**Barbara Klugman comments at launch of “Accelerate Progress: SRHR for All” – The Report of the Guttmacher-Lancet Commission on SRHR**

**9 May 2018, Constitution Hill, Johannesburg**

Thank you Phindile,

I can lay claim to having represented the South African government in the ICPD working group that negotiated the definition of reproductive health, which included the right to a safe and satisfying sex life. I’ll never forget the honourable delegate from Iran asking how we would measure this! So, this is a long road….

Let me start by congratulating the *Guttmacher Institute* and *the Lancet* for taking this initiative, and the Commissioners for a fine report that pulls together the public health evidence and the human rights values required to deliver sexual and reproductive health and rights for all.

I have to tell you that I read the Report of the Commission and wanted to weep. Why? Because in 2010 the South African Department of Health commissioned the development of a *Strategic Framework for Sexual and Reproductive Health and Rights* – essentially a national version of your report, led by a National Steering Committee of experts from government, academia, clinical professionals and civil society. The framework was called, ‘**Sexual and Reproductive Health and Rights:** **Fulfilling our Commitments**: **2011–2021 and beyond’**. I spent over a year co-ordinating the research and drafting process. When I read your report, I went back to this framework and lo and behold, its rationale, and also its list of components of sexual and reproductive health and rights (p10/11) matches exactly, those of your report (p81). In 2011. But despite the high level of consultation, the strong reliance on evidence and that it brought together existing national laws and policies, nothing happened. It was never published and never taken on board as a basis for mobilising government and the public towards acceptance and delivery of SRHR.

This provides a critical lesson for how you all may need to communicate the findings of this report and that is, that **political will trumps all other factors**.

We demonstrated just how political will can very rapidly save thousands of lives, firstly by how within a few years of implementation of the abortion law, our maternal mortality from abortion dropped – the figures are in your report; and secondly by how once we decided to provide anti-retroviral services, we managed to roll out to millions of people. This is called political will. But no amount of good laws, ensure that such political will is sustained. For it is lack of political will that explains not only why the framework was never taken on board, but why access to abortion services, among others, has declined dramatically with a related likely increase in maternal mortality and morbidity,[[1]](#footnote-1) indeed every day we field desperate queries from women unable to access abortions in the public health system. Can you believe it? It is similarly lack of political will that explains why comprehensive sexuality education is still not operative nationally, and, despite having amongst the highest levels of sexual violence in the world, why our National Programme of Action Addressing Violence against Women and Children 2013-2018 is not being implemented in every school, community, health service and police force to shift social norms and practices in favour of sexual and reproductive rights.[[2]](#footnote-2) Is our government’s decision to launch this report as well as She Decides a sign of renewed commitment to action? I hope so.

So this talks to my second lesson – **the importance of sustaining organised civil society** in its many roles – from building evidence to training public health providers to monitoring quality of services, to organising and ensuring the participation of those most excluded from services to both know their rights and to speak out when they’re not met, using a range of accountability mechanisms. The original victories in SRHR in South Africa were won through a coalition of highly organised and highly strategic civil society groups which, having won the necessary laws and policies, and supported government in their implementation, slowly vanished. Funders lost interest because ostensibly the battle had been won. Funding poured in for HIV, and only HIV, both funders and HIV organisations utterly ignoring its links to gender-based violence, unwanted pregnancy and unsafe abortion, exacerbated by the global gag rule. Over 10 years, all but one of the groups that had got SRHR onto the national agenda were closed and the one remaining, had shifted focus to only HIV. So, my second lesson is that civil society organising needs to be sustained and continually vigilant if we’re to achieve SRHR for all. I should say, that over the last three years the Sexual and Reproductive Justice Coalition, of which 3 of us on this panel are members, has vigorous and effectively held back ongoing attacks in parliament, and confronted stigmatisation in clinics and in communities – precisely the social norms your report addresses.

There is a similar story in relation to the huge civil society mobilisation around HIV that came next, where once the right to ARVs were won, many funders stopped funding the grounded organising of civil society and that, in turn has mean that the brilliantly effective forms of ‘treatment literacy’ implemented by the TAC are no longer operative and incidence rates are not continuing to drop and indeed, among some groups, they’re going up again.]

That said, as always, civil society in this country continues to develop innovations from which others can learn. I want to alert you to lessons others could draw on ways of addressing one of the challenges raised in the report, “the problem of lack of consistent supplies of health commodities” (p76) Some years ago a mix of organisations, from the Treatment Action Campaign to Section 27, to the HIV Clinicians’ Society to the Rural Health Advocacy Project, to Medicines Sans Frontieres, started collaborating in protesting against the continuing absence of drugs, particularly ARVs, especially in rural clinics. This has become the Stop Stockouts Project. They encouraged clinic users to let them know, ultimately putting stickers in buses and other public spaces providing a cost-free phone number. Each time the SSP hears drugs are missing, they contact the local clinic. If they do not resolve it, SSP contacts the district level managers. If they don’t resolve it they take it higher. What began with public protests the government ultimately realised would help them work out what is going wrong where, and so SSP and the Department of Health negotiated what they call an ‘escalation protocol’ giving government at each level a certain amount of time in which to redress the commodity gap, before SSP goes public and using the media to draw attention. This example reinforces my point about the critical importance of supporting diverse kinds of groupings in civil society to organise and collaborate. In this case, for example, organised rural health providers can whistle blow to the SSP – so while they’re organised, they don’t render themselves or their clients vulnerable. That said, they have not taken on the medical abortion drugs – misoprostol and mifepristone – despite requests which is a sign of the continuing discomfort with sexual and reproductive rights even among progressive civil society groupings.

So, to open this conversation my contribution is firstly that political will trumps all, and secondly, because of that, funders need to stay committed and civil society needs to stay organised, bringing together users of services, researchers, communicators. Thank you.

1. – but we no longer collect information on maternal deaths specifically related to abortion – we collect on miscarriages spontaneous and elective – and the data is difficult to discern. And HIV positive woman who dies from a septic abortion is most likely to be recorded as a death from HIV. 34 % of maternal mortality is from HIV 9.5% from unsafe miscarriages, septic miscarriages [↑](#footnote-ref-1)
2. The report notes that ‘where HIV is endemic, HIV/AIDS services have often received priority and external donor assistance. Yet, domestic and international funding for other SRH services – related to abortion, STIs, sexual violence, sexual function, infertility, and reproductive cancers – has been much more limited.’p19 [↑](#footnote-ref-2)