

# **Sexual and Reproductive Health and Rights in the Post 2015 Development Agenda<sup>1</sup>**

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## **1. Background**

Women's health is currently shaped by the confluence of two important policy trends. On the one side, the evolution and transformation of health system reform policies has shaped and continues to influence the amount and type of health funding, policies towards human resources for health, the definition of health service priorities, pharmaceutical and technology policies, and management and regulatory frameworks. This has been complemented by macroeconomic policies that affect budgets and policies for key social determinants of health outside health service provision such as nutrition, water and sanitation. On the other side, from the early 1990s on, a strong articulation of a human rights based approach to health has emphasized laws and policies to advance gender equality and sexual and reproductive health and rights (SRHR). While women's health and the problem of gender inequity in health are broader than SRHR (Sen and Ostlin 2010), the latter raise a set of core human rights challenges for development, which this paper addresses.

The two trends identified above have overlapped at times but have more often than not been contradictory in recent decades. Under the aegis of neoliberal economic reforms and structural adjustment since the 1980s, health systems and health sector reforms have tended in many countries to constrain availability of and access to health services while raising their cost through user fees and price decontrol of key inputs such as drugs (Homedes and Ugalde 2005; Van Doorslaer et al 2007; Leive 2008). Such reforms have been challenged by many as violating the fundamental right to health that is a key element of the human development agenda, and of the normative framework for human rights. However, as enunciated until the

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<sup>1</sup> Discussion Paper for ICPD *Beyond 2014 – International Conference on Human Rights, Netherlands, 8-10 July, 2013.*

early 1990s (and by many actors even up to the present time), the right to health was understood to refer mainly to health services and other actions such as the provision of potable water and sanitation that were to be undertaken directly or indirectly by states on behalf of their citizens. From the vantage point of SRHR, this traditional approach to the right to health is certainly preferable to neoliberal health reforms, but it doesn't go far enough.

The drive for sexual and reproductive rights represents an inclusive trend toward human rights to health that goes beyond the right to health services. It was in the United Nations conferences of the 1990s (especially the ones held in Vienna in 1993 on human rights, in Cairo in 1994 on population and development, and in Beijing in 1995 on women) that women's organizations transformed the traditional understanding of the right to health by directing attention to girls' and women's rights to bodily autonomy, integrity and choice in relation to sexuality and reproduction.

The International Conference on Human Rights in Vienna recognized violence against women (VAW) as a violation of women's human rights in both public and private life, noting that, barring conflict situations, most of VAW is perpetrated not by the state but by intimate partners and through harmful customs and practices (Zulficar 1995). It thus brought the violation of women's human rights down to families and communities, and recognized that VAW is embedded in gender power relations that are experienced and reinforced in the life of the community. Because of its serious consequences for the lives and health of women and girls, VAW requires recognition that the right to health goes beyond the right to health services or narrowly defined social determinants of health. It includes a right to be protected from the harmful consequences of gender power relations on health. These consequences are experienced both directly on health, and indirectly through other elements such as education, freedom of mobility, income earning, or others that affect women's ability to be free of violence. This more gender-responsive concept of the right to health requires the state to respect this right in its own laws, policies and institutions; and to take active measures to fulfil them in homes, communities, markets and other institutions.

The above more inclusive understanding of the right to health was deepened further at the International Conference on Population and Development (ICPD) whose consensus outcome spelled out sexual and reproductive health and rights as part of daily life even in the absence of violence. SRHR was understood to include other elements affected by gender power relations such as women's rights to exercise choice in sex and reproduction within or outside marriage; to bodily autonomy and integrity; to decision-making and control by women over their own bodies *vis a vis* not only states and religious hierarchies, but also in relation to families, partners, and communities. The ICPD also spelled out many of the harmful community and family level practices that violate girls' and women's human rights including their right to health, and identified positive steps that would need to be taken. The Fourth World Conference on Women held in Beijing in 1995 reinforced the outcomes of Vienna and Cairo in a number of ways, most importantly by specifying women's equal right to sexuality "free of coercion, discrimination and violence" (United Nations 1996, para 96).

Vienna, Cairo and Beijing (as these conferences are colloquially called) thus affirmed a more inclusive meaning for the right to health: for women and girls in particular, the right to health is not only about obtaining health services, or providing nutrition, clean water and sanitation. The right to health includes the right to decision-making, control, autonomy, choice, bodily integrity, and freedom from violence and fear of violence. States have a responsibility not only to provide access to health services but also to respect, protect and fulfil the above aspects of women's and girls' human rights *vis a vis* states' own actions as well as those of families, communities and the private sector.

The emergence of this more inclusive agenda of women's human rights to health has been contentious, but arguably no more so than other human rights. An expanded concept of the right to health to include sexual and reproductive health and rights is essential if laws, policies and programs are to respect, protect and fulfil the health of girls and women. However, this expanded understanding has been ghettoized from the more mainstream debates on the right to health, and was only partially included in the Millennium Development Goals (MDGs) as is well known. Barring HIV/AIDS, SRHR and, in particular, ICPD's transformation of the meaning of rights has tended to be marginalized from health

sector reforms discussions including the debates on universal health coverage for instance (Ravindran and de Pinho 2005). And it has faced opposition from conservative religious and other forces opposed to gender equality and women's human rights.

Concerns about how to position SRHR in relation to the Post 2015 Development Agenda have, in consequence, ranged from concerns that it may be ignored or set aside as unimportant, to fears of aggressive negative politics against SRHR. This paper argues in favour of a two-fold approach to placing SRHR effectively in the context of the Post-2015 Development Agenda: *first*, firmly ground it in an inclusive approach to the right to health; and *second*, drawing on two decades of national level implementation, propose a forward looking agenda that builds on good practice while addressing critical challenges central to the development framework itself. The next sections of the paper address these two aspects.

## **2. An inclusive concept of the right to health**

Paragraph 7.3 of the ICPD Programme of Action (POA) states: “Bearing in mind the above definition,<sup>2</sup> reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents....” The paragraph goes on to clarify what this means: the right of individuals and couples to choose whether, when and how many children to have, and to have the information and means to do so in the form of family planning and other programmes and services; as well as the right to make these decisions free of coercion, discrimination and violence, and to attain the highest standard of reproductive and sexual health. Government- and community-supported policies have a duty to promote these rights, including the promotion of respectful and equitable gender relations, and especially to meet the educational and service needs of adolescents “to enable them to deal in a positive and responsible way with their sexuality”.

The rights and duties referred to in this paragraph of the POA were clearly seen as part of existing human rights. Further delineation and refinement have taken place by

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<sup>2</sup> Definition of reproductive health including sexual health in para 7.2 of the POA.

intergovernmental consensus, global and regional agreements, and General Comments of human rights treaty bodies since then, *inter alia*:

- In paragraph 96 (on the human right of women to control and decide on matters related to their sexuality free of coercion, discrimination and violence) of the Beijing Platform for Action (United Nations 1996);
- in paragraph 63 (iii) (where abortion is not against the law, health systems should train and equip health-service providers and take other measures to ensure that abortion is safe and accessible) of the Key Actions for the Further Implementation of the POA of the ICPD adopted at the five year review of ICPD (UNFPA 2004);
- in a number of paragraphs (11, 14, 16, 18, 21, 22, 23, 34, 35, 36, 44, 51,52) covering a range of issues including among others SRH information, education, services, harmful traditional and other practices, non-discrimination and equal treatment on the basis of sexual orientation, the right of adolescents to youth-friendly services) of General Comment Number 14 (on the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights (ESCR)) of the UN Committee on ESCR adopted in 2000 (United Nations 2000);
- in the UNGASS on HIV in 2006 (United Nations 2006, para 30) and 2011 (United Nations 2011a, para 53) on the rights of women and adolescent girls;
- in the Human Rights Council Resolution on HIV in 2011 (United Nations 2011b, *passim*) that recognizes the need to protect and promote human rights as understood in previous international commitments;
- in the Agreed Conclusions of the 45<sup>th</sup> Session of the UN Commission on Population and Development (on adolescents and young people) (United Nations 2012, *passim*);
- in the Agreed Conclusions of the 57<sup>th</sup> Session of the UN Commission on the Status of Women (on violence against women) (UN Women 2013, *passim*);
- in the Maputo Protocol (2003) to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Article 14 on Health and Reproductive Rights including *inter alia* the right to medical abortion) adopted in 2003; and
- in the regional outcomes of the intergovernmental meetings held by respective Regional Commissions in Montevideo, Bangkok and Addis Ababa in 2013 (<http://icpdbeyond2014.org/key-events>).

Many of these clarifications and refinements, among others, refer to legal, policy, programme, and budgetary actions that governments and other duty-bearers should take in order to ensure that these human rights are respected, protected and fulfilled.

They also point in the direction of a comprehensive, inter-sectoral and integrated approach so that SRHR is placed firmly within the broad development framework. Despite this, for funding and other reasons, there has been a tendency in the last two decades to split off particular parts of the SRHR agenda for separate treatment as has happened with both HIV/Aids (Germain, Dixon-Mueller and Sen, 2009) and more recently in the discussions on a new thrust for family planning (Sen, 2010); and also to separate SRHR from the broader development agenda.

From a human rights perspective, such splitting off is deeply problematic since it downgrades critical elements of the SRHR agenda, and makes it more difficult for duty-bearers to respect, protect or fulfill those elements. This means, in the context of the Post 2015 Development Framework, that particular attention is needed to ensure the inclusion of all the critical elements of the SRHR agenda, without cherry-picking only the easy or uncontroversial parts. This should ensure inclusion of such elements as prevention of harmful practices such as early and forced marriage, FGM, and a number of other violent practices, supporting girls' and women's right to a full range of SRH services including *inter alia* choice and availability of multiple methods of contraception without implicit or explicit coercion, access to safe abortion services and post-abortion care, the right of adolescents to comprehensive sexuality education and to SRH services with confidentiality and privacy, to name some of the most important ones.

### **3. Positioning SRHR in the Post 2015 Development Framework – Quality, Equality, Accountability**

Two decades of implementing SRHR at the national level have provided considerable experience and understanding of good practices as well as ongoing challenges. It is important in this regard to view the coincidence in time of the Post 2015 and the ICPD 20 processes not as a problem but as an advantage. The potential advantage is that SRHR has the possibility of being elaborated and debated in the public eye and can therefore actively influence the Post 2015 agenda. But to do this, a fresh approach and vision are needed that can capture the public imagination anew while at the same time addressing the unfulfilled parts of the Cairo agenda. Repositioning SRHR in relation to human development and human rights must be done through attention to the main gaps in the last two decades of implementation.

There is considerable evidence to suggest that the three main gaps in both SRHR and MDGs implementation at present are the absence of quality<sup>3</sup> in service provision; the fact of large and growing inequality; and the need for accountability<sup>4</sup>. Globally, and in many countries, the quality of services is poor and services are inaccessible, unaffordable or unacceptable (Germain 2013). Health services quality, especially in low and middle income countries, has been adversely affected by the funding and personnel shortages that followed from neoliberal approaches to health sector reforms. Family planning was one of the earliest health agendas to develop simple and doable approaches to the problem of quality (Bruce 1990). Despite this, and despite the existence of WHO technical guidance, the absence of a culture of quality and insufficient attention to it by funders and governments alike has meant that SRH service quality failures are wide-spread and often border on human rights violations.

This particularly hurts the poorest women and girls, as well as those living in rural and remote areas, or belonging to oppressed or marginalized groups, and makes thereby for high inequalities in service provision and use (UNFPA 2013b). While poor women generally suffer the most from these gaps in services, adolescents and especially young adolescents in the age range 10-14 years often do not even have their sexual and reproductive health needs

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<sup>3</sup> I use Quality here as short-hand for the AAAQ - Availability, Access, Acceptability and Quality.

<sup>4</sup> The most recent evidence of these problems, especially high inequalities, is the Global Review Report on ICPD implementation (UNFPA 2013b) which was published after the first version of this paper was written.

or rights acknowledged as such<sup>5</sup>. Inequality thus has multiple dimensions, not only of poor versus rich, but also on the basis of age, rural versus urban residence, ethnicity or caste, sexual orientation and gender identity, or disability, to name some of the major dimensions. At least one reason for weak attention to inequality is that the paradigm shift from top down population control (pre-ICPD) to more human rights responsive policies needed considerable attention to accountability if policies and programmes were not to slide back into old ways. But this has also been one of the most difficult things to build, as entrenched beliefs, practices and institutions have militated against acknowledging the accountability deficit in relation to human rights.

An approach based on criteria of quality, equality and accountability would advance SRHR laws, policies and programmes towards respecting, protecting and fulfilling the human rights of the most disadvantaged women and young people, especially adolescent girls. Such an approach would also provide new energy and needed momentum in national policies and programmes including those linked to new funding for family planning under FP2020<sup>6</sup>. It could also generate valuable synergies between multiple global institutions: between UNFPA and WHO on how to move towards universal health care; between UNFPA and UN Women on empowering women (particularly but not only by addressing violence against women), and between UNFPA and OHCHR on addressing the challenge of realizing SRHR as human rights in practice.

As discussed earlier, the lessons from the MDGs review process suggest strongly that the setting of goals, targets and indicators is both a technical and a political exercise. *First*, it is essential not to over-quantify, over-simplify or create overly closed systems impervious to lessons from below or experimentation. A mix of quantitative and qualitative metrics is needed in order to place quality, equality and accountability front and center. *Second*, it will

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<sup>5</sup> UNFPA has recently come out in support of a goal for adolescents (UNFPA 2013a) that is cogent and well argued; how much momentum it is able to pick up in the post 2015 discussions remains to be seen. Although there was a full track on Inequalities in these discussions culminating in a multi-stakeholder consultation in Copenhagen in early 2013, inequality has not picked up much momentum so far in the larger discussion except among civil society.

<sup>6</sup> Family Planning 2020 (FP2020) is an initiative of the Bill and Melinda Gates Foundation launched in 2011 with multiple donors to provide new funding and momentum to family planning.



be crucially important to create and maintain space for effective engagement by civil society whose mobilization will be essential in order to retain public attention, and to ensure country level focus and follow through. *Third*, and not least of all, the human development and human rights implications of choices (both what is included and what is left out) and the organizational and individual incentives they generate must be clearly spelled out and addressed.

It is generally agreed that the post-2015 development goals should be fairly broad ones that can be benchmarked as global standards. Targets and indicators should be both more specific and clearly linked to each other and to the goals, but should also allow for more flexibility and appropriateness to the country context. The criteria of Quality, Equality and Accountability need to be applied at both global and country levels.

The usefulness of focusing on quality, equality and accountability is that it brings human rights very naturally to the development of targets and indicators. Targets and indicators can include a focus on specific programmatic aspects and can also be focused particularly on improving the SRHR of women and adolescents as specific target groups. In doing this, SRHR can be linked (especially for adolescents) with the prevention of non-communicable diseases (NCDs) through healthier living including the prevention of smoking and alcohol abuse, and actions to protect adolescent girls from a range of practices and risks such as violence, or early and forced marriage.

#### **4. Conclusion**

This is a critical time when both the SRHR and MDG reviews are running in parallel, and when the Post 2015 Development Agenda is being negotiated. It is important for the advocates of SRHR at multiple levels – countries, agencies, funders, and civil society – not to retreat in the face of a vocal minority opposition. The human development and human rights basis of the SRHR agenda are profound and must be spelled out with clarity and vigor.

At the same time, it is important to be clear about the likely scenarios for the setting of goals and to maximize the potential therein. This can be very valuable for the SRHR agenda provided it is done with care and pragmatism, and with a clear sense of direction.

This is the time for the SRHR community to show leadership for the Post 2015 Development Agenda by putting forward a creative and fresh vision backed up by strong technical work and supported by an energized civil society. Placing Quality, Equality and Accountability at the center of this approach can generate considerable momentum. It will show how SRHR can lead the way to translating rights from rhetoric to actual practice.

Such an approach meets multiple objectives:

- It is rooted in human development and human rights;
- It allows strong synergies with the larger health, gender equality, education and other agendas;
- It builds on key civil society strengths in the organizations of women, young people, and those concerned with family planning.
- It would solidify the support of many countries for SRHR as part of the larger Post 2015 Development agenda.

## **Annex – the UN Process**

The development agenda for the period after the final year of the Millennium Development Goals (MDGs) in 2015 is evolving along multiple and intersecting tracks.

### The MDGs Review process

The MDGs review process has included an intergovernmental process as well as reviews by both the UN secretariat and non-governmental networks. A Special Event to generate political momentum for accelerated progress on the MDGs, to spell out a roadmap up to 2015, and to hold preliminary discussions on the Post 2015 framework took place at the General Assembly session in September 2013. The co-chairs for the Special Event– Ireland and South Africa –included SRHR (under maternal mortality) in their draft of the “elements” for an outcome statement.

Another part of the MDGs review was undertaken by the UN Inter-Agency and Expert Group on MDG Indicators (IAEG-MDG), consisting of international agencies, regional organizations and national statistical offices, which has been responsible for the global and regional monitoring of progress towards the MDGs. The IAEG-MDG created a Task Team on Lessons Learned from MDG Monitoring to share its experiences from the monitoring of the MDGs, to provide technical support to the Rio + 20 follow-up and to guide the formulation of the Post 2015 Development Agenda.

This Task Team’s Report (UN IAEG-MDG, 2013) examined the strengths and weaknesses of the MDGs approach, the criteria for setting targets and indicators, and the role of the statistical community. Its main critique of the current methodology is that it has been too top-down; some goals, targets and indicators were inconsistent; there was no clarity on how targets were set, some of which were over-ambitious and poorly specified; there were distortions in priorities as global targets were taken to be national ones; global trends were dominated by large countries; some countries had problems with inappropriate baselines; the framework did not pay attention to inequalities; and the capacity of statistical offices was very mixed. Based on this, the Task Team recommended, among other things, that the Post 2015 targets should be consistent with

goals; should be quantifiable and time-bound; should be set in consultation with countries, and draw on national statistical capacities. Flowing from this, the Task Team argued that the indicators should be clearly linked to the monitoring of targets and goals, methodologically sound, measurable and understandable, as well as coherent and limited in number.

While apparently straightforward and clear, these recommendations have been challenged as not going far enough by researchers of the independent project on “The Power of Numbers” whose work represents an attempt “...to more fully understand the consequences of the Millennium Development Goals (MDGs) on development agendas, including both the empirical effects on policy priorities and strategies and normative effects on development discourses about important objectives and means to achieve them. In particular, the Project is concerned with whether these effects further the people-centered vision for development enshrined in the Millennium Declaration....” (Fukuda-Parr and Yamin, 2013; p 1).<sup>7</sup>

Drawing on the work of Merry (2011) and others on “indicators as a technology of governance”, the project shows how MDG indicators not only created performance standards but also created so-called ‘knowledge effects’ that re-defined and significantly shaped the purpose and meaning of development itself through acts of both omission and commission. In doing so, the simplicity of the MDGs became overly simplistic; difficult to measure outcomes such as participation, voice and accountability – essential for development as a transformative agenda - were sidelined; and processes of social change where people are active agents and not just passive beneficiaries were lost.<sup>8</sup> This was true for both MDG 3 and MDG 5 where incoherent indicators, targets and

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<sup>7</sup> The full working papers for the project are available on the website of the Harvard School of Public Health / FXB Center at <http://harvardfxbcenter.org/power-of-numbers/>. In particular see the papers on MDG 3 and MDG 5. Shorter versions of the papers will be forthcoming after the usual review process in a special issue of the Journal of Human Development and Capabilities.

<sup>8</sup> “...This Project highlights that goal setting is a poor methodology for elaborating an international agenda and that the instrument of quantitative targets has the power to distort priorities. A simple list of numerical targets cannot articulate an agenda for a complex process, such as sustainable, inclusive development. The studies in this Project strongly argue that by attempting to elaborate an agenda by numerical targeting, simplification, reification and abstraction of quantification creates perverse effects. The post 2015 development agenda and the SDGs need not only to go beyond “finishing the agenda of the MDGs” but also beyond setting goals and targets. Quantitative targets are powerful as a communications tool and can provide benchmarks for monitoring progress. But a transformative future development agenda requires a qualitative statement of objectives, visionary norms and priority action needed to achieve the objectives,

goals together with such knowledge effects diminished and narrowed the ICPD and Beijing agendas and their intersection for SRHR. Moving forward to the post 2015 period will therefore require particular attention to the way goals, targets and indicators are set.

### High Level Panel Report and Thematic Consultations

The second track of the process to determine the future development framework is not an intergovernmental process per se, but one driven by the UN Secretary General's setting up of a High Level Panel (HLP) that produced its own report in mid 2013.. This was supported by a set of thematic consultations co-hosted by pairs of member-states, with different specialized UN agencies providing the technical backstopping. Considerable effort was expended by women's organizations in particular to ensure that SRHR would not be dropped out of the key thematic consultations – on health, on inequalities, and on population dynamics. The result was a mixed beginning.

Although SRHR was highlighted by a number of participants in both the physical and the on-line consultations on inequalities and health, key documents sometimes reflected the ambiguity or conflicting interests of important stakeholders. On inequalities, the vibrant on-line consultation and physical meeting did not appear to lead to strong enough steps towards incorporation of inequalities in the HLP Report. On health, the particular concern for the advocates of SRHR has been the need to retain attention to the health needs and rights of particularly disadvantaged and under-served groups such as adolescents (ages 10-19) and women, even as much of the discussion has been about the need for health system reform through universal health coverage / care (UHC). Experience with UHC in many low and middle income countries suggests that the *path* to UHC may or may not be an equitable one (Gwatkin, 2013). Even if a UHC scheme improves affordability (as happens quite often), this doesn't necessarily translate into better access. Such translation often requires addressing access in a more holistic way. As argued by Giedion, Alfonso and Diaz (2013), it means tailoring UHC programmes carefully to the needs of target populations, and highly focused interventions (such as to adolescents or women) as a

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including legal, policy and global institutional considerations." (Fukuda-Parr and Yamin, 2013; p 8)

valuable first step towards UHC. This is certainly a point worth emphasizing on the path to the 2015 development agenda.

Negotiating a place for SRHR through the health agenda means managing the complex politics of multiple strong organizations and stakeholders. The opposite is true for inequalities where there is no global agency in place; while there are multiple stakeholders, they do not always work with synergy towards common goals. Competition rather than collaboration can weaken civil society efforts to obtain the buy-in of other interests.

Finally, on population dynamics, the challenge is peculiar since this is largely in the hands of UNFPA itself. On the road to Cairo and its change of paradigm from population control to human rights, an important agreement on a *modus vivendi* was the one between women's health and rights advocates and demographers. While that compromise has largely held over two decades, it is a little thin on the margins, with pressure from some environmentalists and others that suggest a resurgence of old population control mindsets. In view of the special funding for family planning through FP2020 and its positioning in relation to that funding, it especially behooves UNFPA to ensure that the evidence base built up over the past two decades is brought to bear to ensure continued support for SRHR in the years ahead.

The final Report of the HLP (2013) was itself fairly clear on SRHR. It called for "...the full range of health services including SRHR..." (p 17), and included "Ensure universal sexual and reproductive health and rights" as an illustrative target in Annex 1 (p 30). However, the Report has come in for considerable criticism from civil society organizations as not providing a strong enough development framework overall, or new directions to address overriding problems of poverty and inequality as well as unsustainability.

#### Post Rio+20 SDGs Process – Open Working Group and the High Level Political Forum

The intergovernmental negotiations at Rio +20 had agreed that the post 2015 agenda would be linked to sustainable development and would be carried forward through an Open Working Group (OWG) of member states. A permanent High Level Political Forum to address the

challenges at an appropriate level was also agreed upon, and is intended to replace the Commission on Sustainable Development within a short time-frame.

Sessions of the OWG are under way in New York under Kenya and Hungary as the co-chairs. While these are not negotiated sessions, member states are taking the process seriously as providing early space for discussions and the laying out of views and directions. The session on Health and Population Dynamics held during OWG4 in June 2013 also surfaced considerable support for SRHR among member states<sup>9</sup>, strong presence of the Women's Major Group (one of 9 Major Groups in the official Rio + 20 process), but also some opposition from conservative states. An even larger group of countries expressed support for SRHR during OWG8 in early 2014. Since this process is the main intergovernmental process for the Post 2015 Development Agenda, it requires continuing attention.

It is clear from the above that the Post 2015 Development Agenda processes are running in parallel with the ICPD 20 review with its Global Survey, Thematic Forums, and the Regional Consultations that were completed by September 2013. Despite concerns expressed a couple of years ago that the ICPD processes might be negatively affected by this, the reality has been somewhat the reverse thanks to effective mobilization and consistent presence including by civil society organizations. The positive effects of the strong results of CPD 45 and CSW 57 have had a favorable impact on the climate for SRHR overall. This is despite the fact that the Rio +20 outcome was itself mixed. Coming shortly after the strong success of SRHR for adolescents during the CPD in 2012, the Rio + 20 outcome's refusal explicitly to acknowledge reproductive rights in so many words was unfortunate even though it did affirm "...commitments leading to sexual and reproductive health and the promotion and protection of all human rights in this context" (Health para 145). Nonetheless, continued progress since then including at the Bali Youth Forum and the 57<sup>th</sup> CSW on Violence Against Women, and strong outcomes at the Regional Commission meetings in Latin American and the Caribbean as well as in the Asia-Pacific give room for cautious optimism.

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<sup>9</sup> Uruguay read a strongly supportive statement on behalf of 24 states from across different regions.

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