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The MDGs:

A Critical Look and Some Proposals for the Post-2015 Development Framework

In the year 2000, governments around the world re-committed to the ideas of universal development and that no human being should be left behind. Out of the Millennium Declaration emerged the Millennium Development Goals (MDGs), which were to encapsulate these global aspirations and achievements into what could be considered key performance indicators.

Adapted by ARROW from the MDG 5 logo

On the one hand, it must be recognised that the MDGs were brilliant and strategic; they were able to bring together the different UN frameworks and agencies to a common platform of development. The work of almost all key agencies were covered by the different goals, and the common platform would enable and strengthen inter-agency cooperation, as well as streamline the processes for monitoring and reporting progress on attainments. This new platform, with its promise of a more streamlined and strengthened global development framework, also renewed interest, belief and funding for the UN system at a critical juncture when all three were waning.

On the other hand, many NGOs and social movements have unflaggingly questioned time and time again the choice of the MDG goals and the indicators, and the processes through which these were derived and decreed. The linchpin that held the different criticisms was: what is human progress dependent upon? The MDGs glossed over the most important element of all, human beings and their empowerment, and made them recipients of what was considered essential for their well-being. This went against the grain of those who have always believed development is a process that involved investment in the building of capacities, institutions and systems.

It did not help that the goals and their prescribed targets did not attempt to challenge the status quo, both between and within countries. Targets for poverty, health and gender equality were pared to the barest minimum. It was also telling that international bones of contention, such as women's access to sexual and reproductive health, though backed by the landmark Programme of Action of the International Conference on Population and Development (ICPD), was left out of the original MDGs. It was only seven years later that target 5b on "universal access to reproductive health" was officially tagged onto Goal 5, while the concept of sexual health still did not make it into the list. Ironically, it is maternal health that is a part of reproductive health and not the other way around. Because reproductive health was subsumed under maternal health, it unduly influenced the indicators created towards the latter; hence, the focus on family planning (with its implied focus on married, heterosexual sex) and pregnancy. The narrow attention to maternal health in Goal 5 and to HIV and AIDS in Goal 6 has also contributed to separate, vertical systems and the lack of comprehensive sexual and reproductive health services on the ground.

Ten years into the implementation of the MDGs and five years before new priorities and frameworks are (re)formulated, it is important to critically review this development framework again.

Firstly, the emphasis on national 'averages' in reporting on the MDG indicators side-steps critical discussions on internal, national inequalities and inequities. 'Average' numbers do not specify whether progress has been comprehensive and equitable.[1] Despite ostensible economic accomplishments of the region, social inequity and inequality—including for health—remain a big concern. Availability of and access to sexual and reproductive health care and services, including pregnancy and chilbirth-related services, are more difficult for women who are discriminated

against, marginalised and suffer from a variety of political, spatial and social exclusions.[2] Huge disparities exist among various groups of women, even in countries that have experienced significant progress. In China, one of the few countries which are 'on track' with target 5a, great disparities in MMR exist among the general population and marginalised groups, such as ethnic minority and internal migrant women. For example, in Shanghai, where the migrant population comprises 34% of Shanghai's total population, migrant women account for 90% of the total MRR in 2006.[3] Meanwhile, as Verghis notes, in Malaysia, another country which has had low MMR even before the MDGs and which has invested heavily in healthcare, access to healthcare remains extremely poor for non-citizens such as migrant workers and refugees.[4,5] Additionally, the national numbers for MMR do not capture the large inter-state and regional variations within the countries in the region. In India, the MMR in the states of Bihar, Jharkhand, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh are much higher than the national MMR. In China, the MMR in the western provinces is significantly higher than the national estimates.[6]

Secondly, the MDGs, with its focus on a limited number of goals and targets, railroads discussions on the contexts and social environments in which development occurs, and the critique that arises from these discussions, especially from the global South. For example, locating national and local progress within the global macro-economic and socio-political context is shown by Bhardwaj on how aggressive trade policies, such as TRIPS-plus provisions, hinder access to medicines, technologies and treatment. Yet, this hardly appears in mainstream MDG reporting, in the same way that critiques of aid conditionalities and of policies that push for reduced public expenditures and privatised health care are not mentioned in highly-publicised MDG discussions.

The MDG framework also overlooks two key international agendas—the human rights agenda and the cultural rights agenda—that have shaped the various gender and SRHR discourses differently in various contexts. The human rights agenda has been used to help frame SRHR issues as human rights issues and to move governments to promote, protect and fulfil these basic human rights—the most recent example being the 2009 resolution on preventing maternal mortality and morbidity by the Human Rights Commission. At the same time, conservative groups frame SRHR issues within 'cultural/traditional/religious' frames to resist moves to confer greater autonomy to women over their sexual and reproductive lives. The tensions between these two international 'operational' agendas are observed in any international negotiations with respect to women's rights, but are also made more difficult by local complicating contexts, as Siddiqui tackles in her article. These tensions continue to hamper progress in gender equality and women's SRHR in many countries. Additionally, the inter-linkages among the goals of health (particularly between SRHR and HIV/AIDS), education, poverty and hunger reduction and gender equality and women's empowerment need to be considered.

Thirdly, the MDG framework does not push the boundaries and cannot be used effectively to do so. For example, the focus on 'maternal' hides the fact that not all pregnancies are wanted; neither do all end in childbirth. Indeed, unsafe abortion is one of the leading causes of maternal deaths in Asia (6%),[7] with as many as 24,000 women dying per year because of unsafe abortions in south-central Asia.[8] An approach which focuses on empowering women's choices, though controversial, would politicise the issue and would make a huge difference in the lives of women. For instance, could the reduction in MMR in Nepal have been possible without a progressive law on abortion, backed up by subsidised services? Similarly, although adolescent pregnancy is an indicator, reporting on this has not helped push access to comprehensive sexuality education nor has it helped institutionalise the legal age of marriage. Gender-based violence, an issue that women's rights activists have long been fighting for, has also been left out of the equation, as Guttenbeil-Likiliki reminds us. Focusing on a death-reduction approach, as opposed to a holistic health approach also obscures the fact that an even greater number of women—an estimated 2.8 million in Asia and the Pacific—suffer from morbidity due to pregnancy and childbirth that in many cases remain untreated and cause lifelong pain and psychological suffering.[9] Additionally, availability or access to services does not provide information on their quality, including whether they are rights-based, adolescent-friendly, women-centred, or whether providers do not impose their moral and religious biases to clients. The MDGs' limitation to quantitative measures—while easier to do—thus, leaves much to be desired.

Lastly, the MDG framework was not anticipatory of future global developments. The world in 2010 was very different from the world of 2000. The discontents of globalisation; an epic financial, food and fuel crises; climate change and the resulting disasters; uprisings and conflict situations due to inequity of resource-sharing; the growing movement for sexual rights; the increased commodification of health; and a renewed attack on access to medicines through free trade agreements and other agressive trade policies—these are some of the realities of today's world that have not been catered for by the MDGs and will continue to impinge and hamper upon the achievements of even very basic development goals. The MDGs also did not take into consideration an era of greater cultural, religious and political conservatism and relativism of countries, and donors being unable to push rights agendas, or becoming regressive themselves, in this framework. This also hampers national level civil society's capacity to push the envelope on these agendas with their own national governments.

So what must our calls for moving forward include?

1. In reimagining and reshaping the international development agenda post-2015, it is critical that the health agenda be not circumscribed to just maternal health, but instead pursue a comprehensive and holistic SRHR agenda.[10] NGOs and donors must be strategic but remain critical in utilising recent international development commitments, including the MDG+10 Summit Outcome Document, the UNHRC Resolution on Maternal Mortality and Morbidity and the UN Secretary General's Global

Strategy for Children's and Maternal Health. Engaging the new UN Women, and ensuring that SRHR is in its agenda as a critical part of gender equality and women's empowerment and promoted in its programmes at national levels, is also needed.

2. Human rights, including sexual and reproductive rights and women's rights, as well as social equity and justice principles, must be non-negotiable principles in development frameworks and their implementation. They must guide the allocation of financial, human and technological resources, the measurement of outcomes and impact, the framing of policies and strategies, and the planning and implementation of interventions that will be used to reach those results. This means asking whether an intervention examines issues of power, exclusion and structural injustice at different levels, and works at changing these positively or whether it perpetuates the status quo. This also means ensuring that the needs and rights of those who experience various forms of discrimination, marginalisation and political, spatial and social exclusions are met.

3. Continuously challenge the varied and intertwined forces that serve to impede the SRHR agenda. As mentioned earlier, these forces include political and religious conservatism, population control discourses, aid conditionalities and agressive trade policies that hinder access to health, from disasters and climate change, as well as the triple crises of food, fuel and finance. Building linkages with other movements is critical to doing this.

4. A comprehensive review and reporting mechanism,that takes into account reformulated indicators (*see* Factfile) need to be put in place at both international and national levels. A proper review process of all international commitments, including the MDGs, is one which involves comprehensive country progress reports involving all stakeholders concerned and backed up with NGO shadow reports, and reviewed by an expert committee that is empowered to make recommendations to governments and hold governments accountable (similar to the CEDAW reporting mechanism). As well, as Abeysekera notes, NGOs need to use current, available processes, such as the Special Rapporteur on the Right to Health and other existing human rights mechanisms, more concretely and consistently to uphold the rights agenda of MDGs and to hold governments accountable. NGOs and donors also have to look at how women's SRHR is comprehensively reported in the health chapter of the CEDAW reporting processes, both in the government reports and in the shadow reports compiled by women's NGOs.

5. Reaffirm the role of NGOs and social movements, including the women's and SRHR movements, as equal partners in development in the final years of the MDGs, ICPD and BPfA, and in the shaping of the post-2015 development architecture. They have to be actively involved in policy-making, programme planning, implementation, monitoring and evaluation at the national, regional and international levels. To help hold governments accountable to their commitments, UN spaces and processes should become more accessible to the full participation of NGOs in the global South.

6. Allocate sufficient resources to meet SRHR of all.

Renewed financial commitments by some donors and national governments have been made towards meeting MDGs 4 and 5, but these need to cover universal access to sexual and reproductive health and health systems strengthening, and enable people to achieve their sexual and reproductive rights, and not just focus on maternal and child health. Financial commitments should also match the resource requirements, which according to the revised computations of UNFPA, totals US$457.68 billion from 2009 to 2015. Compared with the estimated US$1.531 trillion world military expenditure in 2009 (of which US$276 billion is spent by Asia and the Pacific)[11] and with the US$18 trillion dollars mobilised globally within one year to bail out banks and financial institutions during the financial crisis,[12] funding for SRHR for all can readily be met if there is political will.

Through the above, we can hope to guarantee that the post-2015 international development architecture captures and realises our vision: a world where the health and wellbeing of all—regardless of sex, sex at birth, age, caste, citizenship status, ability, ethnicity, gender identity, geographic location, marital status, race, religion, sexual orientation, socio-economic status and work, among other factors—are assured, and where they are able to realise their sexual and reproductive rights, as an overall part of development.

Endnotes

1 *Kabeer, Naila. 2010. Can the MDGs Provide a Pathway to Social Justice? The Challenges of Intersecting Inequalities. NY: United Nations Development Programme. 66pp. Available at www.ids.ac.uk/go/idspublication/can-the-mdgs-provide-a-pathway-to-social-justice-the-challenges-of-intersecting-inequalities*

2 *These include those who are poor, young, less educated, internal migrants, non-citizens, displaced (due to conflict, 'natural' disasters or climate change), HIV positive, in sex work, from ethnic and religious minorities and indigenous populations and from lower castes, as well as those who do not follow gender and sexual norms, have disabilities, live in remote, rural or urban slum areas and live in conflict and disaster areas (among other intersecting aspects of identities and axes of discrimination and privileges).*

3 *Shanghai Women's Health Care Institute. Concept note for WHRAP-China Phase 2 (2011-2013), an ARROW-coordinated project.*

4 *See also Health Equity Initiatives (HEI). 2010. Between a Rock and a Hard Place: Afghan Refugees and Asylum Seekers in Malaysia, A Report. Kuala Lumpur, Malaysia: HEI. http://refugeerightsasiapacific.org/pdf/Afghan_RNA_final%20_report_June%20_2010.pdf*

5 *See also Abdullah, Rashidah. 2009. "Increasing access to the reproductive right to contraceptive information and services, SRHR education for youth and legal abortion." Kuala Lumpur, Malaysia: Asian-Pacific Resource and Research Centre for Women (ARROW). http://www.arrow.org.my/publications/ICPD+15CountryThematicCaseStudies/Malaysia.pdf*

6 *Thanenthiran, Sivananthi & Racherla, Sai Jyothirmai. 2009. Reclaiming & Redefining Rights – ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW). www.arrow.org.my*

7 *United Nations Children's Fund (UNICEF). 2008. Progress for Children, A Report Card on Maternal Mortality. New York: UNICEF. www.unicef.org/childsurvival/files/Progress_for_Children-No._7_Lo-Res_082008.pdf*

8 *Singh, Susheela, et al. 2009. Abortion Worldwide: A Decade of Uneven Progress. New York: Guttmacher Institute. www.guttmacher.org/pubs/AWWfullreport.pdf*

9 *It is estimated that for every woman who dies from a pregnancy-related cause, around 20 experience injury, infection, disease and disabilities (UNICEF 2008 Report Card on Maternal Mortality). The morbidity figure above is estimated from the number of maternal deaths in Asia and the Pacific as per the 2008 inter-agency figure multiplied by 20.*

10 *As it is critical that gender equality and women's empowerment are not limited to gender parity in enrolment, proportion of wage earners and parliamentary representation and parity, but this is the subject of another article.*

11 *Stockholm International Peace Research Institute (SIPRI). 2010. SIPRI Yearbook 2010. www.sipri.org/yearbook/2010/05*

12 *Deen, Thalif. 2009. "Western aid declines, financial bailouts mount." Inter Press Service. http://ipsnews.net/news.asp?idnews=47374*

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Fatwas limiting women's sexual autonomy in rural Bangladesh are rarely only about the right to interpret religion.

SPOTLIGHT

The Politics of Sexuality, Morality and Human Rights in the Making of the MDGs

The global context. A global reconfiguration of economic and political priorities was well underway in the decade preceding the Millennium Development Goals (MDGs). By the new millennium, dominant ideas of development had been recast in depoliticised and instrumentalised terms. Enumeration and quantification displaced more diffuse goals of social mobilisation, for instance. Thus, unlike the Beijing Platform of Action and the International Conference on Population and Development Programme of Action (ICPD), the MDGs were conceived entirely outside a rights framework.

The prevailing environment also formed the backdrop for an expansion in conservative ideologies and movements in many parts of the world, including the US. The neo-liberal market economy—by then the undisputed model for the pursuit of 'progress'—produced numerous social dislocations and visible inequalities. These in turn created conditions for reframing grievances in the language of religion, nationalism and identity claims.

For many people, preserving national morality came to represent a form of resistance to uneven globalisation processes. At the same time, and as is well-known, the US government, with an eye to domestic constituencies, actively embraced evangelical Christian groups and 'faith-based' policies, and the Vatican surfaced as a significant global voice in matters of morality. Sexuality emerged as a flashpoint at UN fora at this critical historical conjuncture. In an echo of earlier colonial scripts, women's bodies/sexuality became the grounds on which other struggles over power took place.[1] Southern governments, including members of the G77 and the Organization of Islamic Countries, did not hesitate to invoke such rhetoric when convenient.

The scramble to forge 'consensus' in UN documents invariably led to compromise on sexual matters. In their original form, MDG goals made no reference to sexual and reproductive health; it was only after much concerted lobbying that universal access to reproductive health services was included as an MDG goal in 2005. A deep discomfort with and reluctance to acknowledge young people's—especially young women's—sexuality outside the bonds of heterosexual marriage characterised opposition to the provision of sexuality education, contraceptives and abortion at this time.

Accordingly, sexuality and sexual rights were either excised or reduced to a minimum in the making of the MDGs—acknowledged only within the parameters of sanctioned motherhood (reproductive health, narrowly conceived), or in relation to disease (e.g., HIV and AIDS), re-inscribing dominant heterosexual gender ideologies in many cases.

Reframing the debate. "The problem is not just that institutions with conservative values around gender and sexuality are gaining strength. It is also that ideologies around sexuality become a tool to further political power."[2]

It would be reductive to read the increased policing of sexuality in the Asia-Pacific region only as signs of rising fundamentalism. Framing the debate in binary terms—religion versus modernity or culture versus rights—obscures both the context and the dynamic relationship between 'authentic' cultural practice and political economy. Such practices may be rooted firmly in the conditions of modernity but are rendered acceptable through the language of tradition. The spate of so-called 'honour' killings recently enforced by some caste *panchayats* (village councils) in Haryana, North India provides

a case in point. Analyses indicate that education and political consciousness among *Dalits* and women has led to an attempted re-consolidation of upper caste *panchayat* power.[3] Among other things, maintaining caste borders and policing female sexuality has taken on new significance. Disregarding the existing multiplicity of marriage practices, self-proclaimed representatives of cultural authenticity have carried out a violent campaign against marriages of choice.

Similarly, *fatwas* (Islamic religious rulings) limiting women's sexual autonomy or issuing violent punishments for women who challenge sexual norms in rural Bangladesh are rarely only about the right to interpret religion. Invariably, these cases are enmeshed in local power struggles: contests over land, political rivalry, challenges to social authority and so on. Policing morality and 'protecting tradition' are means of exercising class and gender domination.[4]

In contrast, in neighboring Nepal, (hetero)sexuality does not appear to be a site of struggle over national identity and citizenship. Nepali law recently conferred full legal recognition to a third gender; an openly homosexual member of the Constituent Assembly has tabled a bill to legalise same-sex marriage which he is optimistic will go through. Observers attribute the lack of resistance to these radical moves to the fact that Nepal was never colonised. Tropes of tradition/modernity, or authenticity/contamination do not carry any historical baggage.

The Nepali example is especially significant. On the one hand, right-wing nationalists have long argued that homosexuality is a western import, despite widespread evidence of vernacular forms of same-sex desires and relationships. On the other hand, 'the homosexual question,' infused with a sharp dose of Islamophobia, has become the latest 'barometer of civilisational aptitude.'[5] Homosexuality is, in other words, the latest tool to further political goals shaped by contemporary geo-politics.

It has been argued that the post-colonial landscape in Southeast Asia is shaped by the intersection of nationalism, capitalist development and religious institutions.[6] The Malaysian experience with so-called *khalwat* laws and the recent furor over an anti-pornography bill in the Indonesian parliament are instructive in this regard. In both instances, we find the deep entanglement of political considerations in marking the boundaries of the religious or moral sphere. *Khalwat* refers to the 'close proximity' of any Muslim man or woman with a non-*Mahram*[7] person of the opposite sex. The definition of proximity is open to interpretation and so can be highly politicised at both national and local levels. *Khalwat* laws are instruments of state surveillance and control over potentially dissenting or disruptive citizenry. It can be in the interests of the state to encourage moral policing at one moment, while discouraging it at another point in time. So for example, calls to extend *khalwat* laws to non-Muslims foundered on possible negative effects on the highly remunerative tourist trade.

Among other things, proponents of the 2006 anti-pornography bill in Indonesia suggested that 'guarding' women's morality was a fundamental aspect of securing national identity. Notably, the bill set out to criminalise not only pornography but also anyone exhibiting 'sensual body parts and movements.'[8] The latter provision was widely interpreted as an attempt to regulate specific non-Muslim ethnic minorities. In this instance, an ostensibly secular provision sat comfortably with broader strategies of homogenising and Islamising national identity.

Religion/tradition is always politicised; it is critical to understand the specific complicating contexts in which politicisation occurs and question the discourses through which we frame problems. The point is not that we should avoid critiques of religion. Rather, if we address the underlying interplay of forces, then reductive and essentialising arguments will not hold up to analysis.

Health, sexuality and rights: Why it matters. Addressing questions of sexuality, morality and rights is not a luxury. For many people, sexual rights are a matter of survival, of life and death. The right of a woman to refuse unprotected sex with a partner may make a difference between contracting HIV or not; the right to safe, affordable abortion may determine whether a woman who needs to terminate a pregnancy lives or dies. Breaking sexual norms can also invite violence, as the examples above illustrate.

I have tried to show through my analysis that sexuality and power are deeply intertwined. Challenging sexual norms not only questions male domination but also threatens the social order of things. In other words, sexuality is not a free-standing issue but one that profoundly shapes an individual's experience of the world. It is an important determinant of health services, education and employment, for instance. By the same logic, the MDGs themselves are interconnected.

Activism around sexuality and rights must be located in relation to broader movements for social justice. Unfortunately, recent activism has delinked gender equality issues from the sexual rights agenda. Partly because of more visible activism around sexual orientation and gender identity (SOGI), sexual rights are synonymous with identity-based SOGI rights for many people.[9] It is imperative to work toward a more inclusive sexual rights agenda, both to resist future attacks on SRHR and to ensure a world in which everyone can enjoy their rights without fear or discrimination.

Endnotes

1 *Mani, Lata. 1998. Contentious Traditions: The Debate on Sati in Colonial India. Berkeley: University of California Press.*

2 *Ilkaracan, Pinar and Jolly, Susie. 2007. Gender and Sexuality. Bridge Cutting Edge Pack. UK: IDS. p. 17.*

3 *Sangwan, Jagmati. 2010, May 7. "Khap Panchayat: Signs of desperation?" In Times of India.*

4 *Siddiqi, Dina. 2011. "Gender, nation, Islam: The social life of Bangladeshi Fatwas." In Deanna Heath and Chandana Mathur. (Ed.). Communalism and Globalisation: South Asian Perspectives. UK: Routledge.*

5 *Puar, Jasbir. 2010, June 2. "To be gay and racist is no anomaly." The Guardian.*

6 *Aihwa Ong, Aihwa. 2006. "Sisterly solidarity: Feminist virtue under Moderate Islam." In Aihwa Ong. Neo-liberalism as Exception: Mutations in citizenship and sovereignty. Duke University, p.3.*

7 *Someone with whom marriage is prohibited under prevailing Muslim law.*

8 *Yentriyani, Andy and Dara, Neng. 2008. "A new bill sparks intense debates: A draft anti-pornography bill divides Indonesia." In CSBR E-news Sexuality in Muslim Societies, Vol. 2, Issue 1. www.kadininsanhaklari.org/files/CSBR-enewsJan2008.pdf*

9 *Baghat, Hossam. Oral presentation on the Human Rights approach at the Repoliticising Sexual and Reproductive Health and Rights, 3-6 August 2010, Langkawi, Malaysia.*

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SPOTLIGHT

MDG 5: Missing Out on Migrant Workers[1]

Improving maternal health and providing universal access to reproductive health for migrant workers has been missed out in the 5th Millennium Development Goal (MDG 5).

How could this happen though, when migration shares inter-linkages with almost all the eight MDGs?[2] Evidence with regard to Goal 1 (Poverty Eradication) indicates that migration could be both a cause and consequence of poverty. Poverty might be exacerbated if migration is unsuccessful; it can also be alleviated if remittances, which have become an important source of foreign exchange in many developing countries today, are used to repay foreign debts and purchase important imports.[3] Goal 3 on promoting gender equality and empowering women is a critical developmental goal, given that more women are migrating and the empowering experiences of increased autonomy of women migrant workers who migrate independently of their male spouses on the one hand, as well as experiences of disempowerment brought about by the informal, unprotected and undervalued work performed by women migrants on the other hand. Migration has also been known to predispose migrant workers to health risks, making it vital for Goals 4, 5 and 6 to include a focus on migrant workers. Equally, environmental migration makes an important link with Goal 7 (Environmental Sustainability), as do the growing numbers of urban migrant poor with no/poor access to infrastructure and amenities. Finally, Goal 8 (Global Partnership for Development), has significant links with migration, given the need for stable and non-discriminating international financing systems for transfer of remittances and the need for regional/bilateral cooperation between countries of origin and destination to secure greater human rights protection for migrant workers.

This paper posits that the trend toward mediation of health rights via citizenship rights and the architecture of the MDGs are key factors contributing to the omission of migrant workers from the MDG agenda.

Citizenship rights vs. health rights of migrants in destination countries. International labour migration is an important component of economic globalisation, and represents an arena of tension between two conflicting forces. The first is of market forces within globalisation that drive the transnational movement of capital, technology and cheap and flexible labour. The other is of State sovereignty which seeks to control its borders and membership.

Membership in the nation state via citizenship confers status, identity and rights not enjoyed by non-citizens. In practice, the enjoyment of citizenship rights slides between anti-poles of how democratic or despotic the political framework of a country is, and the level of social responsibility assumed by the State in guaranteeing the socio-economic rights of its citizens.

While human rights and citizenship rights are both based on the premise of equality, human rights are based on personhood and global notions of shared humanity and offer migrant workers internationally protected rights. This does not often coincide with citizenship rights, as this is a function of exclusive national identity and exclusionary membership in a political community.[4] Citizenship rights, contested as they are by various identities (derived, for example, from race, ethnicity and sexual orientation among others) within the nation state, have in recent years come to exclude the non-citizen/migrant from the civil and political, economic and social entitlements and freedoms they embody.

The growing salience of citizenship rights in negotiating accessibility to social protection, including accessibility to healthcare and other health rights in destination countries puts non-citizens in a place of ongoing disenfranchisement and disadvantage. This leads to various exclusions experienced by migrant workers in terms of their health rights.

In Malaysia, for instance, contrary to accepted health financing principles, as foreigners, migrant workers pay a much higher user fee than locals at government hospitals, even though they are among the highest tax payers in the country. This makes their accessibility to health care problematic.[5] In fact, Malaysia's most-recent MDG report (2005) attributed 42% of all maternal deaths to non-Malaysian women, citing limited access of migrant women, especially the undocumented, to maternal healthcare.[6] This reality sharply contrasts with the country's reported 'achievement' of MDG 5.[7] With regard to HIV, a survey by the German AIDS Foundation (2005)[8] revealed that 102 out of 169 countries that they had reviewed used HIV status (often identified through mandatory HIV testing) to restrict entry, stay and residence of HIV positive migrant workers. This denies them the right to access to treatment and continued employment.

Interestingly, though these exclusions are invoked using the non-citizen status and lack of citizenship rights of migrant workers, they are not enforced via citizenship laws and policies, but rather via migration laws and policies. The exclusions related to health are meant to regulate who enters the nation's borders and act as deterrents to the integration of migrant workers in the host country.

Development discourses which emphasise peoples' participation fail to consider that participation is essentially political and practically linked to nationality/citizenship, effectively barring migrant workers and other categories of non-citizens from making rights claims related to development in destination countries where most rights violations occur. As this particular population is left behind in development agendas, as the process of the MDGs have shown, one wonders if it will not be difficult to depose the framework of citizenship rights in favor of human rights to enhance protection for migrant workers. This is given the contest of the domain of citizenship being one of the last strongholds of state power, even as globalisation threatens state sovereignty in new and challenging ways.

Architecture of the MDGs. While the MDGs represent cross-cutting and intersecting themes, the fragmented approach to its interpretation and implementation could have been another factor contributing to the exclusion of migrant workers from its goals.

Poverty of legal/political status. A combination of temporary labour migration policies supported by current economic globalisation processes, employment of migrant workers in deregulated work and labour sectors marked by poor labour protection and informalisation of work, and the lack of effective redress mechanisms to challenge violations of rights, creates not only job insecurity but also an insecure legal/political status for migrant workers in destination countries.[9]

Women migrant workers, who perform unrecognised and undervalued work like domestic work, are disproportionately burdened within the evolving exploitative international division of labour.

Such a situation has been known to trigger migration-related poverty through unsuccessful migration outcomes. Further, while income poverty itself poses health risks to migrant workers, their insecure legal and political status, particularly of women migrant workers working in unprotected work sectors, presents another qualitative dimension of poverty that has the potential to exacerbate their vulnerability to ill health. Unfortunately, the narrow income poverty framework of Goal 1[10] fails to capture this multi-dimensional character of poverty.

Predictors of maternal health. The twin targets of Goal 5, namely, to reduce maternal mortality by three quarters and achieve universal access to reproductive health by 2015, are interrelated. While the causes of maternal death are attributed to eclampsia, haemorrhage, infection, obstructed labour and unsafe abortion, thus prioritising the availability of emergency obstetric services,[11] there is equal evidence to suggest that maternal deaths could be attributed to lack of access to healthcare and due to socio-economic marginalisation.[12] Equally, there is evidence that 20% of obstetric-related maternal deaths and morbidity could be avoided through the use of effective contraception.[13]

Migrant workers are exposed to several sexual and reproductive health (SRH) risks through migration policies that require them to come without their families, prohibit them from getting married in the destination country, and do not provide access to SRH information and services, including contraceptives.[5] Further, in almost all destination countries in the Global South, including in South East Asia and the Middle East,[14] pregnancy is terms for loss of employment and deportation for female migrant workers. This often forces them to resort to unsafe abortions,[15] one of the leading causes of maternal mortality. (Incidentally, access to safe abortion services is absent in MDG 5 indicators.)

The complex and intervening gender, political and economic inequities experienced by migrant workers, especially women migrants, escape the narrow assumptions about the predictors of maternal health implied in MDG 5's targets and indicators. Moreover, a more robust rights-based appraisal[16] of universal access, especially for marginalised populations like migrant workers, requires disaggregated data to identify exclusions, and indicators that measure barriers to physical, economic and information accessibility and discrimination that impede equality of opportunity to health care and the socio-economic determinants of health.

Conclusion. While progress in relation to MDG 5 on the whole has been inadequate,[17] very little is known about the disaggregated experiences of migrants. This is reflected in the country reporting on health MDGs of many origin and host countries of migrant workers, which focuses mostly on the control of HIV and AIDS and infectious diseases in relation to this population.[18]

This paper has attempted to show how the limitations of the MDG framework have reinforced specific exclusions experienced by non-citizen migrant populations. Making MDG 5 a shared goal that includes migrants requires disaggregation of monitoring data and holistic approaches to issues addressed by the MDGs. An expansive conceptualisation of poverty that embraces the emerging dimensions of deprivation caused by insecure legal/political status is required. As well, more expansive definitions of citizenship and interpretations of human rights protection to non-citizens, including to the right to health, is necessary to respond to the emerging dimensions of globality.

Endnotes

1 *This paper excludes a focus on white collared professionals who migrate overseas for employment.*

2 *International Organization for Migration (IOM). The Millennium Development Goals (MDGS) and Migration. Geneva. www.un.org/esa/population/publications/PopAspectsMDG/18_IOM.pdf.*

3 *IOM. 2010. World Migration Report: The Future of Migration, Building Capacities for Change. Geneva.*

4 *Cohen, JL. 1999. "Changing paradigms of citizenship and the exclusiveness of the demos." International Sociology. Vol. 14, No. 3, pp.245–68.*

5 *Coordination of Action Research on AIDS and Mobility Asia (CARAM Asia). 2005. State of Health of Migrants 2005: Access to Health. Kuala Lumpur.*

6 *Economic Planning Unit, Prime Minister's Department, Malaysia. 2005. Malaysia: Achieving the Millennium Development Goals; Successes and Challenges: United Nations Country Team, Malaysia.*

7 *MDG monitor: Tracking the Millennium Development Goals. "Malaysia progress by goal." www.mdgmonitor.org/country_progress.cfm?c=MYS&cd=458*

8 *Among countries that place such restrictions are Brunei, Kuwait, Malaysia, Oman, Qatar, Saudi Arabia, Singapore, South Korea, Syria, United Arab Emirates and Yemen. For more information, see: Quick Reference: Travel and residence restriction for people with HIV and AIDS 2005. Berlin: Deutsche AIDS Hilfe e.V.; 2005. http://npsitalia.net/download-file-76.html.*

9 *For example, NGOs working in Bahrain, Kuwait, Lebanon, Malaysia and South Korea and other countries have been raising concerns about the tenuous position of migrant workers in these countries because of inadequate labour protection.*

10 *Waage, Jeff, et al. 2010. "The Millennium Development Goals: A cross-sectoral analysis and principles for goal setting after 2015." Lancet and London International Development Centre Commission. The Lancet, Vol. 376, No. 9745, pp.991–1023.*

11 *World Health Organization. 2005. The World Health Report 2005: Make Every Mother and Child Count. Geneva. www.who.int/whr/2005/en/index.html.*

12 *Thaddeus, S. & Maine, D. 1994. "Too far to walk: Maternal mortality in context." Soc Sci Med. Vol. 38, No. 8, pp.1091–110.*

13 *Collumbien, M.; Gerressu, M.; & Cleland, J. 2004. "Non-use and use of ineffective methods of contraception." In: Ezzati M., et al. (Eds.) 2004. Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors." Geneva: World Health Organization, pp. 1255–320. In McCoy, D. et al. 2010. "Maternal, neonatal and child health interventions and services: Moving from knowledge of what works to systems that deliver.: International Health. [doi: DOI: 10.1016/j.inhe.2010.03.005]. Vol. 2, No. 2, pp. 87–98.*

14 *E.g., Bahrain, Brunei, Malaysia, Singapore, Saudi Arabia and United Arab Emirates.*

15 *Leiter, K. et al. 2006. "Human rights abuses and vulnerability to HIV/AIDS: The experiences of Burmese women in Thailand." Health and Human Rights, Vol. 9, No. 2, pp. 88–111.*

16 *Committee on Economic, Social and Cultural Rights. General Comment 14, para 12 (b): The right to the highest attainable standard of health. E/C.12/2000/4.*

17 *Hogan, M.C., et al. 2010. "Maternal mortality for 181 countries, 1980–2008: A systematic analysis of progress towards Millennium Development Goal 5." The Lancet. [doi: DOI: 10.1016/S0140-6736(10)60518-1]. Vol. 375, No. 9726, pp.1609–23.*

18 *See MDG progress reports of Indonesia, the Philippines, Thailand, Saudi Arabia and Sri Lanka. www.undg.org/index.cfm?P=87&f=A*

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SPOTLIGHT

Photo by Women's and Children's Crisis Centre of Tonga

Gender inequalities exacerbate the challenges that Tongan women survivors of violence face—an inability to attain financial independence and employment further alienates women and thrusts them into a life of ongoing hardship and poverty.

Gender-based Violence and the MDGs in Tonga

The word 'gender' is not readily understood in Tonga. This is despite the fact that the Tonga Government endorsed, under the late King Taufa'ahau Tupou V, the National Gender and Development Policy (GAD) in 2002. In fact, talking about Gender-based Violence (GBV) is further limited to organisations and persons working directly in the area of violence against women (VAW). This is reflected in our national Millennium Development Goal (MDG) reporting processes, where the issue of gender-based violence lacks meaningful analysis and attention. The reality is that there is still a lack of political will, 11 years later, to embrace the 2002 GAD policy in its entirety.

Because it is still more common to talk about Domestic Violence (DV) and Family Violence (FV), references made in Tonga's *2nd National Millennium Development Goals Report*[1] to GBV is limited to a few paragraphs under MDG 3 (Gender Equality); it is not featured at all under MDG 5 (Maternal Health and Universal Access to Reproductive Health). However, with that said, GBV should and must become a critical component of the Millennium Development Goal framework, particularly in Goals 3 and 5.

GBV and MDG 1 in Tonga. If we take a look at all the MDG goals, it is relatively clear-cut how addressing GBV can give a more comprehensible analysis to each goal and the status of progress. For example, Goal 1 aims at eradicating extreme poverty and hunger and achieving full employment for all. When you look at Tonga's case, it is obvious that the number of men outweighs the number of women in paid employment. In the workforce, men continue to be in higher paid and key decision-making positions. Women also do not have equal access to land, and as a result, face extreme challenges when trying to access credit. Tonga's economy is heavily weighted towards a subsistence lifestyle—barriers to land and employment effectively place women into a position of dependence upon men. If women are to act as independent agents, the lifestyle options available to them are less desirable than those afforded to men, and more commonly steeped in economic hardship and poverty. When we talk about women who are survivors of GBV, the gender inequalities exacerbate the challenges that women face—an inability to attain financial independence and employment further alienates women and thrusts them into a life of ongoing hardship and poverty.

The Women's and Children's Crisis Centre of Tonga (WCCC) is a non-government organisation that provides counselling, transitional housing, support and advocacy for survivors of all forms of Violence Against Women (VAW), and is the only NGO to do so in Tonga. In 2010, the WCCC received a total of 354 clients for the Tongatapu region alone. Two hundred and ninety of those cases were for GBV.[3] Lived realities from these women's stories tell of how they are currently

faced with having to deal with missing work and having pay cuts as a result, or a complete loss of job for others. Those who are not in paid employment but are working tirelessly at home are faced with lack of or no access to the husbands' earnings, and at many times are forced to budget family meals and children's needs on a shoestring budget without questions. As one client recounts:

> *"…we always end up fighting when I ask him [survivor's husband] for money, and even when I make some money from the mats that I weave, he still takes control over my money and I always get angry and upset because my children's needs are never met and food is always short….so now I hide part of what I make from my mats so that I can ensure that my children have food to eat and never go hungry especially at school."*
> — WCCC survivor account, 2010

It is critical that the Tongan Government understands that when we invest in women and target them as the focus of poverty, we are essentially investing in the family and the community as a whole.

GBV and MDG 3 in Tonga. Goal 3 aims at achieving equality between women and men and is crucial to reducing poverty and ensuring that all people are able to fully participate in their communities. Part of the MDG indicators is looking at the number of seats held by women in parliament. The United Nations has recorded that women hold only 18.5% of parliamentary seats throughout the world, and in some countries there are no women in parliament. The Tongan parliament has 28 seats in total, with nine of those reserved exclusively for men.[4] Currently, there is only one woman in the Tongan parliament,[5] who holds the Ministerial post for Education, Women's Affairs and Culture. Since 1951, only four women have been elected to Parliament and three women appointed to Ministerial posts.

Again, when we bring to light the stories of survivors of GBV, the struggle to have the right to openly express views and opinions, let alone make decisions in the family, is a reflection on women's ability to participate holistically in wider community decision-making processes. So the idea of women in parliament is an absolute illusion for many women—an idea embedded by deep patriarchal attitudes that gave birth to the belief that women's place is in the house—not the house of parliament. The distressing reality is that often women who live in hardship and poverty and who are survivors of GBV are more likely to believe this myth. This is reflected on voting day, wherein female voters outnumbered male voters in the last elections, and yet not one of the 11 women candidates got voted into parliament.

As survivors of GBV, stories tell of the naked truths where these survivors have reported being beaten, punched, slapped, burnt, raped and violently abused mentally to ensure their inferiority to their male partners. Reinforced stereotypes are a daily reminder to these survivors that they must stick to what they should be doing, i.e., household chores and raising the children, rather than meddling in 'important' affairs such as asking for financial statements or wanting to take part in family decisions. A WCCC survivor's account tells of her being beaten and bashed by her husband because she spent the last $10 on buying food for the family dinner. The husband had wanted to buy a packet of cigarettes to take to his *kava*[6] session instead.

In fact, Tonga's MDG report, under Goal 3, highlights a few weaknesses in the current legislation that is again a clear indication of gender inequalities reinforcing male dominance over his female partner. Rape is still limited to penile penetration; any other form of sexual violence charged under the offence of indecent assault attracts a lesser penalty. Furthermore, marital rape is not criminalised. As a survivor of GBV, faced with these impediments, it is no question as to why women are still unrepresented in decision-making processes.

GBV and MDG 5 in Tonga. MDG 5 aims to improve maternal health through ensuring universal access to reproductive health services, including increasing the number of births attended by skilled health personnel and improving women's access to health care services during their pregnancies.

The World Health Organisation estimates that over half a million women every year die during pregnancy or childbirth, and over 90% of these largely preventable deaths occur in developing countries. It is well-known that having births attended by skilled health personnel, supported by emergency and comprehensive obstetric care, is crucial in preventing

SOME DEFINITIONS

Abusive/Violent Behaviour: Intentional use of physical force or power, threatened or actual to control behaviour, including (but not exclusive to) physical abuse, sexual abuse, emotional abuse, economic depravation and social isolation

Domestic Violence (DV): Abusive behaviour used by one partner in a relationship to cause fear in order to gain and maintain control over another's life

Family Violence (FV): Abusive behaviour used by a relative (by blood, kinship or marriage) to cause fear in order to gain and maintain control over another's life

Gender-Based Violence (GBV): Violence that targets individuals or groups of individuals based on their gender and takes advantage of the unequal power relations between men and woman [and also transgenders]

Violence Against Women (VAW): Violence that targets women or groups of women, taking advantage of gender inequities through access to privilege and power

maternal deaths and disabilities. It is also important to ensure that women have access to good pregnancy and after birth care, and are able to time and space their pregnancies through contraception.

What is less often mentioned is the link between gender-based violence and maternal deaths and disabilities, as well as maternal health and reproductive health. This is seen in the Tongan MDG 5 report where there is no mention of GBV.

Nevertheless, there is an obvious link between MDG 5 and GBV. Women's ability to choose when to have children, protect themselves from HIV and sexually transmitted infections and survive a pregnancy are affected by gender inequality within the family and society, including GBV.[7] Survivors of violence are also more likely to experience delay in accessing ante-natal care or have fewer visits; undergo premature labour and bleeding in pregnancy; have a non-live birth (due to miscarriage, abortion or still birth), have low-birth babies, have vaginal and cervical infections, and have higher prevalence of HIV and STI. They also report more numbers of children, tend to have more unintended and unwanted pregnancies, tend to stop using methods of contraception, and have higher unmet needs for family planning.[7]

It is crucial that the Tonga Government in its next report carry out a more comprehensive analysis of GBV and MDG 5. In other countries, such as Bangladesh and India, GBV, DV and intimate partner violence have been identified as a definite cause of maternal deaths.[7] In Tonga, the 2008 National Survey on Domestic Violence[8] reports that 22% of women experiencing physical violence were beaten while pregnant. Again, turning to the stories of survivors, the WCCC has documented stories that tell of women being physically, mentally and verbally abused by their partners while pregnant. Many of the WCCC survivors failed to report the incidents to their lead maternity carer. With regards to family planning services, one of the most alarming policies is the requirement by the Ministry of Health that the a husband's signature is required on the tubal ligation form, which leads to women being unable to assert their reproductive rights. As one WCCC client recalls:

> *"....my body felt so weak during my last two pregnancies and I just wanted to stop after my fifth child but I have had another three just because my husband refuses to sign the form....and I'm too scared to take the pill otherwise he will find out and beat me up."* — WCCC survivor account, 2010

It must also be noted that young girls who marry at an early age, or have sexual relationships at an early age, are often more at risk for violence and that for many, the reality of their sexual debut is that it was coerced or forced, and was unprotected. Significant amounts of social stigma continue to permeate the lives of those who are young and whose virginity is in question. Even based on rumors alone, a family will remove girls from education, and girls are often forced to marry those who are responsible for the loss of virginity, even in the instance of rape.

One client, who was raped at age nine, was removed from school with her parents believing that it would be wrong to continue investing in the client's future. Her account of the social stigma surrounding rape is below:

> *"I was in class 6 when I was first raped. And then my father raped me when I was only 12. That was the hardest time in my life. I knew what my father was doing to me was wrong. I was relieved when the judge placed me at the safe house until I reach the age of 21. The truth is I was too scared to go back home and to my village. I knew that if I returned people would gossip about me, not really knowing what happened to me."* — WCCC survivor account, 2010

Promoting understanding of the situation that girls and women who are survivors of GBV continues to be a challenge that needs to be addressed in order to improve access to sexual reproductive and general health services.

Conclusion. Addressing gender-based violence in Tonga is essential to achieving the MDGs. The current reporting and legislative approach indicates that there are significant gaps in the approach to addressing MDGs 1, 3 and 5 that need to be urgently redressed. In an attempt to include GBV analysis under MDG 5, the WCCC has been working closely with the Ministry of Health and will be lobbying for the national hospital's data collection to include GBV in its statistics among pregnant women. Currently, the WCCC holds twice weekly visits to the national hospital antenatal clinic in an effort to make the linkages between MDG 5 and GBV. It is also our hope that the Government of Tonga will also acknowledge the strong inter-sectionalities between GBV and the other MDGs, particularly MDGs 1, 2 and 3.

Endnotes

1 *MDG Status and Progress between 1990-2010, Ministry of Finance and National Planning, September 2010*

2 *The total population of Tonga is approximately 100,000; Tongatapu, one of five divisions, accounts for about 60,000. Tongatapu is the main island of Tonga and the location of its capital Nuku'alofa; it is the centre of government and the seat of its monarchy.*

3 *GBV is not statistically available in Tonga and despite having data available for DV, it is still highly unreported in Tonga. In 2010, the Ministry of Police reported a total number of 2,753 DV cases between 2000-2009.*

4 *WCCC. 2010. "What are the chances for female candidates." Nukualofa, Tonga: WCCC.*

5 *Dr. 'Ana Taufe'ulungaki was not elected in the recent November 2010 General Elections but appointed externally by the Prime Minister.*

6 *Kava drinking is for men only and often takes place in the evenings at village halls or homes and can last for up to 5-6 hours a night.*

7 *ARROW. 2010. "Understanding the critical linkages between gender-based violence and sexual and reproductive health and rights: Fulfilling commitments towards MDG+15." Malaysia: ARROW.*

8 *Ma'a Fafine mo e Famili, National Survey on Domestic Violence, 2008 funded by AusAID.*

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Editorial Note:

The following article highlights a very important side of the battle for access to medicines. The other aspect, which is outside the purview of this paper but also needs to be emphasised, is that many of non-patented medicines (which comprise about two-thirds of essential medicines) are also out of reach of people who need them. For example, MDG 5 requires medicines, such as contraceptives, methergine, mifepristone and misoprostol, that have long been patented but are not affordable or readily available for a variety of reasons, including the lack of price control, insufficient political will to prioritise SRHR, and in the case of mifepristone and misoprostol, the impinging of moralistic and religious tenets into national laws and policies.

Photo by Rico Gustav, APN+, Stop the EU-India Trade Agreement

More than 3,000 HIV positive people and advocates from across India and Asia protested against the strict intellectual property rights clauses of the EU-India Free Trade Agreement that will hinder access to affordable, quality medicines. 2 March 2011, New Delhi, India.

Back to the Future:
How the WTO and Free Trade Agreements Threaten the Health MDGs

The MDGs are the 'Minimum' Development Goals that countries are willing to commit to, and represent an attempt by States to limit the actual expansive obligations on them outlined in international human rights law. This article, through a case study of access to HIV medicines, seeks to show that even these limited goals—this minimum standard of development—cannot be met in light of the larger international economic framework promoted through the World Trade Organisation (WTO) and bilateral trade agreements.

WTO, TRIPS and access to medicines. The Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) came into existence along with the WTO[1] in 1995. TRIPS globalised intellectual property rules, including on patents. Patents are granted on medicines when the research and development (R&D) into that medicine meets certain criteria.[2] The holder of a patent can prevent others from manufacturing, using, selling, importing or offering for sale the product or process that they have a patent on for a period of 20 years under TRIPS. TRIPS is of such importance to multi-national pharmaceutical companies (MNC pharmas) that Pfizer, among other US businesses, led the push to include TRIPS in the WTO.[3]

The underlying justification for granting such a monopoly is that the promise of exclusive rights serves as an incentive for greater research and development (R&D) in medicines; this in turn benefits the public.[4] Evidence shows, however, that the implementation of TRIPS in developing countries does not significantly boost R&D in the medicines required in such countries.[5] In practice, the TRIPS-mandated patent system has had a very different impact on the global South, particularly on access to medicines.

MDGs, HIV and access to medicines. In April 2000, when UN Secretary General Kofi Annan issued his Millennium Report asking for a global development plan, he noted that Africa was being ravaged by AIDS.[6] Annan pleaded for greater access to HIV treatment for the 36 million people living with HIV, and for the pharmaceutical industry to collaborate in this effort. The document's goal on HIV was ambitious (to halt and begin to reverse the epidemic by 2015), and was included in the UN Millennium Declaration from which the MDGs were later derived.

Nevertheless, securing access to HIV treatment was not included as an MDG target. Furthermore, efforts to get the pharmaceutical industry to collaborate in making HIV treatment accessible were not succeeding.[7] The best discount that MNC pharmaceuticals were willing to offer was approximately US$10,000 per patient per year, a sum that was unaffordable to governments and peoples in the global South.

However, within six months of the UN Millennium Declaration, the HIV treatment scenario changed dramatically. Unbeknownst to world leaders, international humanitarian organisations had been looking for a more sustainable solution to providing anti-retroviral drugs (ARVs) than depending on the goodwill of MNC pharmas. In February 2001, Médecins Sans Frontières (MSF) and an Indian generic company made a joint announcement that stunned the world: the Indian company would offer first-line AIDS treatment for US$350 per patient per month to MSF and for US$600 to developing country governments.

In June 2001, a more ambitious UN General Assembly adopted the 'Declaration of Commitment on HIV/AIDS.' The

Declaration referred to the achievement of the MDGs, but had clearer direction to offer on access to medicines, with a specific recognition that it was a fundamental part of the right to health.[8] By 2006, when governments met to review the progress of the Declaration, they agreed to come as close as possible to "universal access to care, treatment and support by 2010."[9] This became target 6b of the MDGs in 2006.

The optimism to achieve universal access was made possible through the entry of several generic companies into the global ARV market. Generic companies were critical to increasing accessibility, as they brought down prices dramatically (first-line medicines are now available for US$60 per patient per year) and ensured greater availability of ARVs. Moreover, generic companies simplified HIV treatment. Previously, people living with HIV had to take multiple pills as part of their treatment. Generic producers combined the medicines into fixed-dose combinations, and "Two pills a day saves lives" became the abiding slogan for treatment activists.[10] As different MNCs held patents on different medicines, they had been unable to offer these combinations.

The offer by the Indian companies meant that governments around the world could no longer claim cost or complicated treatment as an excuse for not providing life-long HIV treatment. Global political will met the generic offer with the funds to help countries in the South set up extensive government-run HIV treatment programmes. Even Northern aid programmes like the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) could not sustain reliance on patented drugs and soon switched to generic suppliers.[11]

How India became the pharmacy of the developing world. Today, over five million people in the South are on ARVs, over 80% of which are supplied by Indian generic companies.[12]

India was not always the 'pharmacy of the developing world.' For several decades after independence, India had in place the patent system it inherited from the British—one that protected only the interests of patent holders. As a result, medicines had to be imported and were available only at very high, often exorbitant, prices.

Through the 1960s, various government committees along with health groups identified the policy and legal changes required to improve the situation of access to medicines in India and pursue self-sufficiency in the production of medicines. One of these measures was changing the prevailing patent system through the Indian Patents Act of 1970. The law continued to allow companies and others to apply for patents, but for food and pharmaceuticals, only process patents could be granted. What this meant was that the medicine itself, i.e., the 'product,' could not be patented and companies could manufacture the same medicine through different processes. Patents lasted seven years under this law. This law, along with key industrial policy measures and collaborations with public sector research institutions, led to the development of a strong and vibrant Indian generic industry featuring large, medium and small scale companies—an industry that over the next several decades was able to provide safe, effective and affordable medicines to much of the South.

TRIPS catches up with India. However, India, like Indonesia, Malaysia, the Philippines and other countries in the South, had signed TRIPS. Unlike the 1970s patent law, TRIPS required India to grant 20-year patents on 'products' and 'processes.' This meant that the medicines would now be patented and generic companies could no longer produce them, even by using different processes. The company holding the product patent then has a monopoly on the manufacture and sale of the medicine. TRIPS also required patents to be granted on medicines invented as far back as 1995.

TRIPS provided 'developing countries' additional time to comply with its provisions. For India, in the area of medicines, the deadline was 1 January 2005; a date that caused tremendous concern across the globe. Protests and rallies worldwide asked India not to shut down the supply of generic ARVs.[13] UN bodies wrote to the Indian government asking them to safeguard access to treatment.[14] Faced with complying with TRIPS on the one hand and with the fundamental right to health enshrined in the Indian Constitution, the Indian parliament resolved to make the maximum use of 'flexibilities' in TRIPS.

'Flexibilities' in TRIPS are supposed to allow countries in the South to safeguard their health concerns. However, as with the MDGs, TRIPS does not function in a vacuum. When South Africa tried in 1999 to use these flexibilities, it was sued by 39 pharmaceutical companies. Global outrage finally forced the companies to drop their law suit. It also prompted all WTO members to discuss the impact of TRIPS on access to medicines and issue the Doha Declaration on TRIPS and Public Health in November 2001, which re-affirmed "that the (TRIPS) Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, *to promote access to medicines for all*" (emphasis added).[15]

The Indian Parliament incorporated several of these so-called 'flexibilities,' including a unique provision: Section 3(d), which guards against the common practice of 'evergreening' by the pharmaceutical industry. Through 'evergreening,' MNCs extend patent terms by making modifications to original molecules (also known as 'new chemical entities') or finding new uses or new forms of existing medicines (such as applying for a new patent on the syrup form of an old medicine).

The need for a provision prohibiting this practice was based on increasing evidence that the majority of new medicines were minor modifications of existing medicines. The *1999 Human Development Report* noted that between 1981 and 1991, less than 5% of drugs introduced by the top 25 companies in the US were therapeutic advances.[16] A 2002 study by the National Institute for Health Care Management Foundation (NIHCM) of 1,035 new medicines approved by the USFDA between 1989 and 2000 showed that 65% of the approved medicines contained active ingredients already on the market, the majority differing from earlier medicines only in dosage form, route of administration, or were combined with another active ingredient, while the remaining other medicines were identical to products already available on the market.[17] The NIHCM report noted that modifying older products enables brand manufacturers to extend their intellectual property protection

by patenting new features of the modified medicines.

As the Indian law allows any person to challenge a patent application, Indian groups have used Section 3(d) and other safeguards in India's patent law to file several patent oppositions on key medicines with some success. Despite their efforts, over 3,000 patents have been granted on medicines and the impact is beginning to show. Raltegravir, a newer HIV medicine is patented and priced in India at US$2,500 per patient per year. This is exorbitant compared with US$60 per patient per year for the price of the current first line of HIV of three medicines. The breast cancer medicine, Trastuzumab, is patented and priced in India at over US$2,000 per vial.

India has also become the site of intense lobbying and litigation against the safeguards in its patent law. The Indian government is being sued over Section 3(d). Swiss MNC Novartis challenged this provision in Indian courts, and though it lost that case, it has filed yet another in the Indian Supreme Court trying to weaken this provision. Other companies, including German MNC Bayer, are also challenging other safeguards. Where litigation is not succeeding, resources are being ploughed into heavy lobbying through the US and EU governments. The most recent example of this is a letter by the US Secretary of Commerce to the Indian government over the rejection of US company Gilead's patent application for the HIV drug, Tenofovir.

The new TRIPS-compliant law in India is also having an impact on the business models and considerations of Indian generic companies; several of these have been taken over by MNC pharmas or have tie-ups with them. While the Indian promoters of these companies have benefited from this situation, the situation is grim for improving and increasing access to treatment. These buy-outs and tie-ups mean that these companies are now extremely unlikely to challenge patents, launch new medicines, take on MNC pharmas in legal battles or manufacture medicines if the Indian government were to issue a compulsory license (i.e., allow generic production of a patented medicine without the permission of the patent holder).

Free Trade Agreements: From the frying pan into the fire. Even as the TRIPS deadline looms over least developed countries (they have to comply with TRIPS in 2016, just a year after the MDG deadline), and as developing countries struggle to work within the WTO framework to provide medicines, developed countries are working to get their trade 'partners' to sign Free Trade Agreements (FTAs). These FTAs, which are used by developed countries to win even greater trade liberalisation commitments from the South, have provisions on intellectual property that are far worse and far more aggressive than TRIPS. Known as TRIPS-plus demands, these provisions can limit the ability of governments to use even the limited TRIPS flexibilities. These are done by:

1. Extending patent terms beyond 20 years;
2. Restricting compulsory licences;
3. Introducing new monopolies like data exclusivity, which effectively allows MNC pharma to use clinical trials as a barrier to prevent the registration of generic medicines;
4. Requiring tax payer's money to be spent on enforcing private patent rights of companies; and
5. Allowing MNCs to sue the government to protect their investments, even as governments cannot make MNCs accountable (investment provisions).

Also known as regional trade agreements (RTAs) and Economic Partnership Agreements (EPAs), FTAs are negotiated country by country or by regional blocks. As such, Southern countries have decreased bargaining power to resist these agreements.

Europe, a relative latecomer to the FTAs and intellectual property game, is determined to more than make up for lost time. An FTA being negotiated between the EU and India features some of the most aggressive provisions on intellectual property ever seen in FTA negotiations. If India agrees to these demands, the EU-India FTA will represent the end of the Indian generic experiment, the impact of which will be felt by countries worldwide that import generic medicines from India. The European Commission (EC) is ignoring even the European parliament, which had directed the EC in 2007 not to negotiate TRIPS-plus measures in agreements with developing countries. Public interest groups in a recent expose have demonstrated how the EC agenda appears to be more aligned to the interests of big business.[18]

Evidence is now available of the impact on access to medicines of these TRIPS-plus provisions. A study on the impact of data exclusivity (introduced by the US-Jordan FTA) found that of 103 medicines registered and launched since 2001 that currently have no patent protection in Jordan, at least 79% have no competition from a generic equivalent.[19] A study of medicine prices in Guatemala has shown price differences in the same therapeutic class ranging up to 845,000% because of data exclusivity introduced in Guatemala by the Central American Free Trade Agreement (CAFTA).[20] Data exclusivity is a key demand of Europe.

The MDG Outcome Document and access to medicines. What FTAs and the continuing expansion of the WTO framework mean is that the few tools and policy options that governments in the South have cannot be used to achieve health objectives. And yet, international development actors and States failed to highlight or pose solutions to this problem at the heavily-publicised September 2010 MDG Summit.

The MDG Summit Outcome Document lists access to medicines as essential to the achievement of the goals on child mortality, HIV, malaria, tuberculosis and for the proper functioning and strengthening of health systems.

However, it fails to note that this access is difficult to achieve in the above discussed scenario. In fact, behind-the-scenes negotiations on the document indicate the pressure created by the North in this regard.[21] The US and EU were unwilling to even allow a commitment ensuring access to affordable treatment.[22] Worse, the Outcome Document appears to absolve Northern countries of any responsibility in pursuing these FTAs.[23]

It must be emphasised that FTA negotiations do not take place between equal partners. They represent in fact some of the worst features of globalisation, i.e., everyone must be on an equal footing in the global free market, even if everyone is not equal. They decrease or limit the ability of countries to nurture and protect local

industry. As noted above, they impair the ability of countries to provide access to medicines in a scenario where TRIPS has already made that extremely difficult. Not satisfied even with TRIPS and these FTAs, developed countries with some of their Southern allies have secretly finalised the Anti-Counterfeiting Trade Agreement (ACTA), which requires even greater intellectual property enforcement than TRIPS.

Back to the future. In 2001, a year after the Millennium Declaration, the world changed. Or so many activists thought. What the world witnessed in the late 90s and the early 2000s with the HIV treatment crisis was really a glimpse of the future. Where medicines were monopolised, countries in the South could not manufacture them and patients were held hostage to the profit motives of pharmaceutical companies.

Ten years ago, those left out of the great international economic experiment looked to India for an answer to their medicine problems. As the TRIPS noose tightens, as FTAs make an already bad situation worse, as Indian companies are taken over by MNCs, India will move from being a pharmacy for the developing world to a pharmacy for the developed world.

Looking back at a decade of highs and lows in access to HIV treatment, it seems more and more that the arrival of generic ARV medicines was an aberration in the slow but inexorable push of the global economic framework towards monopolies in medicines. The question for many governments and public interest groups now is that if a country like India, which has a strong international stature, remarkable generic industry and vibrant civil society, cannot counter the adverse impacts of TRIPS, what hope is there for other countries. In the end, the Indian experiment may only show that no amount of patchwork, band-aids and use of 'flexibilities' can counter the systemic bias in the international economic system, stacked as it was from the beginning against the South. The bilateral pressure created on countries using these flexibilities from the North and the legal and other challenges by multi-national pharmaceutical companies play no small role in entrenching this system. In the end, it seems we are back to where we started.

Post script. As this article goes to print, protests against Europe's actions in its FTA negotiations are taking place in Cambodia, India, Indonesia, Nepal, Russia, Thailand, Europe and across Latin America.[24] The movement for the right to health and the right to treatment needs the support, solidarity and direct action of other movements. As the battle for access to medicines enters its most critical phase and governments charged with protecting and promoting the right to health negotiate this right away in the name of trade, public interest and health groups across the globe are starting to speak out. Groups are approaching the UN Special Rapporteurs with complaints, documenting and publishing research on the adverse effects of monopolies on medicines and shining a bright spotlight on the actions of the EU that many considered a traditional ally in the human rights field. As they challenge the stranglehold that business and other vested interests appear to have on our governments, health, patients and public interest groups face a difficult battle—but one they are determined to win. After all, the lives and health of millions are on the line.

Endnotes

1 *The WTO is based on international trade agreements negotiated between several countries that aim to liberalise global trade. Not all countries are members of the WTO. See www.wto.org*

2 *TRIPS requires patents to be granted for products and processes that are new, inventive and useful. However, these terms are not defined in TRIPS and the manner in which these criteria are applied is different across different countries or regional blocks. They are also not to be understood within their usual 'English dictionary' connotations. "New," for instance, typically means a product or process that has not been written about in any literature. Some countries provide that this requirement is assessed against literature available across the world, while some limit it to that which is published only in their own country.*

3 *Edmund T. Pratt Jr., Edmund T. 1995. "Pfizer Forum: Intellectual Property Rights and International Trade." The Economist. 27 May 1995.*

4 *For least developed countries, the specific promise of TRIPS was the transfer of technology from the developed world, much of which is yet to materialise. See UNCTAD, LDC Report, 2007.*

5 *Public health, innovation and intellectual property rights, Report of the Commission on Intellectual Property Rights, Innovation and Public Health. World Health Organisation. 2006.*

6 *Annan, Kofi. 2000. We the Peoples: The Role of the United Nations in the 21st Century. United Nations.*

7 *In 2000, various UN agencies set up the Accelerating Access Initiative (AAI) with top multinational pharmaceutical companies. The AAI's 2002 report noted, "despite the major reductions in ARV prices, the annual cost of ARV treatment for a person living with HIV still exceeds the annual per capita gross domestic product of many least developed countries." WHO and UNAIDS. 2002. Accelerating Access Initiative: Widening access to care and support for people living with HIV/AIDS, Progress Report, June 2002.*

8 *Although there was still a call to collaborate with the private sector, this UN Declaration encouraged countries to develop domestic industries and to evaluate the impact of trade deals on domestic manufacture. In particular, governments resolved "to cooperate constructively in strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order further to promote innovation and the development of domestic industries consistent with international law." Declaration of Commitment on HIV/AIDS "Global Crisis — Global Action," United Nations General Assembly Special Session On HIV/AIDS, 25 - 27 June 2001.*

9 *UNGASS Political Declaration on HIV and AIDS, 2006.*

10 *"Johannesburg: A turning Point for AIDS Treatment." Sunday Times (Johannesburg), 10 August 2003.*

11 *The United States President's Emergency Plans for AIDS Relief. 2008. "The Power of Partnerships: Fourth Annual Report to Congress on PEPFAR," Annual Report to Congress.*

12 *Waning, B., Diedrichsen, E., Moon, S. 2010. "A lifeline to treatment: The role of Indian generic manufacturers in supplying antiretroviral medicines to developing countries." J Int AIDS Soc.. Vol. 13, p.35.*

13 *'Global Events around 26 Feb 2005, the Global Day of Action against the Indian Patents Amendment', Global Campaign against Indian Patents Amendment (GCAIPA), 16 March 2005.*

14 *Letter from U.N. Special Envoys for HIV/AIDS to the Prime Minister and President of India on the Amendments to the Patents Act Under Debate, 11 March 2005; Letter from Achmat Dangor, Director of Advocacy, Communication and Leadership for UNAIDS, to Kamal Nath, Minister of Commerce and Industry of India, 23 February 2005; and Letter from Jim Yong Kim, HIV/AIDS Director of the World Health Organization to Dr. A Ramadoss, Minister of Health and Family Welfare of India, 17 December 2004.*

15 *Declaration on the TRIPS Agreement and Public Health, Ministerial Conference, Fourth Session, Doha, 9 - 14 November 2001, WT/MIN(01)/DEC/2, 20 November 2001*

16 *UNDP. 1999. Human Development Report 1999. New York.*

17 *National Institute for Health Care Management. 2002. Changing Patterns of Pharmacuetical Innovation..*

18 *Corporate Europe Observatory and India FDI Watch. 2002. "Trade Invaders: How Big Business is driving the EU-India free trade negotiations. Brussels.*

19 *Oxfam. 2007. "All costs, no benefits: How TRIPS-plus intellectual property rules in the US-Jordan FTA affect access to medicines." Oxfam Briefing Paper.*

20 *Shaffer and Brenner, A Trade Agreement's Impact on Access to Drugs, Health Affairs, Health Affairs, September 2009, Vol. 28, No. 5, w957–w968V*

21 *A proposal calling on countries "to refrain from adopting any measures or restrictions related to trade and transit that affect the access by developing countries to medicines, especially generic medicines, and medical equipment" was rejected by the EU and US. This language was proposed in light of the EU's seizure of generic medicines on their way from India to Latin America and Africa. See High Level Plenary Meeting on the MDG's - 20-22 September 2010, Draft Outcome, Compilation of Working Document with compromise proposals from co-facilitators, 2 September 2010.*

22 *A proposal stating, "We commit to deliver on our MDG 8 commitments in all dimensions, including, ODA, market access, debt sustainability, access to affordable, essential drugs and the benefits of new technologies which are critically important in order to meet the MDGs and to enhance efforts in this regard" was rejected by the EU and US. See See High Level Plenary Meeting on the MDG's - 20-22 September 2010, Draft Outcome, Compilation of Working Document with compromise proposals from co-facilitators, 2 September 2010.*

23 *The final MDG Outcome Document states that "it is for each Government to evaluate the trade-off between the benefits of accepting international rules and commitments and the constraints posed by the loss of policy space." See Para 37, Keeping the Promise: united to achieve the Millennium Development Goals, United Nations General Assembly, A/65/L.1.*

24 *See donttradeawayourlives.wordpress.com*

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Source: United Nations Information Service - Geneva, Flickr Creative Commons

Human rights bodies and mechanisms need to be utilised more effectively, including ensuring that gender equality and SRHR issues are covered in interactive dialogues at the UN Human Rights Council, and in the Universal Periodic Review of all UN member states.

Addressing Gender Equality and Sexual and Reproductive Rights through International Human Rights Platforms

The outcome document of the MDG+10 Summit held in New York in September 2010, *Keeping the Promise: United to Achieve the Millennium Development Goals*,[1] sets out commitments with regard to women's rights quite comprehensively. It recognises that gender equality, the empowerment of women, women's full enjoyment of all human rights and the eradication of poverty are essential to economic and social development, including the achievement of all the Millennium Development Goals (MDGs). It also affirms the right to health, including for sexual and reproductive health, and references key international agreements and treaties on gender equality, human rights and sexual and reproductive health and rights (SRHR).[2]

However, in analysing the MDG+10 Summit and its outcomes, a main concern is the absence of any reference to global political and ideological trends that have an impact on the achievement of the MDGs. While *Keeping the Promise* articulates the significant impact of the global financial and climate crises on MDG implementation, it maintains a silence with regard to the growth of diverse forms of conservatism and fundamentalism around the world that have an impact on the achievement of the MDGs, especially in terms of gender equality and SRHR. In the past decade, human rights defenders around the world have watched with grave concern as an agenda that is patriarchal and hetero-normative had advanced within the international human rights system. These initiatives most often denounce women's rights of choice and the rights of those facing discrimination because of their sexual orientation or gender identity in the name of culture, traditional or customary practice. These initiatives are sometimes linked to militarised political movements that espouse extreme forms of nationalism or religious fundamentalism.

The Outcome Document is also silent on any reference to the impact of the global war against terror on people's lives and livelihoods. This includes the impact of large-scale and systematic displacement of large populations due to on-going or imminent conflict on the increase in poverty, maternal deaths and poor sexual and reproductive health.

In this context, monitoring the implementation of the MDGs within a framework of women's human rights, including their rights related to sexuality and to reproductive and sexual health care and services is critical. This calls for continued attention to ensuring reflection of these rights in the entire MDG reporting process, other than in reporting on goals 3 and 5 which are specific to women and reproductive health. For example, reporting on MDG 1 should include looking at the impact of poverty on women's capacity to make choices and to have access to appropriate and affordable health care, while implementation of MDG 6 on combating HIV/AIDS, malaria and other diseases should emphasise the need to adopt a gender-sensitive approach to prevention, treatment and care, as well as a focus on women as health care providers.

Yet, although governments who signed on to the MDG+10 Summit Outcome Document committed to the achievement of the MDGs by 2015 as scheduled, there is little said either

in the Outcome Document of 2010 or in the MDG Reports issued by the UN with regard to establishing mechanisms for any concrete and comprehensive monitoring of progress. The last three paragraphs of the 2010 Outcome Document, under the heading "Staying Engaged," contains only a call to the Secretary General to report back on MDG implementation to the General Assembly on an annual basis. However, the lack of a coherent monitoring mechanism for the MDGs is a concern that has been expressed by civil society organisations since the establishment of the MDGs in 2000. For example, the current MDG process does not impose obligations on states in the same way that the system of international human rights law does, for instance. Nor does the process allow for scrutiny of implementation, except through the process of individual member states of the UN submitting their country reports to the various international and UN agencies that form part of the Inter-Agency and Expert Group on MDG Indicators.

Our efforts to monitor implementation of the MDGs must create synergy between the processes of monitoring MDG implementation using a rights-based framework and those of monitoring other human rights obligations of states. Working together with women's rights groups engaged in monitoring the implementation of the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) would be a critical step towards ensuring that all aspects of women's rights with regard to the MDGs are reflected in the reporting and review process to CEDAW. The comprehensive framework of CEDAW enables this to be done quite easily. For example, reporting on Article 2 of CEDAW on equality can link to review of MDG 3 while reporting on Article 12 on health can connect with MDG 5.

Among other strategic ways in which this synergy may be achieved are ensuring that:

1. There is adequate attention paid to SRHR issues in reporting to the treaty Bodies of the UN human rights system;

2. SRHR violations are brought to the attention of Special Procedures of the UN human rights system that have a mandate that encapsulates some of the rights that have been violated, including both Thematic and Country mandates, with a special focus on the Special Rapporteur on the Right to Health and the work of the Committee on Economic, Social and Cultural Rights;

3. SRHR issues are covered in country reports and interactive dialogues at the UN Human Rights Council, and particularly in the processes of Universal Periodic Review (UPR) of all member states of the UN that is undertaken by the Council (this advocacy could be referenced to the findings of the OHCHR study on preventable maternal mortality and morbidity and human rights);[3]

4. The annual reporting to the MDGs reflects a human rights-based approach when it comes to SRHR;

5. The Resolution[4] on maternal mortality and morbidity that is now on the annual agenda of the UN Human Rights Council is also linked to state commitments to achieve the MDGs; and

6. All the advocacy related to points 1, 2 and 3 above are linked to the commitments of states as set out in the MDG+10 Outcome Document.

Endnotes

1 *UN doc A/65/L.1*

2 *These include the Platform for Action of the Fourth World Conference on Women (BPFA), the Programme of Action of the International Conference on Population and Development (ICPD POA), and the obligations of states under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child and the International Labour Organisation (ILO) Conventions.*

3 *(A/HRC/14/39): The study addresses both the violations of rights that are involved in maternal mortality and morbidity and the key human rights principles that need to be considered in adopting a human rights-based approach to addressing the issue. It ends with a series of recommendations related to what needs to happen next at the level of the Council on this issue.*

4 *The Resolution of September 2010 calls upon states to strengthen their statistical systems and collect disaggregated data in relation to maternal mortality and morbidity for effectively monitoring progress towards MDG 5. It also calls on the OHCHR to compile an analytical report on good or effective practices in adopting a human rights-based approach to eliminating preventable maternal mortality and morbidity, which may in turn be a useful resource in monitoring implementation of MDG 5.*

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***ARROWs for Change (AFC)** is published by ARROW with funding support from **Oxfam Novib** and the **Swedish International Development Cooperation Agency (Sida)**. It is a peer-reviewed thematic bulletin that aims to contribute a Southern/Asia-Pacific, rights-based and women-centred analyses and perspectives to global discourses on emerging and persistent issues related to health, sexuality and rights. AFC is produced twice-yearly in English, and is translated into selected strategic Asia-Pacific languages several times a year. It is primarily for Asian-Pacific and global decision-makers in women's rights, health, population and sexual and reproductive health and rights organisations. The bulletin is developed with input from key individuals and organisations in the Asia-Pacific region and the ARROW Information and Documentation Centre. Articles in AFC may be reproduced and/or translated with prior permission, provided that credit is given and a copy of the reprint is sent to the Editors. Copyright of photos belongs to contributors.*

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International

Repoliticising Sexual and Reproductive Health and Rights, a global gathering of about 50 academics, activists, civil society representatives, donors and policymakers, was held in Langkawi, Malaysia on 2-6 August 2010. The meeting aimed to propose a transformative agenda for moving beyond ICPD and the Millennium Development Goals (MDGs) to re-politicise the analysis of and work on sexual and reproductive health and rights (SRHR). It is based on the recognition that, to inform advocacy, action and activism, a solid, well-informed, theoretically sound analysis and position are required.

Presentations of position papers, reactions and discussions revolved around the following themes identified as critical to the SRHR agenda: macroeconomic influences on sexual and reproductive health (SRH); SRHR in public health education; medicines and technologies for SRH; human rights; donors and funding; and perpetuating power.

Among other concerns, the conference highlighted the narrowing of the SRHR agenda, the fragmentation of the SRHR movement, and the decrease in SRH activism for social justice. The gathering thus called for working together across all the parts of the SRHR agenda and at all levels in order to bring back a focus on equity and equality. To address SRHR, it also urged for the following: provision of the full range of SRH services, strengthening of the health system, using a human rights framework and taking into consideration the underlying social and economic determinants of health.

The meeting was organised through the combined efforts of a global organising committee brought together by *Reproductive Health Matters*, with support provided by the Asian-Pacific Resource and Research Centre for Women (ARROW). The initiative was funded by the Norwegian Agency for Development Cooperation. To access the presentations, go to http://arrow.org.my/index.php?option=com_content&view=article&id=295

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On September 2010, governments gathered at the United Nations to assess progress on the implementation of the Millennium Development Goals. The outcome document of the High Level Plenary Meeting, *Keeping the Promise: United to Achieve the Millennium Development Goals*,[1] reaffirms the Cairo Programme of Action's goals, including achieving universal access to reproductive health by 2015. Governments expressed their commitment to accelerate progress in promoting global public health and delivering comprehensive and affordable primary healthcare services in order to improve maternal health, child health and combat HIV/AIDS (MDGs 4, 5 and 6).

Women's health and rights activists worked with governments in the lead up to the Summit. Our purpose was to ensure that women and young people's sexual and reproductive rights and health were highlighted and prioritised in plans to accelerate progress on achieving the MDGs. We were successful in advocating for specific language, and governments committed to "take steps to realise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including sexual and reproductive health… and to address reproductive, maternal and child health in a comprehensive manner, through the provision of family planning, prenatal care, skilled attendance at birth, emergency obstetric and newborn care, and the prevention and treatment of sexually transmitted infections such as HIV."

However, a clear absence in the negotiations was the need to address unsafe abortions as a major cause of maternal mortality and morbidity. Further, adolescents and young people were not recognised in the outcome document except for the need to "empower women and adolescent girls to increase their capacity to protect themselves from the risk of HIV infection." This is despite the fact that one third of the world's population is under the age of 15 and many adolescents around the world do not have access to comprehensive sexuality education, SRH services, or have their human rights protected. Governments were not willing to engage on any substantive debate about 'controversial' issues that are crucial to the achievement of the MDGs.

During the Summit, the UN's Secretary General also announced a Global Strategy on Women's and Children's Health.[2] This Strategy, initially focused on care during pregnancy and delivery, has now become a commitment to deliver an integrated package of essential services (contraception, safe abortion, maternity care, prevention and treatment of STIs, including HIV) to strengthen health systems to deliver these services, and to better use health resources towards this end. This work will only be successful if civil society, including women's groups and young people's organisations, particularly those from the global South, as well as communities, are engaged in decision-making and implementation at every stage of this process to ensure that comprehensive sexual and reproductive health services and protection of human rights are adequately funded, programmed and implemented.

Source: Alexandra Garita, Programme Officer, International Policy, International Women's Health Coalition. Email: agarita@iwhc.org

Although the MDGs are not very reflective of a rights-based approach, the global attention to them has aided in emphasising the importance of human rights in achieving them. The case of MDG 5, improving maternal health—one of the MDGs most lagging behind—is a good example.

In recent years, there is a movement at the UN Human

Rights Council (UNHRC) to recognise that preventable maternal mortality and morbidity has human rights dimensions, which need to be addressed. There is recognition that maternal health is not just a health or development issue, but is strongly tied in with other human rights, including freedom from discrimination and rights to life, health, education, equality and benefit from scientific progress, as per Council resolution 11/8.[3]

We must continue to remind governments that to meet MDG 5, they will have to ensure that all girls and women have full access to these human rights. We also have to work with governments to ensure that a rights-based approach is employed in policy formulation and programming, based on the principles of accountability, participation, transparency, empowerment, sustainability, international cooperation and non-discrimination.[4]

This year, as the UN General Assembly discussed the MDGs, the HRC reaffirmed its commitment to address the human rights dimensions of maternal health. Through a resolution, it requested the Office of the United Nations High Commissioner for Human Rights (OHCHR) to collect information on initiatives by governments, UN agencies and NGOs that effectively employ a rights-based approach to eliminate preventable maternal mortality and morbidity. It is important that NGOs working on women's sexual and reproductive health and rights make relevant submissions to the OHCHR. The OHCHR will produce a report analysing such information, which can be used by governments, UN agencies and civil society to further improve their policies and programs.

Progress on the MDGs thus far has been promising but it is unacceptable that the human rights of girls and women continue to receive such low priority as is obvious from the slow progress on MDG 5. It is time that policymakers put girls and women's rights and gender equality on top of their list of priorities and worked to improve women's status in societies.

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Regional

"The MDG 5 Watch: Women Are Watching Their Governments" website is an interactive, web-based campaign/report on the progress of the Millennium Development Goals 3 and 5 in 12 countries in Asia. The countries covered are Bangladesh, India, Nepal and Pakistan in South Asia; Indonesia, Malaysia and the Philippines in Southeast Asia; Cambodia, Laos, Thailand and Vietnam in the Mekong; and China in East Asia.

The MDG 5 Watch aims to present alternative information on the status of progress on MDGs 3 and 5. Reporting is based on the UN indicators and additional critical indicators around the two goals. Furthermore, it contrasts and compares national numeric reporting with local evidence and research to show where the gaps are. More importantly, this report aims to address the limited space for NGOs to participate/to voice an alternative opinion to the reporting provided by governments and international agencies. It also serves as an internet campaign to remind governments and international agencies that they are being watched closely by women's rights and feminist organisations around the region to see whether they will deliver on their promises on gender equality and universal access to sexual and reproductive health.

Individuals and organisations can show support by doing the following: endorsing the campaign (read the campaign statement at http://mdg5watch.org/index.php?option=com_content&view=article&id=175&Itemid=201); disseminating information about this campaign widely to networks; viewing the MDG 5 Shadow Report at www.mdg5watch.org; contributing stories and resources from the ground on MDGs 3 and 5 so these can be published on the website; and setting up an alternative country shadow report.

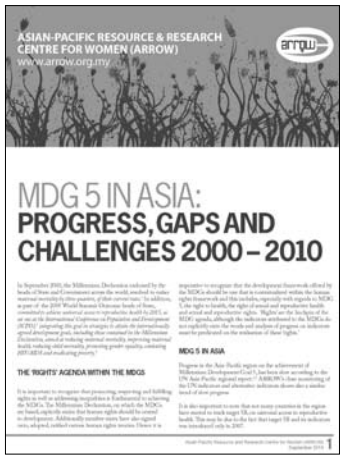
Contact: Sai Jyothirmai Racherla, Sivanthanthi Thanenthiran and Suloshini Jahanath, ARROW. Emails: sai@arrow.org.my , siva@arrow.org.my and sulo.arrow@gmail.com

Endnotes

1 *www.un.org/en/mdg/summit2010/pdf/mdg%20outcome%20document.pdf*
2 *Human Rights Council Resolution 11/8. http://ap.ohchr.org/documents/E/HRC/resolutions/A_HRC_RES_11_8.pdf*
3 *www.un.org/sg/hf/Global_StategyEN.pdf*
4 *Study by the Office of the High Commissioner on Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights (A/HRC/14/39). www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.39.pdf*

National

- **India:** "Public Dialogue on the Report of the Mission to India of UN Special Rapporteur on the Right to Health," 13 August 2010, New Delhi, India. Organised by the National Alliance on Maternal Health and Human Rights (NAMHHR). *Contact: Jashodhara Dasgupta, Executive Director, SAHAYOG, India. Email: namhhr.india@gmail.com Website: www.sahayogindia.org/pages/programmes/maternal-health-and-rights/events.php*
- **Pakistan:** Women's Deaths Are Preventable: Alliance on MDG 5b. Organisers: Shirkat Gah and Family Planning Association of Pakistan. *Contact Persons: Khawar Mumtaz (Shirkat Gah) and Syed Kamal Shah (Family Planning Association of Pakistan). Emails: khawar@sgah.org.pk and nmalick@fpapak.org*
- **The Philippines:** "Women Deliver Philippines," 15-17 September 2010, Quezon City, Philippines. Organised by the Department of Health, Likhaan Center for Women's Health and the United Nations. *Contact person: Junice Melgar, Executive Director, Likhaan Women's Centre for Health. Email: office@likhaan.org Website: www.likhaan.org/content/women-deliver-philippines-2010*



ARROW. 2010. "Regional overview of MDG 5 in Asia: Progress, gaps and challenges 2000-2010." Kuala Lumpur, Malaysia: ARROW. 8p. Available at www.arrow.org.my/publications/MDG5RegionalBrief.pdf

This regional brief examines the progress, gaps and challenges of MDG 5 implementation in Asia. It calls for investment to ensure that sexual and reproductive rights underpin policies and programmes for sexual and reproductive health (including maternal health); revisit the existing MDG indicators to assess MDG 5 and address data gaps; strengthen health systems capacities at the national level; and institutionalise a comprehensive review process that affirms the critical role of NGOs and social movements. A Chinese edition is also available.

ARROW. 2010. "Understanding the critical linkages between Gender-based Violence and Sexual and Reproductive Health and Rights: Fulfilling commitments towards MDG+15." Kuala Lumpur, Malaysia: ARROW. 12p. Available at www.arrow.org.my/publications/GBVBrief.pdf.

This advocacy brief aims to inform policy-makers and decision-makers on the critical linkages between eliminating gender-based violence (GBV) and achieving the MDGs, particularly improving maternal health and providing universal access to reproductive health (RH).

Bradbury, Jill and Clark, Jude. 2009. "Millennium development goalposts: Researching the score on and off the field." *Journal of Health Management,* Vol. 11, pp.391-404.

This paper provides a conceptual critique of the MDGs, and proposes an alternative framework for understanding development and the relations between structure and agency. It also suggests that narrative methodologies offer a productive research trajectory.

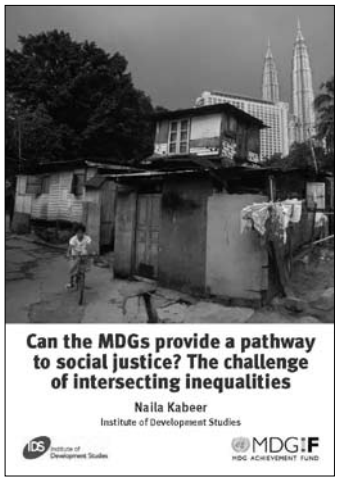
Ghai, Anita. 2009. "Disability and the Millennium Development Goals: A missing link." *Journal of Health Management*, Vol. 11, No. 2, pp. 279-295.

This article locates disability issues within the discourse of the MDGs, and questions the failure of the goals in addressing disability. It also discusses the ways in which state policy has addressed 'disability' in a globalising context, and outlines the paradox of identity politics and its nuances. It calls for the expansion of the democratic space to ensure that the rights and needs of disabled people within the MDGs discourse are given due consideration.

Hulme, David. 2009. "Reproductive health and the Millennium Development Goals: Politics, ethics, evidence and an 'unholy alliance." Manchester, UK: Brooks World Poverty Institute. 29pp. Available at www.bwpi.manchester.ac.uk/resources/Working-Papers/bwpi-wp-10509.pdf Email: David.hulme@manchester.ac.uk

This working paper provides a chronological account of the evolution of the concept and policy of reproductive health and its initial entry, and subsequent exclusion from UN declarations. It particularly highlights the political role of faith-based groups in this process, and questions the historically privileged but ambiguous status of the Holy See at the UN.

Kabeer, Naila. 2010. *Can the MDGs Provide a Pathway to Social Justice? The Challenges of Intersecting Inequalities.* NY, USA: UNDP. 66p. Available at www.ids.ac.uk/go/idspublication/can-the-mdgs-provide-a-pathway-to-social-justice-the-challenges-of-intersecting-inequalities



Approaching the MDGs from a social justice lens, this report demonstrates that inequalities matter. They matter especially for excluded groups who are not able to benefit from aggregate trends, and they matter for the prospects of MDG achievement and long-term sustainable development.

Reichenbach, Laura and Roseman, Mindy Jane (Eds.). 2009. *Reproductive Health and Rights: The Way Forward.* Philadelphia: University of Pennsylvania Press. 292p. [print copy only]

This collection of critical essays by leading experts from diverse disciplines asserts that the International Conference on Population and Development (ICPD) agenda still has great merit, even as it explores shortcomings and recommends ways to strengthen the reproductive health and rights approach. The book aims to supply readers with a better understanding of how reproductive health and rights have developed, how they fit into the global policy agenda, and how they might evolve more effectively in the future.

Waage, Jeff, et al. 2010. "The Millennium Development Goals: A cross-sectoral analysis and principles for goal setting after

2015."The Lancet, DOI:10.1016/S0140-6736(10)61196-8. Available at http://download.thelancet.com/flatcontentassets/pdfs/S0140673610611968.pdf

This study provides a cross-cutting analysis of the challenges facing the implementation of the MDGs, such as the fragmentation and lack of synergy between the MDGs and the lost opportunities created by limited goals. It also suggests principles for goal development post-2015, explores the implications of these principles on health, and concludes that future health development goals should focus on sustainable health systems built around delivering health objectives across the life-course.

WHO, UNICEF, UNFPA and the World Bank. 2010. *Trends in Maternal Mortality: 1990 to 2008 Estimates Developed by WHO, UNICEF, UNFPA and the World Bank.* Geneva, Switzerland: WHO. 55p. Available at www.who.int/reproductivehealth/publications/monitoring/9789241500265/en/index.html

An important reference material when assessing the progress of MDG 5a , this report presents trends in maternal mortality from 1990 to 2008 at country, regional, and global levels. This publication came out of ongoing efforts by this inter-agency group to revise and improve the methodology of estimating maternal mortality.

WHO, UNICEF, UNFPA & World Bank. 2010. *Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health.* Geneva: WHO. 20p. Available at www.who.int/making_pregnancy_safer/documents/fch_10_06/en/index.html

This document describes the key effective interventions organised in packages across the continuum of care through pre-pregnancy, pregnancy, childbirth, postpartum, newborn care and care of the child. The packages are defined for community and/or facility levels in developing countries and provide guidance on the essential components needed to assure adequacy and quality of care.

WHO. 2011. *Universal Access to Reproductive Health: Accelerated Actions to Enhance Progress on Millennium Development Goal 5 Through Advancing Target 5b.* Geneva: World Health Organization, Department of Reproductive Health and Research. 31p. Available at http://whqlibdoc.who.int/hq/2011/WHO_RHR_HRP_11.02_eng.pdf

An outcome of a WHO technical consultation, this publication presents country strategies for advancing universal access to sexual and reproductive health, and thereby identifying a range of actions for accelerated progress in universal access. Case-studies from seven countries—Brazil, Cambodia, India, Morocco, United Republic of Tanzania, Uzbekistan and Zambia—are showcased.

MDG Websites

- ***ARROW's Sexual and Reproductive Health and Rights (SRHR) Database of Indicators (www.srhrdatabase.org):*** This comprehensive database provides data and analysis on 79 rights-based indicators to compare the status of sexual and reproductive health and rights in 12 Asian countries.
- ***ARROW's Women Are Watching Their Governments: MDG 5 Watch Campaign (www.mdg5watch.org):*** An interactive, web-based campaign/report on the progress of MDG 3 and 5 in 12 Asian countries, created by ARROW and partners.
- ***Choike page on MDGs (www.choike.org/2009/eng/informes/302.html):*** Provides news, reports and updates from civil society perspectives, as well as key resources.
- ***IPS To 2015: Progress in Achieving the Millennium Development Goals (http://www.ipsnews.net/mdgs/):*** Provides the latest news related to the MDGs, which highlights voices of the South and civil society.
- ***MDG 5b; A Promise Is a Promise: Universal Access to Reproductive Health (www.mdg5b.org):*** A blog dedicated to news and resources related to the universal access to reproductive health.
- ***MDG Info 2010 (www.devinfo.info/mdginfo2010):*** Provides wide access to the official MDG dataset maintained by the UN Statistics Division, until November 2010.
- ***MDG Monitor (www.mdgmonitor.org/goal5.cfm#):*** This tool shows how countries are progressing in their efforts to achieve the MDGs through interactive maps, country-specific profiles and latest news.
- ***MDGs in the Pacific (www.undp.org.fj/index.php?option=com_directory&Itemid=57):*** This section of the UNDP Fiji website provides a summary of the Pacific's progress in all 8 MDGs, as well as a scorecard.
- ***Millennium Development Goals Indicators (http://mdgs.un.org/unsd/mdg/Default.aspx):*** The official MDG Indicators website presents the official data, definitions, methodologies and sources for more than 60 indicators to measure progress towards the MDGs.
- ***PacificInfo (www.pacificinfo.org):*** This initiative of the UN country teams in Fiji and Samoa features two databases: one tracks MDG data and progress for 15 Pacific Island countries, and another provides a monitoring and evaluation framework for the United Nations Development Assistance Framework using MDG and Pacific Plan indicators.
- ***The Partnership for Maternal, Newborn and Child Health (www.who.int/pmnch/en/):*** Provides updates and resources related to maternal, newborn and child health.
- ***UNDP Millennium Development Goals Country Progress (www.undp.org/mdg/countries.shtml):*** This site compiles the most recent country reports that measure progress towards the MDGs. Regional MDG reports are also available.
- ***UNESCAP MDGs in Asia and the Pacific (www.mdgasiapacific.org):*** Provides information on various MDG initiatives in Asia and the Pacific.

Other Resources

Centre for Reproductive Rights (CRR). 2008. "Briefing paper: Using the Millennium Development Goals to realise women's reproductive rights." New York: CRR. 28p. Available at http://reproductiverights.org/en/document/using-the-millennium-development-goals-to-realize-womens-reproductive-rights

Family Planning International (FPI). 2010. *Integrating HIV and Sexual and Reproductive Health: A Pacific Specific Mapping.* New Zealand: Population Action International and FPI. 30p. Available at www.fpi.org.nz/LinkClick.aspx?fileticket=nwUqD0sIWuU%3d&tabid=388&mid=1087

Hogan, M.C.; Foreman, K.J.; Naghavi, M. et al. 2010. "Maternal mortality for 181 countries, 1980–2008: A systematic analysis of progress towards Millennium Development Goal 5." *The Lancet*, Vol. 375, pp. 1609–23. Email: cjlm@u.washington.edu

Homer, Caroline S.E.; Hanna, Elizabeth; & McMichael, Anthony J. 2009. "Climate change threatens the achievement of the Millennium Development Goal for maternal health." *Midwifery*, Vol. 25, pp. 606–612. Email: caroline.homer@uts.edu.au

The Partnership for Maternal, Newborn and Child Health. 2011. "A review of global accountability mechanisms for women's and children's health." 28pp. Available at www.who.int/pmnch/media/press_materials/pr/2011/accountability-mechanisms/en/index.html

Raghuram, Shobha. 2008. "The MDGs in a world of multiplying inequalities and differentiating complexities." *Development*, Vol. 51, pp. 241-244.

Stuckler, David; Basum, Sanjay & McKee, Martin. 2010. "Drivers of inequality in Millennium Development Goal progress: A statistical analysis. PLoS Medicine, Vol. 7, No. 3: e1000241. doi:10.1371/journal.pmed.1000241 Available at www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000241

Thiesmeyer, Lynn. 2009. "What's millennial about the MDGs? Discursive boundaries of public health in Southeast Asia." *Journal of Health Management*, Vol. 11, No. 1, pp. 15–33.

UNESCAP, ADB and UNDP. 2010. *Asia-Pacific Regional Report 2009/10: Achieving the Millennium Development Goals in an Era of Global Uncertainty.* Bangkok: UNESCAP, ADB and UNDP. 132p. Available at www.mdgasiapacific.org/regional-report-2009-10

UNFPA. 2010. *How Universal Is Access to Reproductive Health? A Review of the Evidence.* New York, USA: UNFPA. 52p. Available at www.unfpa.org/public/site/global/lang/en/pid/6532

UNFPA. 2010. *Sexual and Reproductive Health for All: Reducing Poverty, Advancing Development and Protecting Human Rights.* New York, USA: UNFPA. 76p. Available at www.unfpa.org/public/site/global/lang/en/pid/6532

WHO and UNFPA. 2008. *National-level Monitoring of the Achievement of Universal Access to Reproductive Health: Conceptual and Practical Considerations and Related Indicators.* Geneva, Switzerland: WHO. 46p. Available at www.who.int/reproductivehealth/publications/monitoring/9789241596831/en/index.html

Youth Coalition. 2010. MDG Factsheet Series: 1) "The Linkages between the MDGs and Young Women's Health," 2) "The Linkages between the MDGs, Young People and HIV," and 3) "The Linkages between the MDGs and Comprehensive Sexuality Education for Young People." Ontario, Canada: Youth Coalition. Available at www.youthcoalition.org/site08/html/index.php?id_art=286&id_cat=7

ARROW's Publications

Thanenthiran, Sivananthi & Racherla, Sai Jyothirmai. 2009. *Reclaiming & Redefining Rights: ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia.* ARROW. 162p. US$10.00

ARROW. 2008. *Advocating Accountability: Status Report on Maternal Health and Young People's SRHR in South Asia.* 140p. US$10.00

ARROW. 2008. *Surfacing: Selected Papers on Religious Fundamentalisms and Their Impact on Women's Sexual and Reproductive Health and Rights.* 76p. US$5.

ARROW. 2007. *Rights and Realities: Monitoring Reports on the Status of Indonesian Women's Sexual and Reproductive Health and Rights; Findings from the Indonesian Reproductive Health and Rights Monitoring & Advocacy (IRRMA) Project.* 216p. US$10.00

ARROW. 2005. *Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015, Asian Country Reports.* 384p. US$10.00

ARROW, Center for Reproductive Rights (CRR). 2005. *Women of the World: Laws and Policies Affecting Their Reproductive Lives, East and Southeast Asia.* 235p. US$10.00

ARROW. 2003. *Access to Quality Gender-Sensitive Health Services: Women-Centred Action Research.* 147p. US$10.00

ARROW. 2001. *Women's Health Needs and Rights in Southeast Asia: A Beijing Monitoring Report.* 39p. US$10.00

Abdullah, Rashidah. 2000. *A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing.* 30p. US$10.00

ARROW. 2000. *In Dialogue for Women's Health Rights: Report of the Southeast Asian Regional GO-NGO Policy Dialogue on Monitoring and Implementation of the Beijing Platform for Action, 1–4 June 1998, Kuala Lumpur, Malaysia.* 65p. US$10.00

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Non-negotiable Principles in Development Frameworks

In critically re-examining the Millennium Development Goals and its implementation, as well as in proposing a development framework for 2015, certain key elements and principles must be considered non-negotiable. These includes: a) having gender and human rights perspectives; b) paying attention to equity and social justice principles, such that various marginalisations and vulnerabilities are addressed and universal access becomes a goal; c) consideration of country and regional needs in making priorities; and d) utilising a holistic approach, such that programmes and policies go beyond maternal health and address sexual and reproductive health and rights comprehensively (see definition below). Evidence shows that successful strategies to improve sexual and reproductive health utilise these elements.[1]

Universal Access to Sexual and Reproductive Health Services

This means "[t]he equal ability of all persons according to their need to receive appropriate information, screening, treatment and care in a timely manner, across the reproductive life course, that will ensure their capacity, regardless of age, sex, social class, place of living or ethnicity [other factors include caste, citizenship, (dis)ability, marital status, sexual orientation, gender identity and religion, among others] to decide freely how many and when to have children and to delay or to prevent [or to terminate] pregnancy; conceive, deliver safely, and raise healthy children and manage problems of infertility; prevent, treat and manage reproductive tract infections and sexually transmitted infections including HIV/AIDS, and other reproductive tract morbidities, such as cancer; and enjoy a healthy, safe and satisfying sexual relationship which contributes to the enhancement of life and personal relations."[1]

The International Conference on Population and Development Programme of Action (ICPD POA) also notes, "At the primary-care level, the following reproductive health services should be available. These services should be designed to meet the needs of women but should also be accessible to men (including adolescents and older persons), with referral as required. These services should meet the following needs: family-planning counselling, information, education, communication, and services; education and services for antenatal care, safe delivery [which includes emergency obstetric care], and postnatal care, especially breastfeeding and infant and women's health care; prevention and appropriate treatment of infertility; prevention of unsafe abortion and management of its consequences; screening and treatment of reproductive-tract infections, sexually transmitted infections, and other reproductive health conditions, such as reproductive cancers; information, education and counselling (as appropriate) concerning human sexuality, reproductive health, and responsible parenthood; and active discouragement of harmful practices such as female genital mutilation, including prevention and mitigation of sexual violence."[1]

Controversial Concepts

We bring back in this issue a discussion of some controversial concepts and terms that have been points of contention in international negotiations: 'care' vs. 'services' and 'cultural and religious practices.' These have been left out in MDG discussions, yet it is crucial to understand the politics behind these terms in order to safeguard gains made with regards SRHR in future discussions on the development agenda.

Care vs. Services

"The Holy See (the Vatican), some Muslim and some Latin American States...have opposed the use of the term reproductive health services, arguing that it could include abortion. Instead, they advocate using the word care, meaning access to medical treatment. However, the [ICPD] POA states that reproductive healthcare also includes abortion where it is legal as specified in Paragraph 8.25, as well as a comprehensive range of information and services. Although the definition of care and services are similar, the political impact is totally different. It is therefore very important to use the term services.... It is now the common understanding that services represent the wider concept that includes the right to information, contraception and counselling regarding sexuality and fertility. It also includes other methods of regulating fertility, including abortion where it is legal. Services therefore emphasise having control over one's sexuality and fertility and not just being cared for when sick or bleeding to death."[2]

Cultural and Religious Practices

"Cultural tradition and values have long been used as the basis for conservative states' denial of citizens' right in the sexual and reproductive arena. It is also a way of opposing women's rights to equality and non-discrimination generally. By doing so, countries can avoid implementing controversial provisions.... International conference documents call for respect for cultural diversity and values—but this should not undermine gender equality and human rights. The phrase 'as appropriate' is another watering down 'escape' phrase used by the Opposition in this context....There still remain many cultural practices based on fear of women's sexuality that need to be brought to the surface. This was done regarding female genital mutilation in Cairo when 'the conspiracy of silence' was broken. The PoA also recognised early marriages as harmful....But there are other examples that have not gained the same attention. The practice of drying out the vagina before intercourse (dry sex) and honour crimes are two examples."[2]

Endnotes

1 *WHO. 2011. Universal Access to Reproductive Health: Accelerated Actions to Enhance Progress on Millennium Development Goal 5 Through Advancing Target 5B. Geneva: WHO.*

2 *Bergman, Ylva (Ed.). 2004. Breaking Through: A Guide to Sexual and Reproductive Health and Rights. Stockholm, Sweden: The Swedish Association for Sexuality Education (RFSU).*

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Measuring MDG 5 More Comprehensively:
Proposed Indicators and Data Collection Issues

The fifth Millennium Development Goal (MDG 5) and its targets and indicators do not fully take into account the commitments made by States at UN conferences that made notable strides towards the sexual and reproductive health and rights (SRHR) agenda, such as the International Conference on Population and Development Programme of Action (ICPD PoA). The addition of target 5b on achieving universal access to reproductive health by 2015 to target 5a on reducing maternal mortality ratio five years after the implementation of the MDG, is an improvement. However, this commitment should technically mean the full implementation of reproductive health services as set out in paragraph 7.6 of the ICPD PoA (*see* Definitions), which includes prevention and management of abortion complications, reproductive cancers, and sexually transmitted infections. Yet, MDG 5b indicators still have a limited focus on family planning (and therefore on married, heterosexual sex) and pregnancy. Moreover, the current MDG 5 indicators are still inadequate as they mostly measure the impact and outcome levels. Yet, process-related indicators are equally important to comprehensively measure targets 5a and 5b.

This article aims to examine the gaps in the current MDG 5 monitoring framework, and propose additional indicators that ARROW and her partners in the Asia-Pacific region have identified to comprehensively monitor universal access to sexual and reproductive health. These build on our in-depth monitoring of the ICPD+15 implementation[1] and MDG 5 in 12 countries.[2]

The indicator of Maternal Mortality Ratio (MMR) represents the risk associated with each pregnancy; however, reliable data on this indicator is currently available only in about one third of all countries.[3] Unless countries institutionalise the implementation of vital registrations systems for births and deaths, backed up by maternal death classifications, reporting systems and confidential enquiries on maternal deaths, an accurate assessment of the indicator on MMR will be difficult. It is also important to note that national averages mask the actual state of MMR reduction within the countries, and MMR is not disaggregated by age (especially the recording of maternal deaths below age 18), location, education level, wealth quintile and socially excluded groups.

The MDG 5 indicators of proportion of births attended by skilled health personnel and antenatal care coverage are more process-oriented indicators. However, the definition of skilled health personnel vary in different countries and standardisation is difficult. Meanwhile, antenatal care coverage does not capture whether women receive all interventions and components of care effective in improving maternal health (for example, monitoring blood pressure, blood testing for severe anaemia, clinical examination and recommendation for emergencies).

Going by the ICPD vision of women and men having more control over the desired number, spacing and timing of their children, the current MDG 5 indicators of Contraceptive Prevalence Rate (CPR) and unmet need alone will not be sufficient. Unmet need in the Asia and Pacific region is severely under-estimated as Demographic and Health Surveys take into account only currently married women and their contraceptive needs. The computation of unmet need also does not address the unmet needs of women with primary and secondary infertility, who actually want to have children and are not able to conceive.

Meanwhile, the MDG 5 indicator on adolescent birth rates provides information on the sexual and reproductive behaviour of adolescents. However, it does not indicate whether information and services are being provided to adolescents, especially unmarried adolescents, and the quality of these services.

The list of proposed additional indicators to measure progress towards the MDG 5 framework in a comprehensive manner, with the reasons for their selection as well as the data source and limitations, is in Table 1 (p. 24). It must be noted that efforts are needed to further refine these proposed indicators given their limitations, and at the same time to make the indicators statistically rigorous, measurable and, where needed, consider gender equality, human rights and social equity principles. We call for the integration of these additional indicators within the MDG 5 framework, as well as in the formulation of the post-2015 agenda.

Endnotes

1 *Thanenthiran, Sivananthi; Racherla Sai Jyothirmai. 2009. Reclaiming & Redefining Rights ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia. Kuala Lumpur: ARROW.*

2 *ARROW. 2010. "MDG 5 in Asia: Progress, gaps and challenges 2000-2010." Kuala Lumpur: ARROW.*

3 *World Health Organisation (WHO). 2010. World Health Statistics 2010 – Indicator Compendium Interim Version. Geneva: WHO.*

4 *WHO; United Nations Children's Fund (UNICEF); United Nations Population Fund (UNFPA); The World Bank. 2007. Maternal Mortality in 2005: Estimates developed by WHO, UNICEF and UNFPA. Geneva: WHO.*

5 *Wilmoth, John. 2009. "The lifetime risk of maternal mortality: Concept and measurement." In Bulletin of the WHO, Vol. 87, pp. 256-262.*

6 *Unsafe abortion is defined as a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both.*

7 *WHO. The Prevention and Management of Unsafe Abortion: Report of a Technical Working Group. http://whqlibdoc.who.int/hq/1992/WHO_MSM_92.5.pdf*

8 *Singh, Susheela, et al. 2009. Abortion Worldwide: A Decade of Uneven Progress. New York: Guttmacher Institute.*

9 *Espinoza, Henry; Camacho, Alma Virginia. 2005. "Maternal death due to domestic violence: An unrecognised critical component of maternal mortality." Pan Am Journal of Public Health, Vol. 17 No. 2, pp. 123-129.*

10 *Garcia-Moreno, Claudia, et. al. 2005. WHO Multi-country Study on Women's Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: WHO.*

11 *Averting Maternal Death and Disability Program. "Using the UN Process Indicators of Emergency Obstetric Services: Questions and Answers."*

12 *Paxton, Anne; Maine, Deborah; Hijab, Nadia. 2007. Technical Consultation on Reproductive Health Indicators: Summary Report. Geneva: WHO.*

13 *Maine, Deborah, et al. 2009. Monitoring Emergency Obstetric Care: A Handbook. Geneva, Switzerland: WHO.*

14 *Life threatening, direct obstetric complications affect an estimated 15% of women during pregnancy, at delivery or in post-partum period.*

15 *Rutstein, Shea Oscar; Rojas, Guillermo. 2006. Guide to DHS Statistics. Maryland: Demographic and Health Surveys ORC Macro.*

16 *National Institute of Population Studies; Macro International Inc. 2007. "Fertility preference." In Pakistan Demographic and Health Survey 2006-07 (p. 87). Islamabad: National Institute of Population Studies; Macro International Inc.*

17 *Bearinger, Linda H., et al. 2007. "Global perspectives on the sexual and reproductive health of adolescents: Patterns, prevention, and potential." Lancet, Vol. 369, pp. 1220–31.*

18 *ICPD Programme of Action, paragraph 7.7.*

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FACTFILE

Table 1: Proposed Additional Indicators for MDG 5

MDG 5 Targets	Official Indicators	Proposed Additional Indicators, Definitions and Rationale	Data Collection and Source, Periodicity of Measurement and Limitations of the Proposed Indicators
Target 5a: Reduce by three quarters the maternal mortality ratio	Maternal Mortality Ratio	**Adult lifetime risk of maternal death:** this is the probability of maternal death during a woman's reproductive period (15-50 years), taking into account other causes of death in women of reproductive age.[4] This is a more inclusive indicator as it describes the cumulative loss of human life due to maternal death over the female life course, and is a summary measure of impact of maternal mortality.[5]	This is available from the 2005 and 2008 UN estimates of maternal mortality developed by WHO, UNICEF, UNFPA and the World Bank. The periodicity of measurement is generally every five years. However, the adult lifetime risk of maternal death will vary across geographic areas, socio-economic groups and other groups experiencing discrimination, exclusion and marginalisation within the countries and this limitation needs to be taken into account in refining the indicator.
		Maternal deaths due to unsafe abortion:[6,7] Unsafe abortion mortality ratio is the number of deaths due to unsafe abortion per 100, 000 live births. This is a subset of the maternal mortality ratio and measures the risk of a woman dying due to unsafe abortion relative to the number of live births.[7] Unsafe abortion causes an estimated 70,000 deaths annually). It is also a reflection on whether women's reproductive rights are realised.[8]	Data sources on abortion deaths is difficult to obtain and include those reported by governments to the WHO's mortality database; reproductive age mortality studies (RAMOS); confidential enquiries or community studies; national hospital data; or weighted averages from a number of sites. Currently, only periodic updates of the global and regional estimates are published by WHO. National estimates are not published but need to be done.
		Maternal deaths due to violence against women:[9] This indicator should take into account components such as violent death and violence against women, and the current international definition of maternal death. Adding this indicator to target 5 will ensure that this indication of gender inequality will be captured, and highlight that significant numbers of maternal deaths are being attributed to violence. For example, in Bangladesh, 14% of the maternal deaths are considered to be due to gender-based violence.[10]	The 2005 WHO multi-country study on women's health and domestic violence against women analysed data collected from 24,000 women in 10 countries and examined violence during pregnancy.[10] There is a need for the development of an appropriate terminology and definition to accurately count this type of death across countries in a more rigorous manner and on a regular basis, such as every 5 years, not just one-off studies.
	Proportion of births attended by skilled health personnel	**Availability of Emergency Obstetric Care (EmOC) services:** This denotes the number of facilities that provide basic and comprehensive EmOC. The recommended level is a minimum of one comprehensive EmOC facility for every 500,000 people, and four basic EmOC facilities per 500,000 people.[11]	Currently there is a lack of established data collection systems at the national level, and data on EmOC is collected through ad-hoc studies.[12] However, the World Health Organisation has established guidelines on data collection.[13] The indicator in itself also needs refinement to make it a more sensitive indicator; work is also needed to be done to include births rather than population in its denominator. As well, there is also a need to look at issues of access, quality of services and equity. The periodicity of measurement should be every five years.
		Met need for EmoC services: The proportion of women with obstetric complications treated in EmOC facilities. The minimum acceptable level is 100%, estimated as 15% of expected births. It is important to monitor these two indicators as services to address obstetric complications[14] is a very critical area in addressing maternal mortality (and morbidity) reduction.	
		Access and availability of post-partum care within 48 hours of delivery:[15] A large proportion of maternal deaths occur 24-48 hours after delivery; hence, immediate post-partum care is a critical safe childbirth intervention. The availability and access to postpartum care, especially during the initial 48 hours of delivery, is grossly neglected.	Demographic and Health Surveys (DHS) capture data in selected countries on this indicator periodically. The ARROW ICPD+15 monitoring study was able to collect data from the DHS on this indicator in Bangladesh, India, Pakistan, Nepal, Indonesia, Cambodia and the Philippines. The quality of post-partum care services also need to be considered.
Target 5b: Achieve, by 2015, universal access to reproductive health	Unmet need for family planning	**Total Wanted Fertility Rates vs. Total Fertility Rate:** A birth is considered wanted if the number of living children at the time of conception of the birth is less than the ideal number of children as reported by the respondent.[16] This, and the next three indicators, are indispensible indicators that denote women's control over her fertility. The higher the difference between Total Wanted Fertility Rate and Total Fertility Rate, the greater the lack of control amongst women over their fertility than they themselves desired.	DHS capture data on this indicator at the country level periodically.
		Reasons for non-use of contraception: Percent distribution of currently married women who are not using contraception and who do not intend to use at any time in the future, by main reasons (fertility related, method related, opposition to use and knowledge aspects of contraception) for not intending to use.	DHS capture data on this indicator at the country level periodically. This indicator provides information on issues around non-use of contraception. However, the indicator needs to be sensitive to all women of reproductive age, irrespective of marital status.
	Contraceptive prevalence rate	**Provision of informed choice:** Informed choice of family planning methods is an important reproductive rights indicator. Informed choice includes: information on the full range of methods including traditional and male methods; information on side-effects of all methods and the appropriate course of action; and information on the efficacy of each of the methods.	DHS capture data on this indicator at the country level periodically. However, there is a need to integrate the full rights-based definition of informed choice in the indicator used by DHS.
		Percentage of women of reproductive age irrespective of marital status using a preferred contraceptive method of their choice: The ability of women to choose the method that is most suited to them to exercise control over her fertility is a major indicator of reproductive rights. For a more accurate picture, the contraceptive needs of women who are single, divorced, separated or widowed need to be incorporated.	This data is currently not collected.
	Adolescent birth rate	**Legal age of marriage vs. Median age of marriage:** The comparison of legal age of marriage with the median age of marriage will provide information on whether the legal age of marriage is enforced in respective countries.	The data on legal age of marriage is available in UN database, while the median age of marriage is available in the national Demographic DHS.
		Existence of a national policy on sexuality education as part of school curriculum and for out-of-school youth: Sexuality education is defined as education about all matters relating to sexuality and its expression, including issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and information on SRH services.[1] Sexuality education empowers adolescents and young people to make strategic life choices concerning their sexual and reproductive lives; hence, the importance of tracking this.	Data on this indicator is uneven; there is no standard definition of sexuality education.
		Accessibility and quality of adolescent- and youth-friendly SRH services:[17,18] The right to adolescent and youth-friendly services include having contraception and counselling services around sexual decision-making and behaviour, STIs and HIV-prevention services, diagnosis, and treatment; prevention of cervical cancer; safe abortion; and prevention and care during pregnancy and childbirth in a non-stigmatised environment.	Data on this indicator is uneven; currently there is no database that collects data on accessible and high-quality adolescent and youth-friendly SRH services.

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