The UK Network on SRH & Rights (‘the Network’), made up of about 30 British-based NGOs working in sexual and reproductive health and rights (SRH&R), welcomes the initiative taken by DFID to produce a ‘Position Paper on Reproductive Health and Rights’. We appreciate the opportunity to comment on the paper before it is published and DFID’s openness in sharing its position on SRH&R with the outside world. The paper comes at a time when SRH&R is under threat in many countries across the globe, in part due to pressures by fundamentalist religious groups and governments who question aspects of SRH&R and in part by donors who are moving resources away from SRH&R to other priorities such as HIV.

In addition, we would like to congratulate DFID on producing a clear document that sets out the challenges facing SRH&R globally. Its view of current issues and description of DFID’s stance in relation to the perceived requirements for moving ICPD and the IDTs forward in the context of the MDGs, PRSPs, and SWAps is most welcome.

Making the SRH&R Case
The paper makes a compelling case for working in SRH&R. The Network will comment broadly here and confine detailed comments to the Appendix (attached).

**Sexual and Reproductive Health**  The Network would appreciate clarity on where sexual health fits in DFID’s definition of RH. What exactly is meant by ‘integrating health services’? The Network prefers to include sexual health alongside RH.

**Safe Abortion**  The Network would hope that ‘comprehensive services’ includes access to safe abortion, whether it is legal or not.

**Young People**  The Network is very happy with the paragraph on young people which highlights so many of the key issues facing young girls and women in particular.

**Reproductive Rights**  The SRH Network would like to see DFID make systematic efforts to ensure that sexual and reproductive rights are respected, protected, and to the extent possible, fulfilled in their support of service provision. Encouraging equitable partnerships, human rights education and a right-based ethos within programmes that guarantees a means of redress for the violations of rights are also important factors.

**Working with Civil Society**  The Network would appreciate it if DFID would articulate how it plans to work with civil society in both the North and the South. NGOs are not just seeking financial support from DFID but feel they have a role to play in collaborating and working more closely with DFID, particularly on international advocacy (including involving relevant NGOs in their government delegations for UN meetings). And linking with reproductive rights, DFID could play a useful role in helping both donor and beneficiary governments to ensure that SRH services are available, accessible, acceptable and high quality by encouraging civil society to look at what these concepts mean in specific settings.

Response to DFID RH Position Paper
What is DFID going to do about SRH?

While the Network was generally impressed with the case DFID makes to work in SRH, we were generally less impressed with the statements of how DFID was going to go about it in concrete terms. We would like to pose the following questions:

1) Does DFID have adequate SRH staff?
The paper states that DFID has recently increased staff resources working on RH. Centrally, under the recent DFID re-organisation of the Policy Division, the original RH team within HPD was disbanded and only after some pressure from MPs and NGOs was the RH element added to the MDG team. The proportion of in-country staff time devoted to SRH is harder to monitor. The Network would like to know how many DFID staff or FTE are now working on RH.

2) How can SRH be made a priority within the PRSP context?
As donors have moved away from targeted projects to supporting overall health sector strategies or to budgetary support, we worry that SRH has been lost in the wider picture. We would welcome information on DFID’s strategy on keeping SRH on the agenda at the country level.

3) Can DFID maintain its role as an international advocate for SRH?
The Network hopes that DFID will continue to be an active participant in European, UN and other international fora. DFID’s leadership role is more important than ever before given the lack of leadership by the US at the moment and changing dynamics within the European Union. (This is obviously related to the staffing question, above.)

4) How can DFID ensure that the HIV funding does not disguise little new funding going into SRH?
A closer look at recent funding trends within DFID reveals that very little money went to RH projects in the past few years. There was RH funding to Malawi, Pakistan, and a small amount to Central America. Otherwise, the vast majority of the £270 million in 2002/3 went to HIV.

5) How can SRH be re-prioritised within DFID vis-à-vis HIV?
There is no question that funding is required for HIV care but other important work in SRH must not be forgotten. Comprehensive and integrated SRH services providing information and counselling about HIV, diagnosis and treatment of STI, interventions to prevent mother to child transmission of HIV, and the means to prevent both unwanted pregnancy and disease transmission are essential to reduce the spread of HIV/AIDS.

6) How will DFID use the RH Position Paper?
Will DFID be actively promoting their SRH position internationally? Will the paper be shared within DFID and influence other funding mechanisms such as PPAs and the CSCF? Are mechanisms in place to ensure follow-through at country-level?

An Ongoing Dialogue...
In closing, we look forward to an ongoing consultation on the issues raised in the RH Position Paper and are particularly interested in the model DFID uses to consult with the UK Consortium on HIV/AIDS & International Development. We hope that our planned roundtable with the Policy Division MDG/RH Team in April and our meeting with the Secretary of State in May will be the beginning of a continuing and useful dialogue.
Appendix

1. The following points cover some of the more detailed feedback on DFID’s 24 February 2004 draft Reproductive Health and Rights Position Paper, from members of the UK Network on SRH&R. Analysis of the paper would be strengthened by sight of the DFID Maternal Mortality, HIV/AIDS, Rights-Based Approaches and Research strategies, which no doubt have, or will have, complementary statements and describe strategies of great importance for RHR, and we would like the Network to have had sight of these by the time of the meeting with the MDG/RH Team on 26 April 2004.

2. Para 9 could usefully refer to ICPD paragraph 7.3, which defined reproductive rights. The opening sentence should replace “declarations” by “treaties”, since these have the status of international law.

3. Refugees and Displaced People. We would like to see reference to these groups in both the “What is the scale of the problem” and “What can be done?” sections.

4. Para 17 acknowledges that throughout the world there is violence against women and goes on to list the range of violations. We believe a reference to trafficking of women and girls would be relevant here.

5. Paras 20 and 21 re RH commodities – Access to supplies underpins many aspects of achieving the ICPD goals and 2 of the MDGs. This section could be strengthened by including the following information:

   - RH commodity shortage is a complex issue: Inadequate funding and declining donor trends, lack of government co-ordination at the international and national levels, deficient information exchange on the demand and supply sides, and weak delivery systems in developing countries are all having an effect. As a result, only an eighth of the currently needed reproductive health supplies have sufficient funding.

   - Population growth in the developing world, coupled with the largest ever number of women and men of reproductive age, means that current and projected demands for reproductive health supplies are without precedent. For example, the number of women in developing countries, who will want to use contraceptives in 2015 will rise by 41% (from 525 to 742 million).

   - It would be appropriate to mention that we now have the largest population ever of young people about to enter their reproductive years and the supply of RH commodities needs to grow in line with their needs if we are to take advantage of the “one-off opportunity for investment, growth and poverty reduction”, particularly in Africa.

6. Para 22 could be improved in several ways:

   - Reproductive health services are highlighted as “the cornerstone of efforts to enable people to make informed, safe and healthy choices” and it is stated that DFID supports services through country programmes. It would be appropriate to acknowledge that in many countries it is not the State, but NGOs and the private sector, that provide information and services – indeed, in many countries, due to the lack of both a working comprehensive health system and political support for SRH&R, the State has never taken the lead.

   - In the second bullet point we propose the word accessible should be added before family planning.
• The definition of “comprehensive services” should include *the prevention and treatment of unwanted pregnancy including post-abortion care and, where it is legal, access to safe abortion.*

• As a vital contribution to reducing maternal mortality it is recommended to add *treatment of obstetric complications, provision of emergency obstetric care, and skilled attendance at delivery.*

7. We agree with Para 23 but request that DFID highlight that integration can be problematic in some specific cases - e.g. services based in ante-natal clinics would not be attended by men; getting people to use services accessed by sex-workers may be problematic; men who have sex with men (MSM) and injecting drug users (IDUs) need services designed appropriately for their needs. In such cases fitting solutions need to be sought.

8. In Para 24 which discusses taboos and norms about sexuality and sensitive issues, we think the paper should include mention of the sensitivity and complexity of addressing safe abortion issues.

9. Para 25 could specify advocacy and programme elements of rights-based work to ensure that sexual and reproductive rights are respected, protected and fulfilled. In the first instance, these would include increasing capacity at country level to contribute to human rights reporting, and to hold governments accountable for commitments they have made under the various treaties, and advocacy at the international level to increase recognition and understanding of the human rights dimension of sexual and reproductive health and rights. In the second, it would include programmes that incorporate a sense of entitlement and accountability, and human rights education that empowers people to demand services of high quality.

10. Para 30 states “Laws, policies and regulations may hinder access to services” but should acknowledge it may also be officials’ attitudes and priorities that hinder provision and access.

11. What is DFID’s Position? It would be welcome if DFID could say more about the role it envisages it will play in terms of both financial support and international advocacy for SRH supply shortages somewhere in this section.

12. Para 38 notes that NGOs are supported through CSCF and ‘other mechanisms’. It would be appreciated if the ‘other mechanisms’ could be identified.

13. Box 1. It would be appreciated if a UK NGO example could be cited here (not just 1 US NGO and 2 multilaterals) indicating that the work of UK NGOs is seen as valuable by DFID.

14. Para 41. Reference to improving access to RH services could be strengthened by the addition of a statement such as “We will promote the use of internationally agreed criteria for good practice and quality of care, for example WHO’s recently published *Technical Guidelines on Safer Abortion.*”

15. Box 2. Is a case study re Africa to be included? Ghana could provide an appropriate example.

16. Paras 43-44. We welcome reference to the research and knowledge programmes, and think DFID’s position would be strengthened by a more detailed cross-reference to the new DFID research strategy.