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ICPD+15 at the Crossroads: Health, Rights and Citizenship



Carol Ruiz-Austria reports on preliminary trends from DAWN's Research on SRHR and the MDGs

"Political thought needs categories; political life defies them."

~ Lisa Duggan, (Re) Producing Social Justice
After Neoliberalism (2009)

Background

When the right to health belongs to everyone regardless of race, class, sex and religion, confronting the issue of social inequality is inevitable. Conceiving health as a right makes a profound difference not only on how people claim individual entitlements to health and standards of care, but brings to bear the role of public institutions both in service provision and as reserves of the common good.

In a 2005 global policy research, the Development Alternatives with Women for a New Era (DAWN) examined the ways in which health reform processes affect national responses to maternal mortality, post-abortion care, as well as context specific dynamics regarding the legalization of abortion. Interlinking Policy, Politics & Women's Reproductive Rights highlighted Health Sector Reforms (HSR) as a critical juncture between macroeconomic trends, processes of state transformation and S&R health issues, as components of a reconfigured citizenship and the human rights agenda. (Correa:2005)

Among others, the study: (1) outlined the disconnection between processes and actors concerned with Sexual and Reproductive Health and Rights (SRHR) on one hand, and those concerned with state and HSR on the other; (2) traced the origins of HSR, particularly the World Bank model of HSR which remains the standing policy framework of several developing countries (including 12 countries included in the study); and (3) exposed a trend of "cherry picking" on the part of major institutional players, in terms of engaging and financing the MDGs, much to the detriment of broader SRHR commitments in the BPFA and the ICPD.

The study dovetails with sociological studies which acknowledge the process of HSR both as contested, where interest groups

(including social movements) sometimes capture and influence the state and its key actors, (Gonzales-Rossetii & Bossert: 2000) but at the same time continues to be deeply embedded within the privatization/marketization discourse. (Ravindran: 2005)

In this current project focused on SRHR and the Millennium Development Goals (MDGs), DAWN further explores the link between state policies on citizens' welfare and SRHR by examining government approaches to poverty alleviation alongside MDG initiatives in three countries namely Mexico, India and Nigeria, which when taken together, is said to collectively represent over one third of the world's total maternal deaths. (Fenton: 2008)

The research also provides an opportunity to take a close look at Mexico and India, two countries which have been noted as sites of marked economic growth in recent years and Nigeria, one of several Sub-Saharan African countries where the attainment of the Millennium Development Goals has been a most daunting challenge. As expected, the diversity of contexts reflects substantial differences between all three countries but there are emerging trends and commonalities, among them, structural mismatches that exist between SRHR/ MDG frameworks and national welfare policy and anti-poverty programs.

Discussion of Findings

A disconnection between stated national policies which mention the MDGs and actual social and health security programs was noted in India and Mexico where questions have been asked about whether benefits are reaching target beneficiaries in the face of qualification processes and criteria that often lacked clarity. In Nigeria, the disconnection manifests as the yawning gap between both the numerous state policies on poverty alleviation and high level MDG projects, on one hand, and the actual situation of citizens, on the other.

Critics have long noted that the MDGs invite technocratic and top-down approaches since they are stated as quantitative targets and

either disease or condition specific. And just as the HSR often ends up being narrowly approached solely as a financing agenda which can be disassociated from health delivery systems, the ongoing challenge to engaging the MDGs in many contexts remains linked to the lack of and resistance to holistic and human rights approaches to health.

Some trends emerging from DAWN's research on SRHR and the MDGs are:

1. Primary use and invoking the Millennium Development Goals is notably confined to high-level policy statements and issuances either by ministers when attending international conferences or special projects funded by donors and international development agencies and has little to do in the design of social programs;
2. Of all the MDGs, SRHR related goals, specifically maternal mortality and in relation thereto, abortion, continue to be the most neglected for a number of causes: from avoidance by donors to conservatism within state policy as well as conservative political forces;
3. The rights framework in health, and even more so, an SRHR frame is either weak or non-existent and competing frames and approaches such as population control, maternal and child health as well as financing models inherent in HSR discourse continue to influence programming and influences policy.

While the Millennium Development Goals are cited heavily by government officials at high-level settings by Mexican officials such as international conferences, the MDGs do not seem to be in much use elsewhere. On the other hand, there are a lot of existing "social programs" in Mexico both at the federal and state levels which range from cash transfers, services and infrastructure.

The almost incalculable amount of programs already in place indicates that many of these were more likely reactive responses rather than based on any well thought out master plan. Despite these social programs, however, Mexico's maternal mortality rates remain high. There are very obvious disparate trends between states since health provision is decentralized. But where there is high civil society engagement of the state and the system, there have been notable gains. In 2008, Mexico City successfully passed an ordinance to decriminalize the early termination of pregnancy.

In India, the MDGs are only selectively mentioned in national plans and programs. Overall, there is very little reference to the MDGs in actual policy. Welfare provision seems to be disparate and short-term. Policies such as those providing rehabilitation to rape victims, credit to widow-

victims of farmer suicides primarily treats claimants as "victims" and are not geared toward empowerment.

Like Mexico, the presence of active social movements and key social actors including UN agencies, which support SRHR, gender frames and poverty reduction initiatives somehow makes a difference in the Indian context. Mass movements which facilitated the defeat of the conservative Hindutva-led coalition in 2004 coupled with India's economic growth (2002-2007) made more investments in health possible. Public interest litigation has been a major strategy by social movements in India. In July of this year, the courts also struck down the law criminalizing sodomy, which in the past, had been systematically used to discriminate and harass the gay community.

Meanwhile in Nigeria, the MDGs are not only mentioned but in fact showcased at the highest policy levels since the biggest project funded by donors is run by a special agency directly under the office of the President. ([The project, however, is isolated to select "Millennium municipalities" "see ERRATUM, p.8\)](#) UNDP also provides technical aid to the Federal Government to produce MDG reports. The difficulty of getting reliable data on health remains a challenge in several Sub-Saharan countries and even then, there is very little to track by way of social investments. While it remains the world's 8th biggest exporter of oil, Nigeria's poverty gap, which has been noted as one of the worst in the world, is getting worse. (Sofu,et.al.:2003)

On one level, state policies already reflect some elements of "gender equality" frameworks but on the whole, these stop short of fully engaging issues of women's empowerment and in particular, SRHR. In Mexico, a federal agency under the Ministry of health is even called the National Center for Gender Equality and Reproductive Health. The same agency, however, has refused to take a position on the Mexico Ordinance and continues to steer clear of the issue of abortion.

Likewise, despite the outcome of public interest litigation in India as well as the continuing engagements by civil society, the dominant policy frame in use is population stabilisation and fertility reduction.

Thus far, the trends noted here also tie-in with worldwide trends recently cited in the Lancet:

While there are some noted improvements in achieving the MDGs, in too many countries, coverage of care falls at crucial points across the continuum of care and most seriously affects mothers and children. The gaps in both the availability and quality of care are most striking in poor, rural areas and are usually a factor of gaps in both infrastructure and human resources.

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Advocating for Full Sexual and Reproductive Health and Rights: Still an Uphill Battle

Fifteen years after the Cairo consensus, DAWN joined other civil society organizations at the 42nd Session of the Commission on Population and Development (CPD) held on March 30-April 3 2009 in New York City. A task force of the Sexual and Reproductive Health and Rights (SRHR) advocates met with the purpose of closely following the CPD debates around the proposed resolutions relating to the International Conference on Population and Development - Program of Action (ICPD-POA) and the “Millennium Development Goals”. Their main objective was to push for the inclusion of strong progressive language on Sexual & Reproductive Health & Rights (SRHR) and to avoid setbacks on previously agreed text.

International Women’s Health Coalition (IWCH) and Population Action International (PAI) co-hosted an advocacy strategy meeting the day prior to the CPD Session, which resulted in a document to be used as basis for approaching the SRHR-friendly states and proposing alternative language to the drafted resolutions. This included some progressive language on SRHR but lacked language on social and economic development, financing for development, and references on relevant issues such as migration.

As expected, negotiations started to be carried out in blocks such as the Group of 77 and the European Union. Other blocks, including Mercosol/Mercosur (Argentina, Brazil, Uruguay and Paraguay plus six Associate Member States) or Rio Group (22 states from Latin America and the Caribbean), worked together whenever consensus could not be reached within the larger G77 block. As it was the first CPD of the Obama Administration Era, it was interesting to see the US delegation push for the inclusion of progressive language on Sexual and Reproductive Health, as well as Rights.



Themes at Stake

There were two (2) main controversial issues, one was SRHR and the other was the interrelations between economics, finance and poverty with population and development.



On the SRHR front, there were intense debates and negotiations among some states that centered on how the phrase “human rights” was used in the final resolution. The context of the term “human rights”, to mean, “encompassing the fulfillment of the rights of all peoples” (as against “human beings”), was seen by many conservative states as a potential entry point on for their restrictive language on sexual orientation and gender identity in UN texts. Feminist groups together with some SRHR-friendly states, on the other hand, have been working since Cairo on making more inclusive the meaning and scope of SRHR. One of these efforts is to take into account the connections of the Cairo agenda with the fulfillment of the rights of other identities, such as male and trans people. There is a need to further explore the issues with the inclusion of the needs and aspirations of transgender and inter-sexed people.

In the CPD Session, debates and negotiations were made in an attempt to include men’s SRHR. For instance, PP6 of the final document adopted Paragraph 96 of the Beijing Platform of Action, to include the rights of men “to have control over, and decide freely and responsibly on matters related to their sexuality and reproduction”. The full paragraph reads as follows:

PP6. Recognizing further that population dynamic, development, human rights and sexual and reproductive health and reproductive rights, which contribute to the implementation of the Programme of Action of the International Conference on Population and Development¹ and the Beijing Platform for Action, empowerment of young people and women, gender equality, rights for women and men to have control over and decide freely and responsibly on matters related to their sexuality and reproduction, free of coercion, discrimination and violence, based on mutual consent, equal relationships between women and men, full respect of the integrity of the person and shared responsibility for sexual behavior and its consequences, are important to achieving the goals of the Programme of Action of

the International Conference on Population and Development.

On the “integral health package” negotiations, SRHR-friendly states managed to guarantee a comprehensive paragraph. Although it did not include all our advocacies, it did include key parts of the Task Force’s proposed “package”. OP9 reads as follows:

OP9. *Further urges* Governments and development partners, including through international cooperation, in order to improve maternal health, reduce maternal and child morbidity and mortality, and prevent and respond to HIV/AIDS, to strengthen health systems and ensure that they prioritize universal access to sexual reproductive information and health-care services, including family planning; parental care, safe delivery and post-natal care, especially breastfeeding and infant and women’s health care; prevention and appropriate treatment of infertility; quality services for the management of complications arising from abortion, reducing the recourse to abortion through expanded and improved family planning services and, in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible, recognizing that in no case should abortion be promoted as a method of family planning; treatment of sexually transmitted infections and other reproductive health conditions; information, education, and counseling, as appropriate, on human sexuality, reproductive health and responsible parenthood, taking into account the particular needs of those in vulnerable situations, which could contribute to the implementation of the Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action and the Millennium Development Goals.

As well, we should acknowledge as a positive outcome that references to HIV/AIDS in the final text. The theme appeared in several paragraphs, such as PP7, PP18, OP9, OP11, and OP17 thru OP20. Although the references were limited, there was no restrictive language on culture, religion or parental rights. It discussed positively, among others, prevention by “providing young people with comprehensive education on human sexuality, sexual and reproductive health, on gender equality, and on how to deal positively and responsibly with their sexuality (OP07).” Notably, the formulation of OP15 was quite tricky. It started with recalling the SRHR of adolescents by: *Recognizing* “that the largest generation of adolescents ever in history is now entering sexual and reproductive life and that their access to sexual and reproductive health information, education and care, family planning services and commodities, including male and female condoms;” and ended the discussion with references to “voluntary abstinence and fidelity” as “essential in achieving the goals set out in Cairo 15 years ago.”

Though the intention of the usage of “voluntary” was to mean positively, it can be manipulated by conservatives who discouraged the use of contraceptives as a way to prevent HIV/AIDS. At the end point, what they encouraged, instead, are the practices of abstinence and fidelity.

On the economics/finance and poverty related debates, G77 strongly pushed for references to Financing for Development (FfD). Despite strong resistance from the rich countries, the resolution included in its OP29 the following text:

OP29. Urges developed countries that have not yet done so, in accordance with their commitments, to make concrete efforts towards meeting the target of 0.7 per cent of their gross national product for official development assistance to developing countries and 0.15 to 0.20 per cent of their gross national product to least developed countries to build on the progress achieved in ensuring that official development assistance is used effectively to help meet development goals and targets and, inter alia, to assist them in achieving gender quality and the empowerment of women;

One might expect that 15 years after Cairo when a global commitment to the MDGs is in place that there would be a higher sense of awareness and understanding around the strong connections between long-term inequalities (income and others) and the debates on population and development. But this was disappointingly not so; the resolutions still lacked references to the structural underpinnings of poverty dynamics. Several States, particularly those of the G77, did push for and managed to include strong references to poverty eradication in the final text. However, these references were found together with text privileging “economic growth” and sustainable development” (refer to PP04, PP07, PP08, OP03, OP05, OP06 and OP22). There was no mention of poverty eradication with reference to dynamics of inequalities and widening social gaps between rich and poor countries and peoples.

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SRHR and Global Finance – Crisis or Opportunity?

Gita Sen, speaking for IIMB at Bangalore & DAWN, at the Panel on SRHR and the Global Economic Climate at Global Partners in Action: NGO Forum on Sexual and Reproductive Health and Development – Invest in Health, Rights and the Future, Berlin, 2-4 September 2009



Global trends and needs in health financing

Sexual and Reproductive Health and Rights (SRHR) needs to be understood within the context of overall health financing. This approach is necessary because well-functioning health systems are essential for the fulfillment of the SRHR agenda.

Developing countries need to pay particular attention to health financing since they have 84 percent of the world's population and carry 90 percent of the global disease burden. Unfortunately, these same countries only account for 20% of the global gross domestic product (GDP). Worse, developing countries account for only 12 percent of the global spending on health. As a result, more than half of health spending in poor countries is paid out-of-pocket. People in developing countries have to face the consequences of catastrophic illnesses or accidents, poor primary care and referral systems, and inequitable private and public health insurance systems.

The gap between developed and developing countries is emphasized when noting that, after adjusting for cost of living differentials between the two groups of countries, each person in rich countries spends 30 times more on health.

The UN Population Division's 2008 revised projections see global population increasing to 7.5 billion by 2020 and more than 9 billion by 2050. Changes in population size and composition will raise health care spending needs by 37 percent in East Asia and the Pacific, 45 percent in South Asia, 47 percent in Latin America and the Caribbean, 52 percent in Sub-Saharan Africa, and 62 percent in the Middle East and North Africa. This implies an annual increase in health needs of 2 to 3 percent pushed by demographic factors alone.

The World Bank estimated that in 2002, global health spending was USD3.2 trillion or about 10 percent of global GDP. Of this amount, only USD350 billion is accounted for by low and middle-income countries combined. Ironically, the public share of health expenditure is lowest in the poorest countries. If external sources of financing are to be looked at, about 8 percent of health spending is done by low-income countries if weighted by population and about 20 percent if weighted by country. In 12 Sub-Saharan African countries, external sources account for 30 percent of total health financing.

Sustainable health financing is important because health spending has been found to have a strong impact on improving maternal and child mortality rates. Econometric tests have also shown that parallel investments in infrastructure and education help improve these indicators. Meanwhile, economic growth has a positive and direct impact on and lead to higher health spending.

In 2003, the development aid for health reached USD10 billion, which was about 1/7 of total official development assistance (ODA). Also in 2003, the total ODA was 0.25 percent of gross national income, falling short of 0.7 percent target in the Monterrey Consensus and the Millennium Projects goal of at least 0.54 percent. Global programs targeted at specific diseases account for about 15 to 20 percent of aid to the health sector. A very high proportion of external assistance for health is not recorded in balance of payments (BOP) accounts and can even be off-budget. In a study of 14 poverty reduction strategy papers (PRSPs), it was found that 30 percent was off-BOP and 20 percent was off-budget but accounted for in the BOP. Furthermore, as is typical of the World Bank (WB) and the International Monetary Fund (IMF) approach with PRSPs, there is no road map to integrate sector strategies with macroeconomic policies, there are no micro-macro linkages, nor are there medium to long-term linkages. This implies that, at the very least, there will be no improvements in predictability of health financing.

Potential impacts of the financial crisis on health financing

Three pathways may be identified to assess the potential impact of the financial crisis on health financing. The first is through lower economic growth. Developing countries face difficulties in generating export revenues under the current circumstances because of a resurgence of trade protectionism, such as continued agricultural subsidies in rich countries and buy-American/European campaigns in fiscal stimulus packages. Export revenues, including from services outsourcing activities will also decline along with the decline in demand and the collapse of trade finance. Falls in migrants remittances are also expected. These trends reflect the real sector impact of the losses in the financial sectors. These combined effects would

have a direct impact on the amount of out-of-pocket spending of households and will have gendered effects especially in regions such as South Asia where household spending for health is biased against girls and women.

The second pathway is through the growing dependence on IMF borrowing by countries with balance of payments problems. The consequence for IMF borrowers (Hungary, Iceland, Latvia, Honduras, Pakistan, Ukraine and more) has been a loss of fiscal space. Typical structural adjustment conditionalities have not changed significantly even with the onset of the crisis. Ironically, the US has been pushing governments to raise the stimulus spending to 2 percent of GDP while the IMF requires low-income borrowers to limit budget deficits to 1 percent. This reflects double standards of fiscal stimulus for the rich and fiscal discipline for the rest. This can lead to countries being forced to cut back on social sector expenditures such as on health – a return to the bad old days of early structural adjustment.

The third pathway is through dependence on external sources for health financing whether through bilateral ODA or through the numerous other sources such as funding from the Global Fund to Fight AIDS, TB and Malaria, or private foundations such as the Gates Foundation. While no clear trends are visible in this, a number of bilaterals have begun reducing their financial assistance (e.g. Italy), and private foundations' endowments have themselves been affected by the financial crisis.

Is there a window of opportunity in the crisis?

In another time and in the throes of a different crisis, Keynes said that, "The difficulty lies not so much in developing new ideas as escaping from old ones." The solution to the financial crisis of today cannot be a return to the bad old days of fiscal belt-tightening and reduction in financial resources for health for the poorest countries and people.

What are some alternatives? The immediate need is to insist on the removal of double standards and to demand greater donor accountability in maintaining ODA at least at pre-crisis levels, and to challenge the IMF's fiscal conditionalities. Equally important is for South governments to strengthen domestic resource mobilization through innovative tax mechanisms that are progressive in their incidence and impact, even as they collectively fight against the current double standards. In the medium to longer term, rebalancing growth towards greater employment generation and reduction in output volatility through greater emphasis on the internal market will be essential. ♦

► Advocating for full SRHR

Another key issue related to population and development during the last decade is migration. In the CPD, many countries (Mexico and Philippines, among others) complained that migration was absent from the first draft of the resolution and pushed for its inclusion in some paragraphs (see PP12, PP13 and OP23). This is an area that deserves more attention, both from states and civil society organizations.

The final plenary

After a week of intense negotiations, the CPD resolution was adopted "by consensus". In the morning of the last day, the facilitator presented a text asking states to "take it or leave it," referring to the state of the text at that moment. Most states agreed to "take it," adopting the text as it was. However, at the last minute, Iran took the floor and objected to the term "sexual and reproductive health and rights." In an attempt to save the consensus, the facilitator suspended the session for ten minutes to give the states time for last minute re-negotiation. Finally, when the states returned to the plenary, the facilitator announced that the text would be adopted as is, but with a revised phrasing of "sexual and reproductive health and rights." The text now reads as "sexual and reproductive health and reproductive rights" (see PP04 and PP06). After the adoption of the document that incorporated Iran's eleventh-hour change, some states lauded the document for not having created any new rights that supported or promoted abortion. But Norway took the floor to make a statement expressing disappointment that the term "sexual rights" was not kept in the final text. ♦

► ICPD+15 at the Crossroads

Despite the increases in donor financing, the total volume of ODA to maternal and newborn and child health programs (64% increase between 2003-2006), the sector is still grossly underfunded in relative and absolute terms. Likewise, 95 % of the funds go to projects in the short-term and are not systems directed. The devastating effect of conflicts/HIV pandemic especially sub-Saharan Africa was also noted. (Saloma et.al.: 2008)

Health Care in the Post-Crisis Scenario: No Longer "business as usual"

In the wake of the financial crisis, analysts predicted inevitable aid cuts to developing nations this year. (Frot:2009) At the same time, five billion people in the developing world are expected to further bear the brunt of the global recession in terms of job losses (projected at 50 million), capital flight and an overall dip in remittances from migrant workers. (Birdsall:2009) On top of this, countries with massive foreign debt can expect deficit spending as the need for social safety nets increase.

ICPD Agenda Remains Fragmented!

- Most initiatives directed at strengthening health systems pay minimal attention, if at all, to sexual and reproductive health (SRH) such that research, treatment and resources for SRH-related problems remain marginalised and underdeveloped.
- The interlinkages between family planning, including access to contraceptives, the treatment of STIs and RTIs, and the reduction of maternal mortality, is yet to be recognized.
- The rights and health of young people are dealt with separately from that of adults even in sex education. Instead of integrating HIV/AIDS within the SRHR framework, it has been programmed vertically.
- Health and rights remain isolated from each other, with safe abortion and the transformation of gender relations left hanging in the air. There is a need, therefore, especially for women from the South to push for the integration not only of the ICPD agenda, but also of the entire SRHR framework, within the overall discourse of health and well-being. ♦

- Gita Sen, Based on A Germaine, R Dixon-Mueller and G Sen, "Back to basics: HIV/AIDS belongs with sexual and reproductive Health" Bulletin of the WHO 2009;87:000-000 | doi:10.2471/BLT.09.065425

All three countries are classified as "Emerging Market Countries" by Washington think-tanks with India included in the list of market countries expected to be among the worst hit by the crisis. (Boorman: 2009) Remittances to India and Mexico ranked as the first and second largest in the world (World Bank Fact Book: 2008) but early signs of a slowdown were reported by the Mexican Central Bank in the wake of the US financial crisis.[1]

While this crisis is far from over, however, financial giants acknowledged to be among the major players that caused the meltdown are already posting profits thanks to the generous US government bailout and an ongoing line of credit: Federal Reserve programs that allow them to borrow funds overnight for close to zero percent. But smaller banks which cater to communities have been complaining that not only are they being penalized for a crisis they did not create but that the emerging system or regulation overtly favors big banks. (Orr: 2009) Ironically a big part of the recent windfall by the bailed out banks also come from overdraft fees, which are the penalties imposed on those who have trouble paying their credit card debt.

It is still difficult to shake off the most haunting image that the 2008 financial crisis has left in people's minds: the US government scrambling with massive reserves of borrowed capital to bailout erstwhile titans of commerce and industry - private banks and financial corporations primarily considered responsible for the crisis in the first place. To the rest of the world watching town hall USA, the greatest paradox of our time seems to be that despite their colossal mistakes and utter disregard for ethics, it has been perfectly acceptable for the mythical market's moguls to receive public funds (e.g. government bailout money), but not for government to be involved in public health care.

Indeed getting to the bottom of the core causes of this financial crisis continues to be hotly debated with ideologues

(and public relations) on different sides working overtime to pin the blame on either "high-risk debtors," "speculative excesses," "weak regulation," or "over regulation." But more importantly, the ensuing effects of the crisis are bringing to fore, vital questions that challenge us to urgently rethink notions of citizenship, public systems, social institutions and inevitably, the state.

Moving Beyond the State v Market: The Politics of Health

On one level the state v market conflicts being played out on issues of regulation/deregulation, public/private, continue to resonate as a matter of course for a variety of reasons. Whether reacting in fear of an all powerful government, seeking accountability for irresponsible behaviour in the market, or searching for ways to address social inequality, the state is in issue – and so is its role. Confining the terms of the debate to "state v market," however, severely limits the discussion.

Long before this crisis unraveled, feminists already grappled with how inadequate conventional theory about the state/public v market/private tended to be in making sense of the political economy of globalization. Up till now, states on the global south's side of development have always been portrayed as the bastion of resistance against the onslaught of the global economy to the extent that state regulation of foreign capital, safety nets, and other laws of "fair play" are, after all, state mechanisms. (Bergeron:2001)

Without necessarily maintaining that the state is a monolithic entity they went beyond the question of where the state stood vis-a-vis the market and globalization. Instead, they pointed out what was evident: the role of states had already been transformed from "barrier" to "mediators/adaptors" of the global political economy. (Rai:2007; Cox: 1996) This observation rings true even where resistance takes place (and spaces for resistance exist) within state processes. In very fundamental ways, the privatization and marketization imperative already envelops governance discourse. Calling it the Marketization of

Governance, DAWN feminists described this as the overlap between development discourse and mainstream political reform frameworks, where fast-tracking Western-style political liberalism on the back of economic liberalism is a persistent feature. (Taylor: 2000)

When it comes to the issue of health, specifically financing health care, the marketization model was initially presented as a solution to developing nations looking to improve or overhaul ailing health systems. In 1994 public health experts noted that the declining faith of many developing nations propelled the search for a cure- all for underfunded and inefficient public health systems and led many to rely on the “magic pill of marketization.” (Hsaio: 1994) Arguably, a similar (often valid) distrust of states still exists today especially in the context of corrupt political regimes. On the other hand, the negative impacts of HSR also demonstrate how both market-based and technocratic approaches to health care systems takes are not only inadequate but often inappropriate to address health as a right. As the experiences of many countries within HSR and structural adjustment-led public to private shifts, reordering the structures of core social institutions like public health systems, affects the very terms of terms of health care provision/claiming. (Freedman:2005)

Inasmuch as debates tend to be bogged down by the limited categories of state/market, public/private both as the sources of options and the models of health care delivery, there is an urgent need to re-imagine existing notions of citizenship and state, public and private. Lisa Duggan describes the problem as a conflict between political categories and political reality:

As the dominant political and economic policy paradigm of neoliberalism shifts in the wake of global crisis, it is imperative that we seize opportunities to communicate, organize, strategize and theorize our way out of its cruel projects of expanding inequalities and concentrating power and resources. It is crucial that we demonstrate the ways that social formations of race, gender, sexuality, nationality and religion are central to economic processes and state actions, and are not simply population segments to be progressively included in the status quo. We need concepts and analyses that can capture the shifting relationships of the forces with which we contend, and that can illuminate them in ways that facilitate effective critique and a sense of new possibilities. We need a way out of both simply listing these categories and asserting that they intersect (or are imbricated), or just demonstrating their social construction and incoherence. (Duggan: 2009)

When it comes to the right to health, equating the public debate solely with a fully state-run system tends to be a thorny

issue. Understandably, this tends not to be so much of an issue only in the contexts of better developed (and long-standing) welfare state set-ups. Where there is little by way of public trust in a given government, publicly run and funded health systems will continue to be a bad idea. Yet the notion of the public which overlaps with what we consider the social sphere of the common good goes well beyond the question of government allocated or provided health care. The practice of professions is also shaped by health systems. This can and has in many instances, spelled the difference in the rising cost of health care where it is predominantly privatized and run by corporations.

In order to move forward, there is an urgent need to decouple state/public as well as challenge the state v market dichotomy, specifically when it comes to dictating the terms of the debate. Even as state mechanisms and spaces for resistance remain useful in preserving and defending social services and social institutions like public health systems, we also need to look at how states/state processes limit the rules of engagement.

Fifteen years ago, the International Conference on Population and Development (ICPD) brought a special focus on sexual and reproductive health, which unlike other fields of health, is the most implicated by socio-economic and cultural factors. By doing so, the ICPD brought the frame of health as human rights, front and center. In claiming the human right to health, citizens do more than assert an entitlement to receive services, they also directly engage in defining the terms of social relationships between providers and recipients of care. ♦

[1] Slowdown hits Mexico remittances, BBC Business News, January 2009

ERRATUM: p.2, par. 7, ICPD+15 at the Crossroads: Health, Rights and Citizenship: Please disregard the second sentence which refers to the Nigerian MDG projects as “isolated to select Millennium municipalities” and Millennium Cities.” The special agency called the Office of the Senior Special Assistant to the President on the MDGs (OSSAP MDGs) manages all funds accruing to Nigeria from the Paris club debt relief agreement. These funds are then channeled to projects in various sectors such as health, water and sanitation, energy, agriculture, skills and economic empowerment. Projects are managed at state levels by offices specifically working on the MDGs.

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