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Evolution and involution in the sexual and reproductive health services in Catalonia (Spain)

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SYNOPSIS

In this paper we critically analyze the genealogy of the adoption of SRH*R* approaches in Catalonia. The reflections are based on a two-stage research project carried out within the Catalan Sexual and Reproductive Health Program (PASSIR). The main finding of the first part of our inquiry is a clear gap between discourse and practice. While the PASSIR design appears to incorporate the SRH*R* paradigm, the service is still targeting heterosexual women of reproductive age and mostly adopting a medical approach. Furthermore, as shown in the second part, the data analyzed evidence that the discourse of achieved transformation is far from being consolidated. In fact, the new Spanish and Catalan governments' turn to the right in conjunction with the austerity policies related to the global crisis seems to question the whole basis of the SRH*R* approach. We conclude our presentation by reflecting on the meaning of our findings for feminist practices.

Introduction

During the last 30 years Spanish democracy has been engaged in a process of adaptation to European standards (Dema, 2008), and the "Mediterranean-Latin Welfare State" model implemented has experienced a great impact, both qualitative (adjustment to EU policies) and quantitative (financing of social spending by structural funding), from EU social policies (Gallego, Subirats, & Gomà, 2003). In this sense, one of the main efforts of the different Spanish governments has been towards strengthening the public health system, which has become a robust and positively evaluated institution (García, Abadía, Durán, & Bernal, 2010; Rodríguez, Scheffler, & Agnew, 2000). Focusing on the specific case of the Catalan Sexual and Reproductive Health Services, in this article we wish to analyze whether this convergence with the SRH*R*[1] EU approach has been achieved at discursive and practical levels. Furthermore, the robustness of this change is analyzed in the current specific political and economic context.

Research and methodology

The research for this article was developed in two phases. In the first, carried out in 2011 and funded by the Catalan Women's Institute (ICD), the aim was to analyze access to SRH*R* services in two Catalan cities and to evaluate whether the international shift to the Sexual and Reproductive Health and Rights (SRH*R*) approach (Corrêa, 1997; Corrêa & Petchesky, 1994; Sen, 2010) had been implemented in Catalonia. In 2013 we implemented the second phase, whose main focus was to detect the way in which the worsening of the economic crisis combined with the rise of conservative government, both at national and regional level, affected this process. Maria Olivella, responsible for the empirical part of the research, administered twenty-five semi-structured interviews to: four people in charge (or formerly in charge) of the Catalan institutional SRH*R* Program, or in decision-making positions in this area (policy makers, PM in the article); eight sexual and reproductive health practitioners (SRHP); eight people working in non-profit associations dedicated to SRH*R* (NP); two non-profit officers (NPO), and one politician particularly active in the defense of SRH*R* (POL). Some of the participants were involved in both phases of the research, while others collaborated in just

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one. All explicitly accepted being interviewed and quoted in the context of the research. Furthermore, despite the fact that only some specifically required to remain anonymous, we decided to present all contributions anonymously in order to preclude any possible problem.[2]

The analysis used has been a critical content analysis, both of the SRH*R* policies implemented by the Catalan government (briefly mentioned in this article) and of the interviews. The material is therefore presented following narrative construction methods (Biglia & Bonet, 2009).

Theoretical background

The politicization of sexualities and the SRHR paradigm

The politicization of sexuality has a long history that according to Federici (2004) can be traced back at least as far as the twelfth century A.D. to the Catholic Church's policies on sexuality. Since then, different perspectives ranging from natalist to eugenicist have been driving political control of natality, and therefore of sexuality and women's bodies. In particular, 'fertility control' and 'discipline of the body' were used in late modern times in the configuration of Nation States (Unal & Cindoglu, 2013). Nonetheless, capitalist society opened a new chapter in this history due to the importance assumed by reproduction (in its broadest sense) (Dalla Costa & James, 1972) and later by globalization. In late capitalism however, the significance of reproduction and the design of associated policies cannot merely be read on a local scale, but must be understood in relation to class and geopolitical dynamics (Dalla Costa, 1995). In fact, after the Second World War the actions of the United Nations Organization caused the configuration of a new worldwide demographic order (Luxán, 2007) and led to the development of population control programs in 'third world countries' (Caulier, 2010). According to Silvia Federici (2012), the UN's "self-appointment as the agency in charge of promoting women's rights enabled it to channel the politics of women's liberation within a frame compatible with the needs and plans of international capital and the developing neoliberal agenda" (Federici, 2012, p. 98).

At the climax of the social mobilization that characterized the 1970s, feminists insisted that these policies violated the right of women to have autonomy over their own bodies, in both reproduction (abortion, contraception, reproductive health) and sexuality (pleasure, sexual orientation). The international success of the book "Our Bodies, Ourselves", written by the Boston Women's Health Book Collective (1971), is a sign of the importance of the topic. In particular, in the book as in the street, there was a call for the self-determination of bodies, sexualities and reproductive practices. In this sense, the 1960s discourse of reproductive rights that was promoted by the UN and emphasized couples' choice to decide -when faced with states and other institutions- how many children to have, and to regulate their own fertility (Dixon-Mueller, 1993) was strongly criticized, as it did not take into account the degree to which power relations linked to practices of gender, class and ethnicity frame individual decision making. But feminists did not limit their action to criticism, they also organized many self-help groups and lobbied globally for the recognition of women's rights. Following this last line, it should be mentioned that at the 1994 Cairo International Conference on Population and Development, feminist groups brought to the table the principle of respect for the sexual integrity of women (Girard, 2007). After long discussions and negotiations, the existence of the reproductive rights (RR) of women was finally recognized, and a call was made to improve reproductive health (United Nations, 1995). One year later, at the UN's Fourth World Conference on Women in Beijing, the main challenge was a long-held LGBT claim: the importance of recognizing that sexuality and reproduction do not have to be subsumed (Girard, 2007).

These conferences are therefore considered turning points in the struggle to move from a health logic, focused on population policies and family planning, to a logic that recognizes "women's reproductive and sexual self-determination as a basic health need and human right" (Petchesky, 1995: 152). As Gita Sen (2010) said, there was also a move from an essentially biomedical approach to a perspective that acknowledged "the centrality of power relations […] that shape the most intimate personal decisions and actions" (Sen, 2010: 143) and that framed them within the human rights approach (Repoliticizing SRHR group, 2011).[3] The proposed SRH*R* framework challenges traditional notions of medicine and public health, an approach that according to Jonathan Mann's (1997) perspective, must not only assume a new health vocabulary that places the focus on societal conditions rather than biomedical patterns, but must also move towards justice, autonomy and respect for human rights.

In this section we have clearly, if briefly, shown the international displacement of sexualities and reproductive politics and the adoption, at supranational level, of a language strongly influenced by feminist discourses and claims. We can now, following Smyth (1996), question whether these new languages correspond to a real change of paradigm or are mostly an instrumentalization of feminist claims. This is one of the points that we will analyze in the specific case of the Catalan system.

Sexual and reproductive health in Spain and Catalonia

During Franco's dictatorship, contraceptive pills and abortion were forbidden, adultery was punished, and although homosexuality was legally condemned, lesbianism was mostly neglected (Juliano & Osborne, 2008). Women imprisoned for so-called "women's discrimination crimes" – abortion, adultery, prostitution or lesbianism – were not released in the 1976 (democratic) amnesty because they were not considered political prisoners (Larumbe, 2004). Nonetheless, feminist and lesbian groups that had been working behind the scenes during the dictatorship started very powerful mobilizations during the transition (Larumbe, 2004; Nash, 2007; Zabala, 2008). It was in this period that many collectives informing women about their sexuality and pregnancy control were founded. In Catalonia one of these pioneering groups was DAIA, which created a primitive version of a self-run "family planning" service in Barcelona (Ferreira, 2008; Nash, 2007), and strongly lobbied for centers as nodes of the feminist movement, instead of assistentialist[4] or technical service providers. In 1978 the use of contraceptives was decriminalized, and the following year the first Barcelona family planning center was created, jointly by DAIA and the City Council. Institutionalization soon brought a professionalization

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and technification of the service (Ferreira, 2008) that caused DAIA to abandon the collaboration (Nash, 2007).

This process led to the inclusion of the planning centers in the Spanish democratic healthcare system, a Beveridge or universalistic tax-based regime (Rodríguez et al., 2000) where universal, free access was offered not just for recognized citizens but also for illegal immigrants. The principle of equity (Ministerio de Sanidad y Política Social, 2010) on which this was based was established in 1986 by the first democratic health law (14/1986) that also involved the transfer of health competencies to the regions. The Catalan health system is therefore administered by one of the seventeen Spanish autonomous organs with full jurisdiction. One of its specific traits is that although publicly funded, some of its providers are private companies, consortiums, trusts, foundations, mutual associations, non-profit organizations and health cooperatives (Catalan Health Department, 2010a).

It was in 1990 that Catalonia started the first specialized Women's Healthcare Program (PSAD), intended to provide comprehensive health care for women, especially in the areas of maternity and family planning. The primacy of a medical over a social model seems clear with the choice of professionals linked to the service: gynecologists and midwives (Decree 283/1990). In 2004, the PSAD was renamed the Sexual and Reproductive Health Care Program (PASSIR) (Decree 284/2004), a change that can be seen as a symbolic movement towards a paradigm shift.

A few years later, the Catalan Health Department (2007a,b) approved a strategic plan to implement a homogenous PASSIR model across Catalan territory that included a detailed definition of the program's goals, main characteristics and services portfolio. Here, the target population was defined as "young people and women between 15 and 69 and their partners" (Catalan Health Department, 2007a: 47). Between 2008 and 2010, a PASSIR action plan was designed and implemented to establish strategic protocols giving a response to many of the social debates and worries of feminists in relation to different sexual rights issues, moving beyond a purely biomedical approach. 2010 saw the final approval of the National Law 2/2010, which for the first time treated abortion as a matter of SRH*R*.[5] This law recognizes women's right of decision within the first fourteen weeks of pregnancy (a period extended in the event of medical needs) and indicates that abortion should be included in the public health system services portfolio. Accordingly, the Catalan Health Department (2011) approved pharmacological abortion for up to 49 days of pregnancy, for which the PASSIR would be one of the most important providers. At first glance, the transformation of the Catalan sexual and reproductive services explained in this section seems to clearly respond to a shift from a family planning to an SRH*R* approach.

Findings and discussion

Between theory and practice in implementation of the SRHR approach

PM_2 and SRHP_8 criticized significant aspects of the institutionalization of the services, moving away from the family planning initially characterized by strong feminist participation, resulting in a much more technical environment. PM_2 suggested that one of the problems of the service's inclusion within the public health system was that it became staffed by civil servants, who are not always prepared for giving holistic attention. In the beginning, teams were truly multidisciplinary, did a lot of community work, and were committed to the field: institutionalization brought with it important changes in this sense (SRHP_8).

Nonetheless, NP_5 suggested that sometimes memories can be rather misleading, and that even in the earliest family planning, success depended much more on the characteristics of the person involved than on the structure itself.

However, the transformation of PSAD to PASSIR seems to have been more apparent than real:

> It was a victory that they use the word *sexual* instead of *women*, the problem was that they changed the name but not the contents.
>
> [PM_2]

Nor have health professionals been able to transform their language (SRHP_7). This may be because the sexual and reproductive right's proposal continues to place strong emphasis on reproduction itself: a real change would be acknowledging that reproduction is only part of sexuality, and that there should therefore be a move towards a sexual rights paradigm (NP_5).

The difficulties in adopting a new paradigm could also be related to the limited shift from a medicalized to a much more social approach during the move from PSAD to PASSIR. For example, apart from OB/GYNE and midwives already incorporated in the previous center, the staff of the new services should consist of psychologists and administrative staff, but no social figures are included. Worse still, in some centers like those in Lleida no psychologists are directly employed in the services. Moreover, in Lleida where the PASSIR did not have a plan specifically designed for young people, the SRH*R* attention to young peoples is guided by a medical paradigm, focused on the prevention of pregnancy and sexually transmitted diseases (NP_1).

Nonetheless the distribution of tasks, and specifically the transfer of responsibilities from gynecologists to midwives, aligns perfectly with the direction of the World Health Report, and with the principle of resistance to an excessive medicalization of female bodies, especially in the area of reproduction (Iyengar & Iyengar, 2009; Parry, 2008; Rushing, 1993). In fact it is generally a midwife who is responsible for most issues, and she always makes the first visit. Gynecologists would only be visited in the case of pathology, while psychologists are responsible for providing support in situations that require her/his expertise (Catalan Health Department, 2007b). PM_3 was particularly proud of this change:

> The midwife is the one in charge if it's a normal pregnancy, 85% of cases, and also assumes all preventive aspects of SRH*R* […] pathologies are treated by a gynecologist […] around 20% of population.
>
> [PM_3]

Along the same lines, one practitioner (SRHP_1) highlighted how much the midwife has taken over prevention tasks, and another (SRHP_3) specified that in her services she does a lot of

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community work, running sex education workshops in schools and other preventive activities such as therapeutic maternity groups.

However, many of our interviewees did not believe that a complete displacement to a more social approach had been achieved.

> We reach more people […] but with a medicalized model, even if discourses are different […] we are still in an assistential medical model.
>
> [PM_2]

In fact this trend can be also traced in policy documentation. "For now, the public health system doesn't contemplate the possibility of hiring sexologists" (PM_4).

This assistentialist and medical approach is even stronger when dealing with HIV because medicalization is generally assumed to be the most important part of the therapy, while an integral wellbeing response would be much more consistent with an SRH*R* paradigm (NP_5).

An integral health approach is also difficult to adopt when collaboration with services with a completely different pace of work is needed. Indeed, if a diabetic pregnant woman is referred to a hospital, they consider that she does not need to see her PASSIR midwife during therapy, while from an integral standpoint, maintaining the link is extremely important (SRHP_1). Also a displacement to a more social approach is difficult for users to appreciate if sessions are mostly held in medical treatment rooms (SRHP_7).

Different informants (NP_3, NP5; SRHP_7) also considered that real change would question structural power relationships, which explains why some civil servants strongly resist them: "The problem of many PASSIR is that they have very long-term appointments and a conservative gynecologist, and the old regime is in command" (NP_3).

Reading the interviews, our feeling is that there are great differences between services, and that not all have an equally social or medical approach. Furthermore, it does not seem that a different policy approach has produced a direct change in practices. Instead, the specificity and beliefs of each team seem to be more relevant in focusing attention one way or the other. Many of our interviewees (e.g. SRHP_7) mentioned that the more open and social-oriented activities were organized by practitioners who had been or were related to the feminist/women's movement, or with the earliest family planning experiences.

However, this should not make us underestimate the influence of structures in conditioning possibilities in the centers. In this context, and as part of the power relation issues mentioned above, we found the existence of deep differences in the de-territorialization of the services, which may create discrimination in some geographical areas. In fact, although according to official documents the number of Catalan PASSIRs has frequently been modified, the principle of decentralization has always been respected (Catalan Health Department, 2010b, 2012). In practice however, although one practitioner interviewed explicitly suggested that the service in which s/he worked was very decentralized (SRHP_6), another two practitioners considered that they have a predominantly centralized system (SRHP_1; SRHP_3). Moreover, it seems that this model is not implemented equally for all practitioners: the midwife seems to travel most (PM_3; SRHP _4; SRHP _5). This means that not all PASSIR accomplish the highly appropriate recommendation for SRH*R* services of being walk-in centers (Grant, Nicholas, Moore, & Salisbury, 2002; Nwokolo, McOwan, Hennebry, Chislett, & Mandalia, 2002; Tideman, Pitts, & Fairley, 2003). Conversely the PASSIR structure allows for the collaboration between institutional and non-governmental organizations as suggested by several experts (Church et al., 2010; Nwankwo & Takele, 1996). In this sense, for example, the Youth Centre for Contraception and Sexuality which used to be an NGO providing free SRH*R* services to young people in Barcelona became a PASSIR provider, while other organizations collaborated in the design and implementation of target-group programs developed within the service (Olivella & Biglia, 2011). Nonetheless, although this externalization, and especially the involvement of committed groups from civil society, can be extremely enriching, it can also lead to a delegation of the less medical assistance to the third sector. In fact, as suggested by Dema (2008), NGOs frequently provide services that cannot be assumed by public institutions.

That sometimes implies that the service will not itself take care of all groups of population and that some will be left unattended. For instance, in Lleida, where there is no specific program for young people, adolescents do not use the PASSIR, and do not have a clear referent (SRHP _5; NP_1). Also there is no space for giving the quality and long-term care that some groups (like HIV+) may need (NP_5). Others, like transsexuals or lesbians, may prefer a specific practitioner referred to as non-discriminatory to not having any prior guarantee (SRPH_1), which is not surprising since practitioners frequently assume that users are heterosexual (Dudgeon & Inhorn, 2004). Moreover, centers are frequently described as if they were women-only spaces and are therefore quite blind to transwomen (Gottschalk, 2009).

Most of our informants also coincide that immigrants generally come only if they have problems with pregnancy or a very specific need, but generally speaking nothing is done to overcome this problem (PM_2). However, in one of the PASSIR in a region with high immigration, the collaboration of a cultural mediator (not included as a service professional) has been extremely important in working with Chinese women (SRHP_1).

In general, it is clear that the target group of the PASSIR is women of reproductive age, which means that the service is still more centered on the medical aspect of reproduction than the wider experience of sexualities. This implies, for example, that women over 65 who attend the service are often directly discouraged by practitioners from coming back (SRHP_6; PM_2).

Moreover, we confirm the results of other studies: it is very common to find SRH*R* services that do not consider men as potential users (Forrest, 2001; Kalmuss & Tatum, 2007). "We only attend women, the service can still be described as *care for women*, […] this has to do with a social situation. […] the program is for everybody, but sexual health is still a women's issue" (PM_2).

In fact, most of our interviewees acknowledged that it was logical for men to have access only while accompanying their female companions. Others (SRHP_1; SRHP_3) considered that adolescents and boys are participating more actively

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than older men, but even in the young people's program there is often no special attention for them.

The unresolved tension between universality of access and recognition of the specific health needs of women and the privileged position of men clearly influences many practitioners (Greig, 2006; Olivella & Biglia, 2011). In fact, one of the third-sector practitioners interviewed (NP_5), like the epidemiologist interviewed by Almeling and Waggoner (2013), stressed the importance of targeting men in the PASSIR so as not to place all the responsibility on women. However, others seemed to expect that the new open tendency with the participation of boys will probably lead to a new scenario of participation.

Crisis, rightward political drift and current trends in SRHR

Spanish public health is currently undergoing great changes due to the economic crisis and the election of conservative parties, both nationally (Popular Party — PP) and regionally (Convergència i Unió — CiU) that are implementing a harsh policy of budget cuts.

The strategy of privatization and liberalization of services had already started at the beginning of the 1990s (Colectivo Ioé, 2011), but we are currently witnessing its extreme amplification, with a partial dismantling of the welfare state. "In less than a year [2009–2010] we have seen the greatest ever attack on social rights and public spending in democratic history" (Observatorio Metropolitano, 2011: 17).

The cuts in the healthcare sector and the shift to a mercantile healthcare management model, probably more related to ideological than purely economic reasons (NPO_1), have been implemented in two parallel directions: reduction of budget and reduction of services. The Catalan Health Minister, Boi Ruiz, declared that the Catalan health system has financially collapsed (Noguer & Garcia, 2013).[6] Particularly affected by the cuts are specific programs like HIV prevention (74% in 2012) and transplants (around 20% in 2012) (Belmonte, 2013a, 2013b). According to SRHP_6, the plan to encourage men's assumption of responsibilities in childcare, for which practitioners had been trained, also did not start for economic reasons. Moreover, since the beginning of the crisis many services and health care centers have been eliminated (Balsells & Pellicer, 2011) or closed in summer (SRHP_6).

This has caused some very serious situations. For example, in Sant Boi (near Barcelona) people have no access to free post-coital pills at the weekend because due to the cuts, the service is closed (PM_2). Although the cuts have directly affected public services, they have been even cruder in programs managed by NGOs (POL), which like the specific case we are investigating were mostly directed at people other than reproductive heterosexual women. This has forced a shift to medical from social SRH*R* services along lines already indicated due to the cuts in public services (PM_2). Also the situation of healthcare professionals is worsening every day. There is a high degree of precariousness seen in dismissals and staff reductions (Arroyo & del Pilar, 2012–3): in the PASSIR, with less human and economic resources, the same amount of work is still being done (PM_4).

Another strategy adopted by the government is the introduction of "copago" (co-payment), critically called "repago" (re-payment), because users have to "collaborate" in the payment of some services that have already been covered through tax. Due to the fact that disease is not a personal option but an inevitable condition, this measure breaches the principle of equality established by the 1986 health care law (Acosta, 2012). Indeed, the "limited" amount of "re-payment" required most directly affects people already suffering medical and economic disadvantage. Similarly, choice in method of abortion is becoming a privilege. In fact, women can either advance payment for surgical intervention in a private clinic or have a free pharmacological abortion in the PASSIR: for many women, choice is precluded for economic reasons (SRHP_1).

The problem is particularly serious if we consider that Spain became the most unequal EU-15 country in 2009–10 (Antón, 2012). It is estimated that in 2012, the risk of poverty in Catalonia affected 20% of the population (Bonet, 2012). Furthermore, the Spanish budget for social expenditure has always been below the European average, and it has been women who have mostly absorbed this welfare deficiency, with serious health consequences (Díaz-García, 2012). Gender-average inequalities have not been reduced in the last twenty years. Although women have improved their educational and working status, they have lost out in health and social protection (Colectivo Ioé, 2011). According to PM_3, the crisis means that women in vulnerable situations are accessing the PASSIR less, and worse still, with the cuts, the community work that may help forge links with these women has mostly been abandoned. Moreover, as commented by SRHP_8, it seems that spending power is plummeting, and many women who have never before asked for free contraception are now presenting this demand. Therefore "the different adjustment measures will undoubtedly contribute to an increase in differences in access to preventive programs for more vulnerable groups" (Obregón & Goberna-Tricas, 2012: 89).

One of the clearest and worst effects is the loosening of the principle of universality in access to healthcare. In fact the Royal Decree-Law on "urgent measures to ensure the sustainability of the National Health System and to improve the quality and safety of its services" (RDL 16/2012) establishes that people who are not registered in the national Social Security System will have no right of access to public healthcare provision. Although emergency services, assistance to children (under 18 years) and maternity care are guaranteed, this is a clear breach of the universality principle. Again, with Royal Decree 576/2013, which establishes that adult (18–64 years-old) illegal immigrants must pay a voluntary health insurance to access public health provision, the principle of equality is ignored. This means that although there is a strong network of practitioners who will still attend illegal immigrants,[7] most professionals are less motivated, more angry and resentful, and less sensitive to immigrants' needs (PM_2).

In this context, we can see that "the European social model is being reinterpreted in an increasingly liberal manner, with more prominence of the market in solving social issues, debilitating its more egalitarian, participative and caring characteristics" (Antón, 2012: 60). For example, there is a plan to subdivide the public provider of ICS services into a smaller public rights entity controlled by the private sector legislation (Güell, 2013). In the meantime we are seeing the strengthening of two other forms of public–private collaboration (agreements and concessions), particularly in the

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case of abortion clinics. In this context, the tendering process to be a public health abortion provider has created a price war between clinics: lowering prices means cutting costs and this affects the quality of the health care (NPO_1). This kind of collaboration can be interpreted as a form of covert privatization in which the collusion with private profit interests means providers are unable to guarantee the same level of service as the public entity (Acosta, 2012). In fact, the rationale behind private PASSIRs is cost–benefit, while publicly managed services are more interested in public well-being (NPO_1).

Another expression of this process is the institutional shift from supporting civil society groups to transforming large third-sector groups into service providers. This displacement is for example clearly behind the latest Women's Institute call to support associations and foundations working in the field of gender and women's rights (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2013). The 2013 tender, historically directed mostly at small women's/feminist organizations, includes specifications that only allow the option of funding large social third-sector bodies instead of feminist organizations.

This "anecdote" illustrates the neo-conservative attitude of the current government: we are seeing a clear and direct attack on women's rights. On July 19 (2013) the Minister of Justice, Alberto Ruiz-Gallardón, approved making the shared custody of children preferential in the case of divorce, even if parents are unable to reach agreement (Público, 2013). The Spanish Healthcare, Social Service and Equality Minister, Ana Mato, forced health regions to interpret the 2006 law regulations on assisted reproduction restrictively, to evidence of medical sterility (Sahuquillo, 2013a). This is clearly a reduction of the right of lesbians and women without partners to become mothers, a further step in the drift towards a conservative morality. Similarly, the reduction of funding for many popular contraceptive pills announced by minister Mato is perceived by experts as a very serious barrier to access to contraception that will particularly affect more vulnerable populations (Sahuquillo, 2013b). Even more difficult to accept is that MSSSI has decided to include in gender-based violence statistics only cases where hospitalization of more than 24 h has been required (Carretero, 2013).

But the topic on which this government has been particularly persistent is abortion, opposing the Organic Law 2010, which according to POL and NPO_2 there has not been enough time to completely implement. The draft of the law "For the protection of the conceived life and the right of pregnant women" that has been criticized even by members of the conservative party, is strongly supported by ultra-catholic lobbies and is much more restrictive than the 1985 law. This proposal, in our opinion, is paradigmatic of the conservative approach of this government towards SRH*R* subjecting women's rights to the rights of the embryo.

Cloenda (closing remarks)

In the initial analysis presented, we hope we have been able to show through one specific case the complex relationship between the official recognition of a political claim and the effect of this on policies and practice. In fact, from reading our data it is not always easy to determine whether the inclusion of an SRH*R* discourse in national and international policies can be identified as a success or a failure of the feminist movement's claim to control one's own body. Among the limitations to the implementation of a complete SRH*R* logic in the Catalan system, we have identified the following: the incomplete shift from a medical to a social understanding of SRH*R* (particularly identifiable in the kind of practitioners and the structure of power between them, and the emphasis on medical healthcare instead of communitarian and holistic wellbeing); the maintenance of a focus on the reproductive-age heterosexual female (with young people looked after by third-sector programs, menopausal women not attended, special-needs groups referred to third-sector programs, and men almost completely ignored); and the inability to facilitate equal access for all sectors of society (vulnerable subjects and people who live in less populated geographical areas are disadvantaged). Moreover, the language of SRH*R* has not in itself been able to force a new approach, without a real transformation of institutional structures and bureaucracy, without the political will to invest in this project and finally, without a change in General Practitioner mentality. The inquiry therefore shows that, while the implementation of an SRH*R* discourse may have been useful in order to defend the innovative proposals of some policy makers and practitioners, its institutionalization has created the conditions for a general de-politicization of the sexual and reproductive services. In this context, it is legitimate to question how far it can be useful for a social movement to focus its claims on political recognition, especially at supranational level. Specifically, is it appropriate for feminists to aim to prioritize the inclusion of our demands in international legal/political frameworks? How far can this dynamic achieve an appropriation of language without an in-depth change of logic, and worse still, can it result in more stigmatization and discrimination of vulnerable sectors of society?

The second line of evidence we present is the crucial importance of the economic, political and social setting for the maintenance of acquired social rights. In fact, as with employment rights, we have shown how far sexual and reproductive rights are currently being dismantled, with the justification of the crisis and the backdrop of a conservative ideology. In our opinion, this is clear evidence that we are very far from having achieved an egalitarian society, and that economic and structural reasons are closely related to the status given to personal and social rights. As we have shown in the article, the attacks on SRH*R* at this juncture have been both ideological, for example in the case of abortion, and lumped together with other welfare provisions, justified by economic readjustments.

Furthermore, what is the role of the SRH*R* discourse in a context of privatization and massive dismantling of public services and healthcare? The involution of an allegedly achieved right and the importance of the economic and political setting for its maintenance also pose the challenge of how to assume the volatility of political achievement without falling prey to immobility. As suggested, the analysis presented raises many questions that cannot be resolved within a single academic paper, but must be collectively worked out in daily practice and collaboration. On the positive side, we wish to highlight the fact that the retrogression in Spanish and Catalan SRH*R* is also nonetheless providing conditions for creative, self-run processes. On the one hand, less official support to SRH*R* services also means less control over what is done, and therefore allows for

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more radical dynamics. On the other, practitioners in public centers and the third sector have a greater need for community collaboration to be able to provide services, and this may lead to the more direct involvement of civil society in healthcare provision and decision making. It is particularly interesting, however, that many protests against the cuts and the ideological involution in healthcare have gone beyond the dynamics of resistance and are becoming increasingly proactive and resolutive.[8]

We believe that this process is destined to go further, because a strong, committed and polychrome civil society is needed to achieve complete and non-discriminatory sexual and reproductive rights. Furthermore, the collaboration between different subjectivities and collectivities is essential to avoid sectional and therefore discriminatory politics.

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Endnotes

[1] The debate between the use of SRH*R* and SRH is still unresolved in the Catalan context, in order to maintain this tension but make the text fluid we will use the acronym SRH*R*.

[2] In Spain and Catalonia no official ethical protocol is required for interviewing consenting adults, ethical concerns are the direct responsibility of the researcher.

[3] For a deeper understanding of this paradigm shift and some of the associated dilemmas and debates, see Caulier (2010), Corrêa and Petchesky (1994), Corrêa (1997), Parker, Petchesky, and Sember (2007) and Sen, Germain, and Chen (1994).

[4] The assistencialist model is focused on supporting people to deal with specific problems without helping them to overcome the situation at the base of this problem/need.

[5] According to Zabala (2008) the previous Law (9/1985) that allowed abortion under three circumstances gave no guarantee of the self-determination of women's rights and what was worse, its application was extremely conservative.

[6] In this section, due to the recent nature of the information we frequently use media figures. We cannot guarantee their accuracy, but even if we quote just one source, the figures are basically the same across the different media. We thank the activist of the blog "*Los recortados*" http://losrecortados.wordpress.com/ who has organized many of the links on information about the cuts.

[7] The platform (Universal Sanity: I say yes) http://yosisanidaduniversal.net/actua.php, among many other things, provides information to healthcare professionals on civil disobedience or conscientious objection to Royal Decree-Law 2012.

[8] Apart from the platform mentioned in note 7 that gives advice to healthcare professionals in order to attend illegal migrants, many other initiatives are being developed. Due to its scale, the general mobilization of healthcare professionals has been called "The White Tide" (http://mareablancasalud.blogspot.com.es/p/inicio-blog.html) and served as platform both for street action and self-organized groups. To support it, networks have been organized including the one arising within the 15M mobilization "Grup de Defensa de la Sanitat Pública" that stresses the importance of public services (http://defensasanitatpublica.wordpress.com/) and even a hero figure (http://supersano2011.wordpress.com/) was created. Others, like the "Outraged by healthcare cuts" focus their attention on denouncing the cuts and have even developed a map (https://recortessanidad.crowdmap.com/). These 'new' groups are accompanied by others that have a long history of fighting for well-being like, for example, the Centre of Analysis of Health Programs (CAPS), a reference group for professionals interested in gender issues (http://www.caps.cat/). Cooperation between them has also led to publications with clear alternative proposals to the neoliberal healthcare model (e.g. Sánchez, 2013). These are just a few examples of the current huge and propositive mobilization.

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