? I think we have a lesson to learn from that. Thoraya Obaid went on to talk about how the processes of change must respect cultural traditions, respect the people and respect women.

Paul Hunt described how human rights are more than an added bonus, and I really want to stress that. Human rights are not a nice-to-have, a let's-add-it-on or yes-we'd-better-think-about-it additional extra. I think we all know that, we believe it, but it can happen. He went on to remind us that they are legal obligations that governments are required to respect, protect and fulfil. They are not an 'either/or'; they are legal requirements. He spoke of a deepening of the human rights approach. I just want to pick up on that point. There was some discussion about the figure of 200 million women who lack access to effective modern contraception and whether that is the right number or wrong number. Certainly I have read figures of around 120, 130 million couples. I don't think any of those figures around contracep-

tive prevalence include unmarried women or men, or those not in a relationship, because of course it is assumed that they don't have sex. So these are not realistic figures. It is just the same as we cannot give accurate figures for unsafe abortion or how many women die as a result, because we don't know, because those deaths are so often invisible, as often were their lives.

I think it is really important to remember that we use an evidence base as we heard from Paul, but we also heard from him an absolute passion that this growth of denial of human rights, this huge gender injustice of maternal mortality and morbidity, of one woman dying every minute, simply cannot be allowed to continue. And yes, a new financing development mechanism has been set up. But can we not just have the money to do it without needing a new mechanism? Twenty years on we see no change in global figures.

Françoise Ndayishimiye reminded us of the importance of the involvement of people living with HIV and AIDS. It is the argument, 'Not about us without us'. This is absolutely true. We need to do gender-sensitive planning for reproductive health with people living with HIV and AIDS so that they too are able to enjoy their rights to reproductive health and sexual health. We were reminded of the critical importance of sexual and reproductive health and rights in every situation, including emergency situations which

are all too often overlooked.
Gita Sen asked us a really challenging question: 'Why hasn't the major paradigm shift embedded in ICPD been implemented?' And she gave us seven priorities, which are to: address the structures that foster gender inequity at every level; challenge gender stereotypes; reduce the health risks of both men and women; transform gendered policy; improve the evidence base, and the importance of disaggregated data; take actions to ensure gender mainstreaming are owned, funded and implemented; and support women's organisations. She spoke of the importance of sexual rights and I want to take a moment here, as Gita referred to our new Declaration of Sexual Rights. Some of you might wonder, 'why on earth is IPPF, the International Planned Parenthood Federation, getting into sexual rights?' Well, it is part of reminding people, some of whom would rather forget, that sex does come before reproduction. This is true at least in 99 per cent of cases, probably a little less in some countries now thanks to in-vitro fertilisation and other assisted reproductive technologies. Sex comes before reproduction and very often it is separate from reproduction. How can we address the pandemic of HIV and AIDS unless we address sexual rights? It is sexual activity that largely drives the epidemic. That means that 65 per cent of those infected in many countries are women, that means that 6,000 young people are infected every day – one every 14 seconds – the majority of them women. How can we change that? If we cannot even say 'sex', if we cannot say 'sexuality'? If we cannot even speak of sexual rights, then how will we stop the pandemic that is destroying whole countries, devastating families.
Gita also spoke about the importance of priorities, and these include shaping our institutions and structures to foster gender equity. The other day I watched a group from the EU launch the EU mid-term review of the Millennium Development Goals (MDGs) at the UN high level event. There were six men on that panel, and not a woman in sight. And yet most of the conversation was about MDGs 5 and 3.

We need to challenge gender stereotypes to reduce the health risks for both men and women because one will affect the other, and so transform gender policy. I come from an organisation that surprisingly even a few years was dominated by men. We now have a requirement that the governance board of every Member Association must be 50 per cent women. I believe that is as important as the service delivery we do in many ways, and these Boards must also include young people. It is fantastic to see a couple of IPPF youth volunteers here, because they are the future. If they learn good governance, they will be parliamentarians, they will be prime ministers.

Gita Sen went on to talk about the improving the evidence base and the need for disaggregated data. One of the problems with MDG 5 is that we don't have a benchmark. Why don't we have a benchmark? Because many countries have never counted the number of women who die as result of pregnancy or reasons related to childbirth. And yet, they are the major cause of death for girls ages 15 to 19 in the developing world. Let us never forget that statistic. What a

shameful waste of women who are in the prime of their life, who could contribute to their families, to their communities and to their countries, and to sustainable, social and economic development! We must take action to ensure gender mainstreaming is owned, funded and implemented. We must support women's organisations in terms of funding.

The State Secretary Erich Stather reminded us of how off-track we are in meeting the goals of ICPD and MDGs, in particular MDG 5. He also reminded us that the UN had agreed that maternal mortality is entirely preventable and that we are aiming to achieve both the ICPD Programme of Action and MDG 5. He also shared a stunning statistic that I certainly did not know— that 1 per cent of global assets is owned by women. He also reminded us that some 60 per cent of those who are illiterate are women. Surely we have a long way to go really before men should feel disempowered by the threat of women's empowerment? In all seriousness, giving women empowerment does not mean disempowerment of men. It simply means both can be strong, both can be equal. As a result the family and the community are stronger. The State Secretary also spoke of the importance of gender-sensitive policies and to use the opportunities offered by culture.
We had a great deal of discussion this afternoon; I am not going to attempt to capture what you said. We had some interesting discussions and feedback, including some major suggestions and recommendations. But there is an old saying from the American indigenous people: 'A vision without a

task is just a dream, and a task without a dream is drudgery. But a vision with a task can change the world'.

So what are our tasks after today? Well, just going quickly through some of the recommendations:

From Thoraya Obaid: Look for the common ground. There will always be the edges where we differ, but look for the comment ground, build relationships and be agents of change.

I have already given you Gita's recommendations: seven very clear priorities.

Paul Hunt's: I think if you want a big goal, this is it, and this is our vision in IPPF as well: Embark on an initiative to take maternal mortality through the human rights mechanisms of the United Nations, because it is a human right to health that is denied, it is the human right to bodily integrity that has been denied. That is actually a major initiative and recommendation that a number of people here could work on together. We must find ways to operationalise human rights, not just to talk about them.

I would like to add just a couple things of my own, which I did not hear today. I would like to encourage Germany to take the lead in the EU to prevent a rollback on funding for these issues and the denial of sexual and reproductive health and rights and their importance. We know funding is less than it was and we know the chance of a rollback is greater than it used to be. I urge the government to continue to work with partner governments and with recipient country governments to ensure that sexual and reproductive health and rights do not fall off the agenda. I don't believe because of basket funding and budget support that countries that have spent little so far on sexual and reproductive health and rights, on family planning, or child and adolescent health are suddenly going to say: Oh yes, let's make this a priority now. I think we all in this room have to work towards making sure that these issues that have been so long neglected become the priority they should be.

Moving on, several times we have heard 'involve young people'. Indeed they are not just the future, they are active citizens now and they have the right to participate. They have the right to sexual health, to information and to services in line with their evolving capacity. Also, we must involve men for the sake of their own health and well-being and that of their wives. We have heard many ways of which this could be done. I think this is a critical issue, it is an ICPD issue. Why have we not got further?

Another from me. We have target 5b in the Millennium Development Goals. We fought for years for a ninth Millennium Development Goal: the Cairo goal of universal access to reproductive health, the missing link. Now we have it as target 5b in the MDGs. It has clear indicators. We must – government, civil society and individuals – work to seize that opportunity and really hold governments accountable, and offer to be part, with other members of civil society, of delivering strategies in line with that target. We talk about 2015 as if something, somehow, is going to happen magically, but we need to think

what is beyond. The MDGs are not an end in and of themselves, but a means.

Going back to today's recommendations. A reminder to reach and involve the poorest and most marginalised people; to ensure that culturally appropriate, accessible and of high quality health services are available. For any of us involved in service delivery that is critical. We must carry out maternal health audits, as Gita Sen discussed. We need to use human rights to ensure accountability. We need to develop and implement gender-sensitive policies and programmes. If we only stopped each time we develop a policy or a programme and said: What is the impact of this on women? What is the impact of this on men? What is the impact of this on gay, lesbian, bisexual and transgender people? What is the impact of this on young people? If we asked ourselves those questions every time, whether about a policy or a programme, the world would be a very different place.

We were reminded of the need to encourage the global fund to increase its focus on gender – and I think just in the last year there has been a dramatic change partly through civil society, partly through governments like Germany's. The recommendations are to encourage women's economic empowerment; encourage the integration of sexual and reproductive health including family planning and HIV and AIDS, transmission from mother to child is responsible for 10 per cent of new infections and it can be easily prevented, without infringing on human rights. We were encouraged to remember the importance of language that is inclusive and open, and not judgmental. And we were encouraged to remember the importance of sex education. If we want to break down gender stereotypes, and reduce violence against women.

We must hold governments accountable for the promises they have made to fund policy promises, and monitor the progress and funding levels, and in particular use the opportunity provided by the new MDG target, target 5b universal access to reproductive health by 2015, the goal of the ICPD.

We must reach the poorest and most marginalised who often will include young people, in many countries.

In finishing, I want to go back to the words of Nafis Sadik in 1992. She described a woman's freedom to control her fertility as the freedom from which other freedoms flow and this is as true today as it was then. We are meeting here at a time when civil society has been more strongly promoted at Accra than in the Paris Declaration, but is simultaneously threatened in many countries which fear civil society as advocates for human rights, and at a time when millions are still unable to lead lives of dignity and meaning, and yet Ban Ki-Moon has just reminded us in a recent statement that development is the right of all. We have talked about common ground and collaboration and today has modelled that and we have talked about each of us being responsible for moving forward, so my last recommendation is that we reach out to others across communities, across cultures, and, knowing, with the wisdom of Africa, 'if you want to go fast, go alone; if you want to go far, take others with you'. ■

Curricula Vitae

BRILL, Klaus

is Vice President Corporate Commercial Relations at Bayer Schering Pharma AG, Berlin. 1982 he joined Schering as Medical Advisor in various fields (fertility control, hormone replacement therapy, prostatic cancer). Further career milestones at Bayer Schering Pharma are: Head of Department Medical Affairs Gynaecology / Marketing Gynaecology, Head of Business Unit Gynaecology in the German operations and Head of Strategy and Portfolio Management Global Business Unit Women's Healthcare.

DÜMCHEN, Sybil

is an international management consultant and coach. After gaining a PhD in romance studies she worked as editorial journalist and publisher of the journal 'Lendemains' and as scientific assistant at the Freie Universität Berlin. Dr. Dümchen joined denkmodell® in 1996 as CEO, coach and consultant. Her work focuses on gestalt-oriented organisational development and facilitation, and multi-media coaching in ZOPP and SINFONIE®. Among other she worked for Heinrich-Böll-Stiftung, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, InWEnt – Internationale Entwicklung und Weiterbildung gGmbH and the World Bank.

GÖBEL, Alexander

works as a freelancer for the German and English programmes of DW-RADIO. He studied North American studies, economics and political science in Bonn und Bloomington, USA. He held a scholarship for the 'Deutsch-Südliches Afrika Journalisten-Programm' of the International Journalists' Programmes (IJP). His travel reportages led him to South- and Central-America. Amongst others he worked as crisis reporter for ARD and as lecturer at the DW-Akademie.

GREER, Gill

is Director-General of the International Planned Parenthood Federation (IPPF), appointed in 2006. She is a highly experienced and committed sexual and reproductive health professional and has been the Executive Director of the New Zealand Family Planning Association since 1998. She also chairs the Asia Pacific Alliance (a network of 30 NGOs in seven countries), and the New Zealand NGO Ministry of Health Forum (a network of more than 100 NGOs). Dr. Greer has been a member of the New Zealand government delegations to the United Nations General Assembly Session on HIV/AIDS (2006), the United Nations World Summit (2005), the Commission on the Status of Women (2005) and the Commission on Population and Development (2004). Dr. Greer has been awarded the New Zealand Order of Merit for services to family planning.

HUNT, Paul

is an adjunct professor at the University of Waikato, New Zealand, and a professor at the University of Essex, England. 1999-2002 he served as an independent expert on the UN Committee on Economic, Social and Cultural Rights. In 2002, he was appointed the UN Special Rapporteur on the Right to Health for a three-year term that was extended in 2005 for a second term of three years. At the request of the UN Office of the High Commissioner for Human Rights, he also co-authored draft human rights guidelines for poverty reduction strategies. He has practised as a solicitor in London and held the posts of Legal Officer and Acting General Secretary with the National Council for Civil Liberties in the UK. He has also lived, and undertaken human rights work, in the Middle East, Africa, Europe and the South Pacific. Professor Hunt has published widely on human rights issues, focusing particularly on economic, social and cultural rights.

ITCHYBAN

is frontman of the music group Culcha Candela. He was born in Wroclaw, Poland. The seven members of the band met in Berlin in 2001. They all have different cultural and ethnical backgrounds. They sing and rap in German, Spanish and Patois. The group also shows political commitment. They contributed to the DVD 'Kein Bock auf Nazis', part of an initiative against racism and neo-national socialism in Germany. The band supports the 'Africa Rise Project', which collects money for infrastructural development projects in Africa, such as vocational schools. They are also supporting this year's international 'Stand Up and Take Action' campaign, part of the UN and 'Global Call to Action against Poverty' initiative for the complete eradication of poverty and for the Millennium Development Goals.

MENDOZA URRUTIA, Douglas

is a member of the Training and Alliance Team for Nicaragua and Central America at Puntos des Encuentro since 2004. He took an active part in various programmes for the training of children and adolescents. Amongst other he was administrative coordinator for the youth theater trainings 'Access to IEC and basic Sexual and Reproductive Health Services for Adolescents in Managua' (Marie Stopes international-UNFPA-DFID) in 2003/04 and 'Sexual and Reproductive Heath and Rights' (AMUNIC-UNFPA-UNFIP) in 2001/02. He also was a member of the methodological team and coordinator of the Central American Conference on Sexual and Reproductive Rights organised by Puntos de Encuentro.

MURUGI MATHENGE, Esther

is Kenyan Minister for Gender, Children Affairs and Social Development. She holds a degree in land economics from the University of Nairobi. She campaigned two times before she was elected Member of Parliament for Nyeri town constituency in 2007. Amongst others her work focuses on poverty alleviation and the provision of access of women to the economy, including micro financing, social protection and cash transfers. Throughout her political career she has taken very strong stance against gender-based violence, especially against Female Genital Mutilation.

NDAYISHIMIYE, Francoise

is known as an empowered HIV positive woman since 1996. She was recently appointed Senior Gender Adviser at the Global Fund to fight AIDS, Tuberculosis and Malaria. Prior to that she was Executive Secretary of the National AIDS Council of Burundi, board member of Friends of the Global Fund Africa and board member of the Global Fund representing communities living with the diseases.

OBAID, Thoraya

is the Executive Director of the United Nations Population Fund (UNFPA). Prior to that she was a member of the United Nations Strategic Framework Mission to Afghanistan. She also was a member of the International Women's Advisory Panel and of the Regional Programme Advisory Panel, of the International Planned Parenthood Foundation (IPPF). Thoraya Obaid was in particular involved in women's issues in the Arab States. She has joined the UNFPA in 1999.

PETRY, Hedwig

is head of the GTZ Division of Health, Education, and Social Protection since January 2006. Prior to joining GTZ she was working in international business cooperation with a special focus on health and bio-medical research as well as HIV/AIDS. In the more than 20 years of her professional career she held several senior management positions around the world. Her regional experience ranges from Nordic countries to Africa and the United States where she established and managed teams of scientific and private business background. With a PhD in education and a specialist degree in business management she moved from higher education and academics to international cooperation. As a director of the division she promotes the strong profiling and positioning of GTZ competencies on health, education and social protection.

PFEIFFER, Sibylle

MP, is currently the Deputy Chairwoman of the Committee of Economic Cooperation and Development. She is member of the Petitions Committee and alternate member of the Subcommittee United Nations. She is also member of the following parliamentarian groups: the German-Maghreb Parliamentarian Representation, the German-Korean Parliamentarian Representation, the German-Israeli Representation, the German-Iranian Parliamentarian Representation and the German-Southasian Parliamentarian Representation. Sibylle Pfeiffer is also serving as the parliamentary deputy member for the organisation for Security and Collaboration in Europe (OSZE). Besides she is being Chair of DSW's Parliamentary Advisory Committee.

RADEKE, Claudia

is First Vice President East and West Africa of the KfW Entwicklungsbank, Germany. Dr. Radeke is responsible for the bank's development cooperation with 12 countries in East and West Africa, Sahel. Her first position at KfW was project manager for various countries in Southeast Asia. Later she became director of the KfW office in Moscow. After her return from Russia, Dr. Radeke became head of a directorate at KfW and dedicated herself to commercial projects and export funding to the successor states of the Soviet Union. She then became departmental director and her responsibilities included the development cooperation in the states of East Africa. Dr. Radeke studied economics in Geneva and Munich. She holds a doctorate with a thesis on the economy of developing countries.

SEN, Gita

is professor at the Indian Institute of Management in Bangalore, India, and has been a visiting professor at the Center for Population and Development Studies, Harvard University. Her recent work includes research and policy advocacy on the gender implications of globalisation and economic liberalisation, the gender dimensions of population policies, and the links between population and the environment. Prof. Sen is a founding member of DAWN (Development Alternatives with Woman for a New Era), a network of Third World researchers, activists and policy-makers committed to alternative development and gender justice and member of the Expert Advisory Panel on Health, Science and Technology Policy of the World Health Organization in New Delhi.

STATHER, Erich

is State Secretary in the Federal Ministry for Economic Cooperation and Development (BMZ) since October 1998. Since that time he is also Chair of the supervisory board of the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ GmbH) and Chair of the supervisory board of the Deutsche Investitions- und Entwicklungsgesellschaft (DEG). Since December 2002 Erich Stather is also Chair of the supervisory board of InWEnt – Internationale Weiterbildung und Entwicklung gGmbH. Prior to that he served as State secretary and spokesperson for the state government in Hesse and in the Office for projects, information and communication. Erich Stather holds a degree in social sciences.

VON KIRCHBACH, Friederike

is Provost of the German Protestant Church Berlin-Brandenburg-schlesische Oberlausitz (EKBO) since 2005. She was Sectretary General of the German Protestant Kirchentag. She studied Theology in Leipzig and Jena. Amongst others she was parish priest in Kreischa near Dresden and active in hospital chaplaincy. In the 1990s she contributed to the report 'Gemeinsames Wort der Kirchen zur wirtschaftlichen und sozialen Lage in Deutschland', a joint position paper of the Protestant and Catholic Church on the economical and social condition of Germany. In her work as Provost she is also responsible for community development and community work with children and young adults.

7th International Dialogue on Population and Sustainable Development

Exploring Cultural Diversity and Gender quality: towards universal access to sexual and reproductive health and rights

15-16 October 2008
KfW Berlin Branch, 'Historischer Kassensaal', Entrance: Behrenstrasse 33, 10117 Berlin

Panel Discussion, Wednesday, 15 October 2008
Between freedom and suppression: Gender and sexuality in the 21st century

5.30 pm Registration and ‚happy hour' at the 'Cultural Forum' poster exhibition

6 pm **Welcome**
Claudia Radeke, First Vice President East and West Africa, KfW Entwicklungsbank, Frankfurt
Klaus Brill, Vice President Corporate Commercial Relations, Bayer Schering Pharma AG, Berlin

Gender equality, empowerment and women's rights – a country perspective
Hon. Esther Murugi Mathenge, Minister for Gender and Children Affairs, Kenya

Men and gender equality
Douglas Mendoza Urrutia, Capacity and Alliance Building Officer Nicaragua and Centroamerica, Fundaciòn Puntos de Encuentro

Religion, sexuality and reproduction
Friederike von Kirchbach, Provost of the German Protestant Church Berlin-Brandenburg-schlesische Oberlausitz (EKBO)

Young and in love in a globalising world – young peoples' voices
Itchyban, Member of the music group Culcha Candela

Politics and policy making
Sibylle Pfeiffer, Member of the German Bundestag, Chairwoman of DSW´s Parliamentary Advisory Committee

Closing remarks
Hedwig Petry, Director Division Health, Education, Social Protection Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH

Reception at the 'Cultural Forum'

Conference, Thursday, 16 October 2008
Exploring Cultural Diversity and Gender Equality: towards universal access to sexual and reproductive health and rights

9 am	Registration and coffee ‚Cultural forum' exhibition with poster session
9.30 am	**Welcome** **Claudia Radeke,** First Vice President East and West Africa, KfW Entwicklungsbank, Frankfurt **Klaus Brill,** Vice President Corporate Commercial Relations, Bayer Schering Pharma AG, Berlin
9.40 am	**Opening address** **Thoraya Obaid,** Executive Director, United Nations Population Fund (UNFPA), New York
10 – 12 am	Keynote speeches on the following topics:
	Towards 'gendered' health systems – a new perspective on gender equity in health **Gita Sen,** Professor, Indian Institute of Management Bangalore and Adjunct Professor, Harvard School of Public Health; Co-coordinator of the Knowledge Network and Gender Equity for the WHO Commission on Social Determinants of Health
	Human rights and maternal mortality **Paul Hunt,** Former UN Special Rapporteur on the right to the highest attainable standard of health, Professor, University of Essex, UK
	Promoting gender equity in global funding **Françoise Ndayishimiye,** Senior Gender Adviser, Former Board Member, Communities delegation in the The Global Fund To Fight AIDS, Tuberculosis and Malaria, Geneva
	Gender – culture - reproductive rights and health: a scope for action in German development cooperation **Erich Stather,** Federal Ministry for Economic Cooperation and Development (BMZ), Germany
	Lunch
1.30 – 5.30 pm	**'World Café of opportunities'** following **'Town Hall Meeting'** presenting the main discussion results in plenary
5.30 pm	**Wrap-up of the day and outlook** **Gill Greer,** Director General, International Planned Parenthood Federation (IPPF), UK
6 pm	End of conference

List of Participants

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