WHAT IT TAKES: ADDRESSING POVERTY AND ACHIEVING FOOD SOVEREIGNTY, FOOD SECURITY, AND UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

TK Sundari Ravindran

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THEMATIC SERIES ON LINKING GENDER, POVERTY ERADICATION, FOOD SOVEREIGNTY AND SECURITY, AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

What It Takes: Addressing Poverty and Achieving Food Sovereignty, Food Security, and Universal Access to Sexual and Reproductive Health Services
by TK Sundari Ravindran

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1 & 2 Jalan Scott, Brickfields
50470 Kuala Lumpur, Malaysia

tel	(603) 2273 9913/9914/9915
fax	(603) 2273 9916
email	arrow@arrow.org.my
web	www.arrow.org.my
facebook	The Asian-Pacific Resource & Research Centre for Women (ARROW)
twitter	@ARROW_Women

Production Team:
Project Coordinators: Sivananthi Thanenthiran and Maria Melinda (Malyn) Ando
Paper Reviewers: Clare Westwood, Maria Melinda (Malyn) Ando, Sivananthi Thanenthiran, and Tabinda Sarosh
Coordinating Editor: Ambika Varma
Copy-editor: Cezar Repuyan Tigno
Layout and Graphic Design: Nico Mallari
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WHAT IT TAKES:

ADDRESSING POVERTY AND ACHIEVING FOOD SOVEREIGNTY, FOOD SECURITY, AND UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

TK Sundari Ravindran

INTRODUCTION

The Asia-Pacific region has made impressive gains in poverty reduction during the past three decades. The proportion of poor almost halved during this period: in 2011, less than 20% of the region's population lived on US$1.25 per day or less, as compared to more than 50% in 1990. The absolute number of people living in poverty in the Asia-Pacific region came down from 1.6 billion to about 0.9 billion—still a formidable number—during the same period (United Nations Economics and Social Commission for Asia and the Pacific [UNESCAP], 2013).

Poverty is no longer measured only in terms of income deprivation. The Multidimensional Poverty Index (MPI) measures acute human poverty, which considers people deprived in one-third or more of the 10 indicators of the three dimensions of health, education, and living conditions to be extremely poor. The deprivation of good health reflects the survival of the individual; the deprivation of education shows the lack of knowledge needed to fully participate in all spheres of life; and the deprivation of living conditions relates to a decent standard of living. About 1.1 billion people in the region, which is 200 million more than those affected by income poverty, suffer multiple deprivations as measured by the MPI (Alkire et al, 2011).

Poverty reduction has been accompanied by growing income inequality. In the past two decades starting in the mid-1990s, the Gini coefficient[1] (the most common measure of inequality) has risen sharply in Asia from 38 to 47. If inequality had stayed stable instead of rising, around 240 million more people in Asia could have escaped poverty (Asian Development Bank [ADB], 2012a).

Levels of hunger and malnutrition did not decline at the same pace as the decrease in the proportion of the region's poor. For example, the number of undernourished children declined modestly, from 26% in 1990 to 18% in 2009. South Asia not only had the highest number of malnourished children under five (30%) in 2011-12 (United Nations, 2013), but also exhibited marked inequalities in the decrease of child malnutrition between the richest (37% in 1995 to 26% in 2009) and the poorest (64% in 1995 to 60% in 2009) (ADB, 2012b). Eleven of 14 Asian countries

[1]Income Gini coefficient is a measure of the deviation of the distribution of income (or consumption) among individuals or households within a country from a perfectly equal distribution. A value of 0 represents absolute equality, a value of 100 absolute inequality. Source: World Bank (2012), UNDP HDR website at: http://hdrstats.undp.org/en/indicators/67106.html

were reported to have "serious"or "alarming" levels of hunger in 2011 as measured by the Global Health Index (GHI)[2] (International Food Policy Research Institute [IFPRI], 2011).

Progress in the reduction of poverty and hunger during the new millennium has been severely hampered by recurring crises on multiple fronts. There was an unprecedented hike in food and fuel prices in 2007 and 2008. According to Asian Development Bank (ADB) estimates, if food prices had stayed the same, about 112 million more people could have been saved from poverty every year (based on the $1.25/day poverty line) (ADB, 2012b). In 2008-09, immediately following the food crisis was the worst economic and financial crisis since the Great Depression of the 1930s. In the Asia-Pacific region, the growth rate of GDP decreased from 3.1% in 2008 to 0.5% in 2009. Subregions that depended largely on exports and from remittances from abroad were more seriously affected. Fall in exports meant loss of jobs in the export manufacturing sector, while lower external revenues had negative implications for government budgets (UNESCAP, 2009). Loss of livelihood combined with cuts in public expenditure may have had a significant impact on health and well-being of the population, particularly on women and those from socially and economically vulnerable sections.

Around the same time, the high cost of healthcare prevented about 1.3 billion poor globally from accessing healthcare services. A hundred and fifty million people faced catastrophic health costs; too ill to work and spending beyond their means to get well, 100 million people were driven below poverty line (WHO, 2010a). If cuts in public expenditure on health as a consequence of the global economic crisis made the cost unaffordable, then insecure jobs, low wages, and high food prices left households with little money to seek healthcare (Antunes & Evans, n.d.). Against this backdrop, it is not surprising that universal access to sexual and reproductive health (SRH) services remains an elusive goal, as reported by a recent study of selected countries in the Asia-Pacific region (Ravindran, 2012).

The central thesis of this paper is that it is not possible to achieve universal access to sexual and reproductive health services unless we tackle the root causes of poverty and hunger and of recurring economic and food crises; and further, that the root causes are the forces of neoliberal globalisation. At the same time, sexual and reproductive health and rights (SRHR) is integral to development and achieving SRHR is intertwined with achieving basic human rights, such as the right to adequate food and nutrition. To respond adequately to, or find ways out of, any one issue in isolation would not be feasible because of the many ways in which food security, poverty, and access to healthcare services are interwoven. The movement for SRHR would need to join forces with those working for the right to food and against poverty and neoliberal globalisation to be able to challenge and dislodge the root causes. Similarly, in framing our agendas for food security, food sovereignty, rights to adequate food and nutrition, and SRHR we must not lose out on the centrality of the woman, and her specific needs to adequate quality food, sexual and reproductive health, and the means of achieving these throughout her lifecycle. Specific attention must be given to

[2]Global Health Index (GHI) = (PUN+CUW+CM)/3: where PUN = proportion of undernourished population (%), CUW = prevalence of underweight in children below 5 yrs of age (%), and CM = proportion of children dying before the age of 5 (%).

critical groups of women such as the pregnant, lactating, and those living with HIV and AIDS, who have specific needs to food and therefore have a right to it.

INTERLINKAGES AMONG POVERTY, FOOD SOVEREIGNTY, FOOD SECURITY, AND HEALTH

The next section presents concepts and definitions of poverty, food security, food sovereignty, and universal access as used in this paper and outlines the interconnections between poverty, food sovereignty and health and healthcare access. The right to adequate food and nutrition is integral to the above concepts and linked with all other fundamental rights. Section three defines and describes neoliberalism and the ways in which it influences poverty and food security and often impacts unequally on women as compared to men. Section four explores the effects of neoliberal economic policies on health and universal access to healthcare services, the gendered nature of these effects, and the implications for universal access to SRH services. Section five engages with the way forward in terms of an agenda for crossmovement action to confront neoliberal globalisation.

This paper understands poverty as a multidimensional phenomenon as defined by the World Summit on Social Development in Copenhagen in 1995. Manifestations of poverty include "a lack of income and productive resources to ensure sustainable livelihoods; hunger and malnutrition; ill health; limited or lack of access to education and other basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments and social discrimination and exclusion. It is also characterised by lack of participation in decision-making and in civil, social and cultural life (United Nations, 2012).

Food security is said to exist "when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life" (Food and Agricultural Organisation [FAO], 1996). Food security may be seen as constituted of three crucial components: food production, economic access to available and culturally appropriate food, and nutritional security.

Food sovereignty is a related term, which seeks to distinguish between food security as the result of efficient working of market forces with a passive role for producers, distributors and consumers of food versus food security achieved through the right of people who produce, distribute and consume food to define their own food systems (World Development Movement, 2013). Food security is a component of food sovereignty. Food sovereignty encompasses the rights of people and communities to decide on food and agricultural policies; to adequate, culturally appropriate and safe food; to land and productive resources; to sustainable production and livelihoods; to gender justice, social justice, and environmental justice. Food security does not necessarily achieve food sovereignty.

The Right to Adequate Food and Nutrition. The International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 11.1 of the Covenant, mandates States Parties to recognise "the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions", and article 11.2 urges that immediate steps may be needed to ensure

"the fundamental right to freedom from hunger and malnutrition". The right to adequate food is intrinsically linked to all other human rights especially the right to water, right to health, right to property, right to work, right to livelihood, the right to social security and social welfare (UNCESER, 1999).

If poverty were understood to be much broader than the mere lack of adequate income and as manifested in multiple deprivations, then both hunger and ill-health are facets of poverty. Not having the financial means to purchase food would contribute to food insecurity among households that are net consumers of some or all food items. On the other hand, high cost of food would erode purchasing power of households and, in turn, lead to underconsumption, hunger and malnourishment. Hunger and malnutrition have severe immediate and long-term health consequences. In the short run, they may result in limited ability to work and earn a living and increase risk of illness and disease, affecting income and contributing to poverty. Chronic hunger and malnutrition affects children's growth and cognitive development, affecting schooling. Food insecurity also forces people to work longer hours to earn enough to ward off hunger, and this may cause them to withdraw their children from schools either to support household tasks or to contribute to additional income. Children with truncated schooling have greater difficulty in earning an adequate living (Chhibber et al, 2009).

SRH includes not only normal physiological functions such as pregnancy and childbirth but the ability to control and regulate fertility and to avert and reduce any adverse outcomes related to sexual activity and reproduction (see Annex 1 for detailed definitions). SRH is also about "enabling people of all ages, including adolescents and those older than the reproductive years, to have safe and satisfying sexual relationships by tackling obstacles such as gender discrimination, restrictive laws, sexual coercion, exploitation, and gender-based violence" (Glasier et al, 2006).

Poverty compromises the potential to enjoy good SRH throughout the life cycle through a number of pathways: undernutrition and anaemia, low educational attainment, poor quality of shelter, sexual abuse and intimate partner violence, and poor access to SRH services. For example, a female child may be born with low birth weight because their mothers were malnourished. She may grow up deprived of adequate nutrition to become an undernourished and stunted woman, and living in low quality shelters that exposes her to multiple infections. She would have limited opportunities for adequate educational attainment and may be employed in backbreaking and hazardous occupations. She may be exposed to risk of sexual debut and sexual violence before her teenage years, marry or cohabit early, and give birth as a teenager facing associated risks of death and disability. She will have limited ability to control her sexual and reproductive life and little or no access to quality healthcare services. Data from recent Demographic and Health Surveys for selected countries of the Asia-Pacific Region establishes that women from the lowest wealth quintile experience considerably poorer SRH status as compared to their better-off counterparts (Ravindran & Nair, 2012).

What is universal healthcare and how is it linked to poverty and food security?

Universal access to healthcare is "the absence of geographic, financial, organisational, socio-cultural and gender-based barriers to care" (Pan American Health Organisation, 2007). There are two sets of factors that influence access: supply side or health

system factors, which include affordability, availability, acceptability, and quality; and demand side factors, such as lack of information and decision-making power, restrictions on mobility, social exclusion, and discrimination.

Universal access to SRH services has been defined as follows:

"The equal ability of all persons according to their need 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 to:

- Decide freely whether and when to have children and how many children to have and to delay and prevent pregnancy,
- Conceive, deliver safely, and raise healthy children and manage problems of infertility,
- Prevent, treat and manage major 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" (WHO, 2007).

An earlier analysis of progress towards universal access to SRH services highlighted that in addition to addressing health system factors, achieving universal access to SRH services would involve addressing gender, poverty, food insecurity, and other social determinants that pose demand side barriers to healthcare seeking (Ravindran, 2012). This is because in addition to poverty, unequal gender relations within the household constrains women's ability to make time to seek healthcare, take independent decisions about doing so, travel to health facilities, and pay for healthcare. Short-time food insecurity may impact, among other things, on the time women have to spend in finding cheap food and in preparing food with less-costly ingredients. On the other hand, chronic food insecurity may affect women's time availability through its impact on the well-being of infants and children and older persons, besides affecting their own well-being.

In turn, universal access to healthcare services, including SRH services, would have many positive effects on poverty reduction and food security. For example, universal access to healthcare services would remove the burden of catastrophic health expenditure and ensuing impoverishment, especially for low-income groups. More money would be available for purchasing food and this would contribute to better nutrition if appropriate dietary practices are adopted. Greater population well-being could contribute to higher productivity, economic growth, and poverty reduction. Universal access to sexual and reproductive health services, through its impact on prevention of unwanted pregnancies among others, and preventable disease and disability, improve women's nutritional status, and contribute to improved food security. Another pathway may be through a decrease in the number of work-days in farming lost from ill-health, which would contribute to improved food availability at the household level. Better access to sexuality education and ready access to condoms will help young people prevent STIs and HIV, and in turn, prevent illness and poverty-related consequences for young people.

Thus, poverty, food security, and universal access to healthcare are linked through multiple pathways. Improvement in one will have spill-over effects on the other two. But there is another, more insidious link between these three: neoliberal globalisation, which is a major obstacle to achieving poverty reduction, food sovereignty and universal access to healthcare, including SRH services.

NEOLIBERAL GLOBALISATION, POVERTY REDUCTION, FOOD SOVEREIGNTY, AND FOOD SECURITY

Neoliberal globalisation

'Neo' or new economic liberalism is the successor of economic liberalism that dates back to the 18th century and held sway till the Great Depression of the 1930s. Adam Smith, in his The Wealth of Nations, outlined the main tenets of economic liberalism. According to this paradigm, individual acts of buying and selling to maximise one's own benefit nevertheless promoted the common good, through the 'hidden hand' of the market, or by the workings of the laws of supply and demand[3] (von Werlhof, 2008). It was believed that 'free' markets and 'free' trade, unfettered by state regulations of any kind, unleashed individual creativity and nurtured entrepreneurship and led to economic growth and social well-being. Free markets were also seen to be the most efficient means of allocating society's resources (Dag Einar & Amund, 2013). Neoliberalism of the late 20th century may be understood as the 'globalisation' of the concepts governing economic liberalisation.

Government regulation and state intervention in the markets to restore economic stability became necessary following the Great Depression of the 1930s. The "Keynesian" model of development, named after its proponent John Maynard Keynes, helped rebuild the economies of Europe and USA following the Second World War and also informed the economies of countries that gained independence from colonial rule during the post-war period (Juego & Schmidt, 2009).

Multiple crises in fuel, food, and finances triggered the emergence of neoliberal globalisation in the late 20th century. The oil crisis of 1973 snowballed into a major debt crisis affecting the developing world and motivated the 'Washington Consensus' of 1989, which laid the roadmap for neoliberal globalisation (Juego & Schmidt, 2009).

The Washington Consensus, a set of structural adjustment policies that low-income countries were required to adopt if they were to receive new loans from the World Bank and IMF for debt repayment, included:

- Fiscal discipline and the reduction of deficits, which meant cuts in public expenditure including in health and education;
- Reordering of public expenditure priorities away from non-productive investments, including food and agricultural subsidies;

[3] Producers would only sell at a price that is profitable to them, and of course, acceptable to consumers. Consumers will decide on whether they want to buy a product and how much of it they would buy, based on the price of the product. Their purchases will benefit the producer, but the consumer is motivated by self-interest. The 'market' is the medium through which they interact, and the market, left to itself, thus helps maximise the welfare of consumers, as well as producers.

- Market-driven interest rates and exchange rates, instead of stable rates regulated by the government;
- Liberalisation of trade e.g., removal of tariffs and quantitative restrictions on imports;
- Allowing and facilitating foreign direct investments into the country;
- Privatisation of state-run enterprises;
- Deregulation or the abolition of regulations that impede market entry or restrict competition[4]; and
- Protection of private property rights (Juego & Schmidt, 2009).

The collapse of the Soviet Union and the socialist bloc around the same time removed a strong countervailing force to neoliberalism and paved the way for its wide acceptance as the only way forward for the global community. A series of 'neoliberal' global policies followed.

In 1995, the World Trade Organisation or WTO was established. The international treaties that WTO member countries became party to include the Multilateral Agreements on Investments (MAI) that demanded a total liberation of all corporate activities; the General Agreement on Trade in Services (GATS) that required 'open border' policies to allow private investment from abroad in the services sector, including health and education; the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) that meant to protect patent rights held mainly by transnational corporations; and the Agreement on Agriculture (AoA) that enforces 'free' trade in agricultural products. International Financial Institutions 'encouraged' low-income countries into 'full participation' in WTO-ruled trade agreements (Juego & Schmidt, 2009).

The 'open borders' policies of the WTO applied not only to goods and services, but also to capital, which could now enter and exit countries as it pleased. Foreign and domestic investors could buy national currency and any other financial instruments from any country and off-load them when they were no longer profitable. The Asian economic crisis of the late 1990s was a direct consequence of the free movement of capital across borders. There had been dollar investments in the banks of South East Asian countries that were suddenly withdrawn to speculate in other countries. The economies of several countries were pushed to the verge of collapse, causing great hardship to millions of people.

The miseries brought about by the Asian economic crisis were soon forgotten. During the first decade of the new millennium, speculative movement across borders of finance capital continued. New financial instruments were created to attract finance capital in search of higher and higher returns. The speculative adventurism of finance capital culminated in the devastating global economic crisis of 2008. According to Warren Buffet (2002), innovative financial instruments, such as derivatives, were "lethal financial weapons of mass destruction and time bombs susceptible to explode and cause the implosion of the entire economic system."

The seeds of recurrent crises on multiple fronts are rooted in the very nature of neoliberal globalisation.

[4]Except for those justified on safety, environmental, and consumer protection grounds.

A fundamental assumption governing this development paradigm is that any kind of economic growth is good and that the cheaper things are, the more efficiently they are produced. This is the driving force behind neoliberal globalisation: the urge to find the cheapest way of doing things, the search for cheap raw materials and cheap labour.

Herein lies the problem. The cheaper things are, the more they are produced. But low wages and unemployment means that many people cannot afford them. There is then a crisis of overproduction. When there is no more scope to increase consumption of specific goods, capital accumulates to the point where it no longer knows what to do with itself. When it becomes no longer profitable to invest capital in productive pursuits, other lucrative means of investing capital to maximise profits needs to be found. There is a search for opportunities to invest in banks shares and real estate anywhere in the world. Opening up of all economies becomes necessary for this to happen. With capital free to come in and get out of different countries and with countries free to choose where to import from or export to, every country's economy becomes increasingly vulnerable to global financial shocks. The poorer the country, the more vulnerable it is to these shocks (Ransom, 1997). The world thus totters along from crisis to crisis.

Neoliberal economic policies and poverty reduction

Neoliberal economic policies run contrary to measures essential for substantial and sustained poverty reduction. Many of the policy pathways underlined in the Washington Consensus have contributed to dampening poverty reduction in the Asia-Pacific region.

For example, "fiscal discipline" is an essential feature of neoliberal economic policies. This implies reducing the fiscal deficit in the government budget as far as possible, and hence cuts public investments. Cuts in public investments means that governments may not be able to invest adequately on public infrastructure, such as roads, electricity, water supply and sanitation; or in public services, such as education and health; provide adequate social support to people living in poverty; or provide them with subsidised or cost-free access to credit, agricultural inputs, electricity, land and livestock. Some economists have argued that public investment for reallocating resources towards poverty reduction could in fact propel economic growth, and should not be forsaken in order to curtail fiscal deficit (McKinley, 2004).

Similarly, protection of private property implies that the government will not be able to adopt redistributive measures, such as land reforms, which make available land to the tiller or limit speculative investments in property.

Trade liberalisation has removed restrictions on imports and exports. Countries that developed their export capacities benefited from trade liberalisation through the ensuing export boom. The gains accrued disproportionately to larger enterprises and farmers because small enterprises, including small farmers did not have the resources to take advantage of an increase in export demand and lacked policy support to do so (McKinley, 2004).

Also, the positive impact on economic growth could not always be sustained. For example, in countries such as Nepal whose export earnings come from a narrow range of products (like garments, pashminas, and carpets saw the benefits accruing to a small section of the urban population. However, the surge in imports offset the gains through exports and

resulted in a trade deficit. At the same time, rice farmers suffered losses because of cheap import of rice (McKinley, 2004).

Another consequence of the removal of tariffs, duties, and taxes related to trade has been reduction in public revenue. This further affects governments' capacity/ability to invest in social sectors and in poverty reduction measures.

Financial liberalisation makes countries vulnerable to crises resulting from speculative dealings in capital and capital flights out of the country. In addition to its contribution to economic destabilisation, financial liberalisation has in many countries also resulted in a shrinking of financial services available to small scale producers and to low-income groups. Having to compete with private international and national banks, public sector banks have had to pull back from subsidised credit to small-scale producers and subsistence loans to low-income groups. In countries such as India, the combination of retraction of input subsidies and affordable credit and volatility of product prices have driven hundreds of thousands of households into debt and desperation even before the financial and economic crises of 2008.

Economic growth in many Asia-Pacific countries in the years of neoliberal globalisation was not accompanied by a comparable growth in employment. For every 1% of GDP growth, employment grew only by 0.4% (Chhibber et al, 2009). This was because much of the growth was in sectors that were not labour-intensive and also because competition drove many labour-intensive sectors to adopt labour-displacing technologies. As a consequence, people displaced from agriculture could not be accommodated in other sectors, and a large number of young people entering the labour force were left without suitable employment opportunities. Wages, especially in the informal sector of the economy, remained suppressed because of the large pool of unemployed people. The economic boom made only a limited contribution to human development.

Economic growth through the path of neoliberal globalisation, while making only a modest reduction in poverty since 1990, has accentuated inequalities within many countries of the Asia-Pacific region. For example between 1993 to 2004/05, the Gini coefficient of income inequality increased from 0.41 to 0.47 in China, 0.33 to 0.37 in India, and 0.34 to 0.40 in Indonesia (ADB, 2008).

Low-income groups in the Asia-Pacific region were thus extremely vulnerable to external shocks. Following the 2008 crises, the demand for goods fell in the USA and Europe. This directly affected those working in the export manufacturing and services sectors, and many more whose livelihoods depended on servicing the export sector and its workers also lost their jobs. For example, in Cambodia where 70% of the exports consisted of garments, 18% of the total work force in the sector was laid off during 2008 September-2009 April. Those in casual employment found fewer days of work. For example, in Vietnam, workers reported a 30-50% decline in wage earnings between 2008 and early 2009. Food prices were skyrocketing since the food crisis of 2007. Low-income households had to resort to reductions in investments and consumption detrimental to health and well-being both in the short and long run (Chhibber et al, 2009).

Strategies for poverty reduction promoted or adopted by governments have tended to make the poor themselves responsible for finding a way out of their poverty. For example, microcredit programmes expected to make entrepreneurs out of those living in

dire poverty and to compete in the global market. Cash support programmes for the poor now come attached with conditions of good behaviour, including attending antenatal care or having institutional deliveries, immunising their children, or ensuring that they go to school. The obstacles that prevented the poor from adopting these behaviours in the first place are rarely acknowledged (Ozturk, 2011).

Neoliberal economic policies and food security

Slow growth in agricultural production, increasing costs of cultivation, speculation in agricultural futures commodities and the diversion of agricultural products and cultivable land to the production of biofuels have all resulted in impoverishment of the small peasantry, increasing and volatile food prices and deepening food insecurity among the most vulnerable populations.

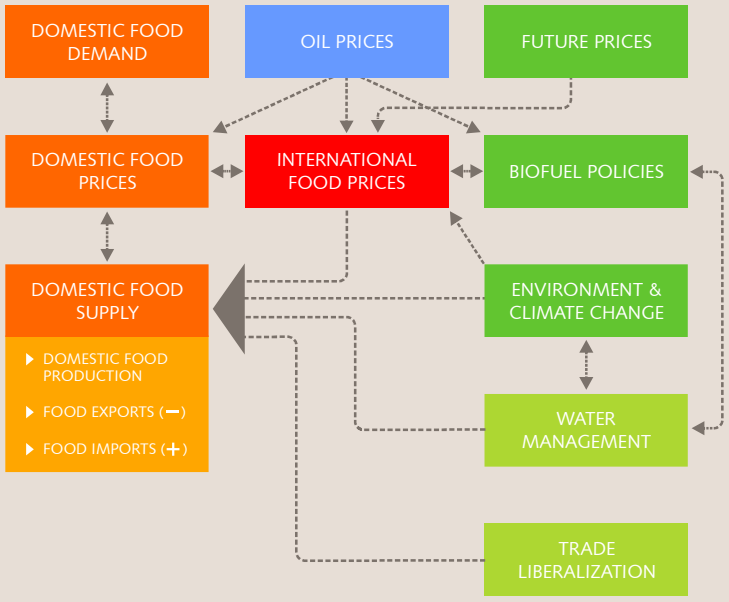
Cuts in public investment have resulted not only in low investment in agricultural infrastructure but also in the neglect of agricultural research. Small farmers with insecure land tenures have had little interest in investing in enhancing productivity of land. These have contributed to lower agricultural yields. Farmers forced to compete in the global market have tended to switch to cash crops, especially if they had the resources to do so. These have contributed to low overall increases in food production (People's Health Movement et al, 2011).

Another factor contributing to slow growth in agricultural production is the exit of small farmers from the agricultural sector because of the unviability of agricultural production. High costs of inputs and credit as a result of cuts in subsidies and competition from the global market have contributed to the impoverishment of small farmers. Also, oil price increases have made petroleum-based fertilisers very expensive (People's Health Movement et al, 2011). Neoliberal economic policies have treated nature as a never-ending resource involving zero cost and have exploited natural resources beyond sustainability. Burning of fossil fuels to produce energy, deforestation, industrial processes, and some agricultural practices have resulted in the emission of large amounts of carbon dioxide and other greenhouse gases into the atmosphere. The build-up of greenhouse gases have contributed to climate change, with unpredictable and erratic climate making the lives of farmers even more insecure than they already were, with droughts and floods alternately hampering agricultural production.
The WTO Agreement on Agriculture (AoA) has had an important role in making agriculture unviable for small and even medium farmers. High-income countries of the global North have been dumping their highly subsidised agricultural products in countries of the global South, destroying the opportunities for sale by small farmers. However, markets of the Global North are closed to most Southern countries by tax barriers (von Werlhof, 2008).

Increases in fuel prices have also contributed to the high cost of agricultural production and increases in food prices. For example, between 2003 and 2008, fuel prices increases ranged from 216% in Afghanistan to 180% in Indonesia, 177% in Malaysia and 155% in Vietnam (Chhibber et al, 2009).

However, the two major drivers of the food crisis of 2007 and the consequent worsening of food insecurity were the financial speculation in the food commodity market and the diversion of agricultural produce and land towards bio-fuel production (Chhibber et al, 2009).

FIGURE 1: KEY FACTORS BEHIND THE INCREASE IN AGRICULTURAL COMMODITY PRICES AND PRICE VOLATILITY



SOURCE: Maximo Torero

NOTE: Because of their impact on transportation and input costs, oil prices directly affect domestic and international food prices. They also indirectly affect international food prices by altering the competitiveness of biofuel production. Similarly, biofuel policies influence water management by creating competition between biofuel production and food production for access to water.

SOURCE: IFPRI, (2011)

In the 1980s, there emerged a market for commodities 'futures' for food items. Futures markets are based on contracts between two parties to buy or sell a specified quantity of a commodity at a future date at a price agreed today. This was meant to protect producers and traders of commodities from sudden changes in market prices. Deregulation in the USA in 2000 permitted speculators with finance capital to enter and play the commodities futures markets and to make huge profits from short-term price rises. This resulted in extreme volatility in the prices of food grains that had nothing to do with supply and demand factors. For example, between 2007 and 2010, global wheat prices alternately peaked and troughed (People's Health Movement et al, 2011).

Use of food crops for the production of biofuels has been another major factor. Several studies have similarly concluded that the demand for biofuel production caused food prices to soar. According to one estimate, increased demand for biofuel

accounted for 30% of increases in real cereal prices, 39% of increase in real maize prices, 22% of increase in real wheat prices and 21% of the increase in real rice prices for the period 2000-2007 (Rosegrant et al, 2008).

Following their sharp increase in 2008, food prices have continued to be volatile at levels even higher than the peak 2008 prices (Table 1). For example, after the spike in 2008, there was again an increase in food prices in 2010, resulting in a spike in food prices in February 2011, which was higher than 2008. It is worth noting the volatility of prices across months of any year during 2009-2013 (Figure 2).

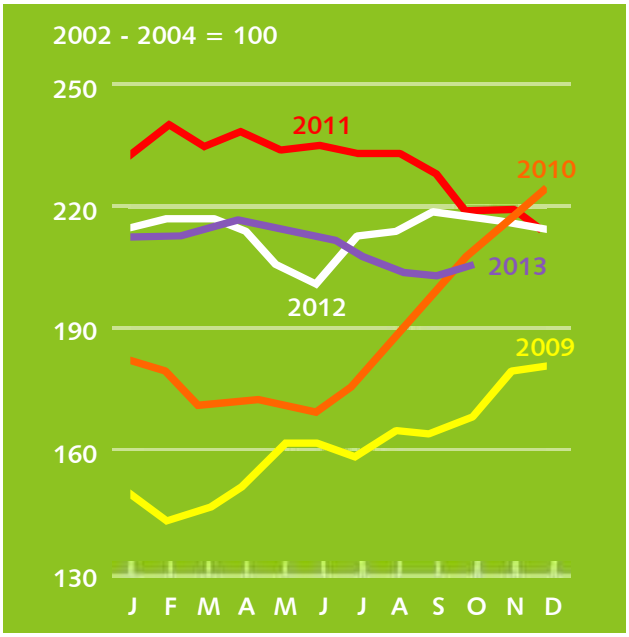
TABLE 1: FOOD PRICES INDICES[5] DURING 2003-2013

YEAR	FOOD PRICE INDEX
2003	97.7
2004	112.7
2005	117.9
2006	127.2
2007	161.6
2008	201.4
2009	160.6
2010	188
2011	230.1
2012	213.4
2013	209.9

SOURCE: FAO, 2014

FIGURE 2: FOOD PRICE INCREASES AND VOLATILITY 2009 -2013

FAO FOOD PRICE INDEX



SOURCE: FAO, 2013

Such excessive price volatility makes it difficult for farmers to make cultivation decisions based on market signals. In the short run, farmers may face huge losses or profits but in the long run, they would be averse to making large investments on farming. Consumers will experience much hardship in maintaining their previous levels and quality of food consumption. Food insecurity would worsen, especially for the lowest income groups.

The global economic crises have contributed also to large-scale land acquisitions in countries of the South by investors in the North. For example, the financial

[5]The FAO Food Price Index is a measure of the monthly change in international prices of a basket of food commodities. It consists of the average of five commodity group price indices (meat, dairy, cereals, vegetable oils, and sugar), weighted with the average export shares of each of the groups for 2002-2004.

crises have driven investment banks, pension funds, and other investors to choose to invest on more stable assets such as land rather than on volatile and unstable financial securities. Increase in fossil fuel prices and switch to biofuels have encouraged some European corporations to invest in biofuel production on overseas land, for which large-scale land is being acquired. Small and medium farmers in countries of the South are being displaced as a result of these large-scale land acquisitions with consequences for their own and the countries' food security and food sovereignty (Adbib, 2012).

Gendered implications of neoliberal economic policies

Neoliberal economic policies tend to impact differentially on women and men across social and economic strata, often to the disadvantage of women. Employment is one route through which women's potential for economic empowerment may be adversely affected. For example, restrictive policies to contain inflation at very low levels could adversely affect employment. Experience in many developing countries shows that when unemployment increases, the proportion of women losing employment is higher than that of men; but they do not gain employment faster than men when jobs become available (Razavi et al, 2012). When the public sector is downsized and privatised, more women are affected because a large share of women's formal employment tends to be in the public sector (Razavi et al, 2012).

Trade liberalisation has created new employment opportunities for women in export-oriented sectors (Razavi et al, 2012). In Southeast Asia, Bangladesh, and Sri Lanka, there were 2 to 5 female workers for every male worker in textiles, garments, and electronic sectors (Dejardin & Owens, 2009). However, because of intense international competition and the need to keep production costs low, there is limited scope for increase in wages and improvements in working conditions (Razavi et al, 2012). During times of crises, women are the first to be laid off. For example, during the Asian economic crisis, seven times as many women in South Korea were laid off as men (Seguino, 2009).

Cuts in public expenditure could mean a decline in public investment on basic needs and services, such as water supply and sanitation, public transport, and childcare services. Because of gender-based division of labour and limited access to cash compared to men, each of these would increase women's workload related to household tasks. Studies from hill districts of Nepal, Pakistan, Vietnam, and China carried out in the late 1990s reported that women's domestic tasks increased their work-day by 4 to 5 hours compared to men, especially in rural low-income households (Balakrishnan, 2005).

Yet another dimension of vulnerability that women face is the possibility of increased domestic violence in times of economic hardship. Studies from India observe that in times of economic crises, more women reported experiencing spousal violence; probably because men tend to vent their frustrations related to economic insecurity on their less powerful wives (Chhibber et al, 2009).

Gender roles cast women in an important role related to food security: as producers and processors of food, as procurers of food, and as preparers of food responsible for the nutritional security of members of their household. They have often to do so against serious odds. While the neglect of agriculture has affected the farming community overall, women farmers face additional difficulties because in most

Asian countries (especially in South Asia), few women possess land titles and legal ownership of the land on which they work. They therefore have less access to institutional credit, subsidised inputs, and extension services and have to incur higher cultivation costs (Chhibber et al, 2009).

Food insecurity and crises take a higher toll on women than men because of their role in procuring and preparing food. A detailed account is available from a study of the effect of food insecurity on rural women in Bangladesh and Ethiopia. This study found that when there were spikes in food prices, women

had to work 4.8 hours more every day to buy or prepare food at a lower price, or work for earning more income (Uraguchi, 2010). In Bangladesh, 21% of respondent women had to take their children out of school to support them. Women often cut down on their own food intake to put more food on the table for their children and husbands. One woman from a Bangladesh village described her situation thus:

> "I and my husband . . .have four children. My husband works on our 0.5 hectare land besides riding his rickshaw during "monga" (lean season). I also work as a daily labourer and earn only 1 dollar a day. I am not able to prepare good food to feed the whole family. I eat only once a day to give more food to my children and husband. I mainly eat fried wheat (sombaja) and puffed rice (muri) with chilli and salt" (Uraguchi, 2010).

NEOLIBERAL ECONOMIC POLICIES AND UNIVERSAL ACCESS TO HEALTHCARE SERVICES, INCLUDING SRH SERVICES

Since neoliberal economic policies have been adopted across the globe, there has been a substantial increase in real world annual income, for example, from PPP[6] $ 25.096 trillion in 1990 to PPP$ 71.845 in 2009 (World Bank, 2013). Increased prosperity and major scientific and technological advances in healthcare have nevertheless not translated into improvements in the lives and well-being of the majority of the world's people. Neoliberal globalisation has influenced health and healthcare by two different routes. One is through the effects of neoliberal economic policies on social and economic conditions, such as food crises, poverty, and inequality. The second is through direct changes within the healthcare system. This section will argue that the changes within the healthcare system are antithetical to achieving universal access to healthcare.

As described in earlier sections, poverty reduction has been stalled, while income inequalities have increased, and food prices have increased to hitherto unprecedented levels. Lives and livelihoods have become unpredictable, with repeated crises on multiple fronts. Together, these would have the effect of increasing risk of physical and psychological distress and illness.

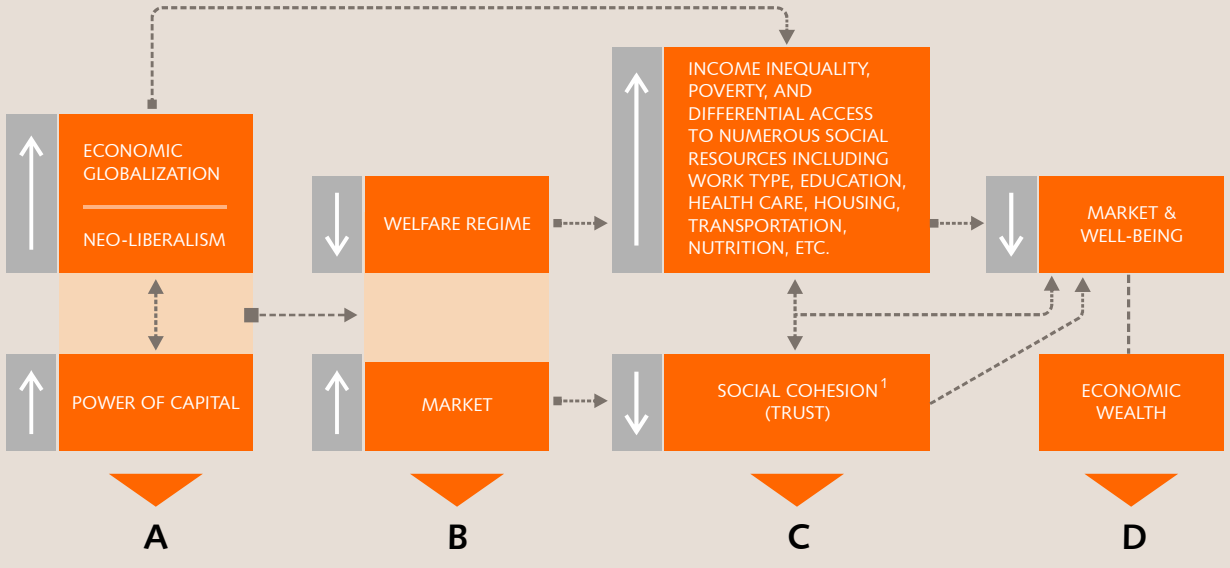
[6]Purchasing power parity (PPP): At the PPP rate, one dollar has the same purchasing power over domestic GDP that the US dollar has over US GDP. PPP rates of exchange allow this conversion to take account of price differences between countries. In that way GNI per capita (PPP US$) better reflects people's living standards. In theory, 1 PPP dollar (or international dollar) has the same purchasing power in the domestic economy of a country as US$1 has in the US economy. Source: HDR website http://hdr.undp.org/en/statistics/hdi/ and glossary http://hdr.undp.org/en/humandev/glossary/#p

TABLE 2: PERCENTAGE DECREASE IN PURCHASING POWER OF HOUSEHOLDS (DUE TO INCREASE IN CEREAL PRICES) ACROSS INCOME QUINTILES 2006 - 2008

QUINTILES	BOTTOM 20%	TOP 20%
BANGLADESH	-19.9	-4.1
CAMBODIA	-23.8	-4.8
CHINA	-28.8	-6.4
INDIA	-14.3	-2.6
INDONESIA	-26.7	-5.0
MONGOLIA	-51.9	-5.4
NEPAL	-13.5	-3.6
PAKISTAN	-17.1	-4.1
PHILIPPINES	-26.2	-3.7
SINGAPORE	-20.0	-1.0
SRI LANKA	-24.4	-2.6
UNWEIGHTED AVERAGE	-24.2	-3.9

SOURCE: Chhibber A. et al. (2009)

FIGURE 3: NEO-LIBERALISM AND HEALTH



[1] Social Cohesion is included separately to provide comparison with Figure 1.

SOURCE: Coburn, 2004

Periods of economic crises cause major setbacks in health: it is estimated that a 1% contraction in per-capita GDP could result in an increase in infant mortality rate of between 0.18 and 0.44 per 1,000 births. Between 1980 and 2004, a million more infants died because of economic setbacks suffered by countries (Chhibber et al, 2009). Increases in food prices decrease the purchasing power of the population with the poorest groups bearing a disproportionate share of the burden. During 2006-2008, increasing food prices decreased the purchasing power of poorest households in the Asia-Pacific region by 24% while the comparable figure for the richest households was only 5% (Chhibber et al, 2009). Lower purchasing power would compromise a household's ability to invest on essential resources for remaining healthy, e.g., preventive healthcare and nutritious food such as milk and fruits.

Structural Adjustment Policies (SAP) ensuing from the Washington Consensus contributed to commercialisation of healthcare in a number of low and middle income countries (LMICs). "Health Sector Reform" policies advocated by the World Bank and other international players argued for a limited role for the state in the provision of healthcare and for an increased role for the private sector in the provision and financing of healthcare. Cuts in public expenditure in health and the introduction of cost-sharing measures and private insurance were all part of the Health Sector Reform package. Governments were to provide only those healthcare services that had a 'public good' characteristic[7] and services which may not have enough takers if they came with a price tag, e.g., health education or immunisation. Thus, primary care was to be provided by the government, while secondary and tertiary care was to be provided by the private sector, with market forces regulating the supply-and-demand of these services.
Hsiao (1994) has provided a comprehensive critique of the 'marketisation' of healthcare, i.e., the use of market forces to finance and provide health services as the most 'efficient' use of resources. The 'market' or 'free and competitive' market works on the premise that both buyers and sellers are on the same level ground and are equal. Each party pursues its self-interest and this creates competition. Sellers try to operate efficiently in order to minimise their costs and maximise their profits while buyers try to maximise their utility and minimise their prices.

The market for healthcare services, unfortunately, does not have any of these features. Patients do not possess the technical knowledge or the information necessary to make decisions and have to depend on providers for guidance. Patients are not in a position to shop around for the best option, especially in a health emergency, and also if they have only one or two providers to choose from. The market system gives the more powerful stakeholders, providers in this case, the freedom to use this power to maximise their profits through inducing demand for healthcare services (rational or irrational, as long as it is not unsafe), fixing higher prices for services, and selecting patients who pose the least risk (Hsiao, 1994).

[7]A 'public good' has two essential features, non-excludability and non-rival consumption. Non-excludability: The benefits derived from the provision of pure public goods cannot be confined to only those who have actually paid for it. Non-rival consumption: Consumption of a public good by one person does not reduce the availability of a good to everyone else; therefore, we all consume the same amount of public goods even though our tastes and preferences for these goods (and therefore our valuation of the benefit we derive from them) might differ. Examples of public goods include flood control, health education, broadcasting services, public water supplies, street lighting, lighthouse protection for ships, and others.

Marketisation of healthcare thus escalates cost of healthcare services within a country. As healthcare service costs escalate, the proportion that incurs catastrophic health expenditure and pushed into poverty as a consequence also increases. Worse still, those who cannot pay for healthcare services at the point of service delivery have to delay seeking healthcare and may reach a health facility when it is too late to save them.

At the same time, marketisation would also contribute to the deterioration of the public sector in health through multiple pathways. One would be through the internal brain drain of health providers from the public to the private sector, leaving many health facilities with vacant positions and underqualified staff. Secondly, investments would decline as the state is no longer obliged to provide anything but the most basic services. Those without the ability to pay for private health services have only two options: to seek public sector healthcare services of inadequate quality or not seek healthcare services at all. This clearly is not the path to universal access to healthcare.

Within this context, private for-profit insurance, also one ingredient of marketisation of healthcare services, adds further complexities. Only the better-off are able to afford private for-profit insurance.

Also, a two-tier system of healthcare services is created in which those who are insured are assured of healthcare services, while the others do not count. The experience of the USA, a country with the highest coverage by private health insurance, shows that the domination of private insurance in the healthcare services market results in phenomenal cost escalation even while leaving out a substantial proportion of the population from access to healthcare services. It also suggests the possibility that over time, the private insurance lobby gets entrenched as a powerful interest group opposed to any policy attempts towards universal healthcare services. The World Health Report 2010 asserts that "it is impossible to achieve universal coverage through insurance schemes when enrolment is voluntary" (as in the case of private for-profit insurance). This is because compulsory prepayment by those who can afford to contribute is needed to cross-subsidise funding for healthcare for those who cannot afford to pay. Where most of the well-to-do buy private for-profit health insurance, the government has no access to this stable pool of money, which may be needed in addition to revenue from taxes, to cross-subsidise health services (Oxfam, 2013).

Besides these changes that are a consequence of policy decisions and actions within a country, neoliberal globalisation has also set in motion a number of global forces that impact on healthcare services within countries.

The first major force is the emergence of Global Health Initiatives (GHIs) in the late 1990s and early 2000s. These partnerships involve several entities: multilateral and bilateral agencies, international NGOs, and for-profit organisations that are usually manufacturers of pharmaceutical goods and medical equipment and supplies. As of 2002, 16 GHIs existed which involved the WHO alongside private for-profit players in significant ways (Buse & Walt, 2002). By 2009, more than 100 GHIs existed, addressing 27 health concerns. Four GHIs are identified as being by far the most influential in global health. These are the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund); the Global Alliance for Vaccines and Immunisation (GAVI); the US President's Emergency Plan for AIDS Relief (PEPFAR); and the World Bank Multi-Country AIDS Programme (MAP) (WHO, 2009).

At the end of the first decade of the millennium, the large GHIs had emerged as leaders in development assistance for health, and had become agenda setters for global health policy, while the WHO and the World Bank became relatively minor (WHO, 2009).

GHIs have moved the clock back to vertical interventions, which pay scant attention to social determinants of health or seek to redress inequities in health. Further, the influx of disease-specific funding into the national health system often distorts health service delivery and pushes the health workforce away from other equally, if not more important, health concerns. For example, whereas access to HIV services increased from 5% to 31% over 4 years (2003-2007), the proportion of births attended by skilled birth attendants showed a very small increase: from 61% to 65% in the 16 years between 1990 and 2006 (Balakrishnan, 2005; Uraguchi, 2010; World Bank, 2013). The presence of highly paid positions in non-state sector projects funded by GHIs has contributed to an already high-level of attrition of the health workforce through international migration (WHO, 2009).

The second force is constituted of WTO treaties and agreements that have a direct bearing on healthcare services. For example, the TRIPS agreement of 2004 was based on the premise that protecting intellectual property rights was essential for promoting innovation in the pharmaceutical and medical products sector. Companies that innovated on a drug or product would patent these and enjoy exclusive rights to market them for the next 20 years and would therefore have the monopoly power to set market prices for that product.

At the time when the agreement was negotiated, LMICs were assured that this will not be at the cost of the health of their populations.

The "compulsory licensing" provision of TRIPS permitted governments to enact domestic laws to manufacture the generic drug even for those drugs that were under patent protection under certain conditions: if the cost of the patented drug was too high; if it was unavailable; or if the drug was not being manufactured by the patent owner. However, the vast majority of LMICs is not able to use this compulsory licensing provision because they do not have in-country manufacturing capacity; and/or have weak institutions that cannot enact and/or implement domestic laws. Another powerful deterrent is political pressure from the high income countries (HICs) that are home to major pharmaceutical companies. For example, when Thailand announced compulsory licensing of the AIDS drug Kaletra in 2007, Abbott laboratories, the manufacturers of Kaletra, announced that it would withhold seven new drugs from sale in Thailand, among which were a new AIDS drug and drugs for arthritis and high blood pressure (Aids activists call for global boycott, 2014). TRIPS has had the effect of driving up drug prices for most drugs, thus escalating costs of healthcare services for individuals and countries. The only exceptions are HIV and AIDS drugs, which have been made available through compulsory licensing in several countries (People's Health Movement et al, 2011).

The GATS of 1995, also a WTO treaty, has opened borders up to trade in health services. According to this Agreement, governments that agree to abide by the GATS for the health sector will be bound to eliminate any restriction to trade in health services by private players. GATS permit delivery of healthcare services across international borders, such as telemedicine or medical transcription services. They support the free movement of patients across borders for receiving health care services, foreign direct investment (FDI) in healthcare services, and

the movement of healthcare providers across borders (Juego & Smith, 2009).

The provision of healthcare services across borders could result in fragmentation of care, especially when telemedicine for diagnostics and consultation are involved. Fragmentation of services has a negative impact on follow-up care, client-provider relationship and accountability of healthcare services, besides posing a considerable challenge for coordination of care across multiple entities. The movement of patients across borders to seek healthcare has caused some governments to aggressively market their countries as regional hubs of medical tourism. Investments in infrastructure and services are made to attract medical tourists. If at the cost of investing on universal access to healthcare services for the country's people, this policy trajectory would be unfortunate. In India, FDI in hospitals has been allowed since 2000. Between 2000 and 2006, 21 hospitals and 69 diagnostic centres have been approved. FDI in healthcare tends to accelerate marketisation of healthcare, and may be detrimental to universal access to healthcare (Juego & Smith, 2009).

Marketisation of healthcare would impact more negatively on women as compared to men. On average, women are reported to incur higher out-of-pocket expenditure than men, probably because of the greater need for healthcare related to reproduction and because of a greater burden of chronic diseases. Using delivery and abortion services and services for reproductive tract infections can cost close to a household's average monthly income and could be several times more than the monthly household income of households living below the poverty line. Vulnerable groups without access to financial resources, e.g., adolescents, the elderly, and women not engaged in the formal economy have greater sensitivity to price changes. When charges for services and /or drugs are introduced or increased, those with limited ability to pay are discouraged from using health services, both preventive and curative (WHO, 2010b).

The introduction and promotion of private health insurance as a health financing mechanism put women at a disadvantage. Since many women are not employed in the formal sector of the economy, their ability to pay regular premiums may be limited. A 2008 report from the United States based on the analysis of 3500 individual insurance plans found that many insurance plans practised "gender ratings" and charged women higher premiums than men of the same age. Insurance companies could reject applications for reasons specific to women, for example, women survivors of domestic violence and women with a previous caesarean section (Codispotim et al, 2008). Another limitation is that routine reproductive health services such as contraception, abortion, and child delivery are considered 'non-insurable' as stand-alone benefits because these are high-probability and non-random events. Individual private insurance plans in the United States do not usually cover maternity services, and those who wish to be covered have to pay an additional premium and yet have coverage only for a limited number of maternity-related services. Many plans cover only some of the reversible contraceptive methods for women, and so on (Codispotim et al, 2008).

A 2005 synthesis of available evidence from Asia, Africa, and Latin America on how neoliberal "health sector reform" policies had affected reproductive health services found that health sector reform ran counter to and undermined the International Conference on Population and Development (ICPD) goal of achieving universal access to reproductive

health by 2015. Various reform elements had exacerbated inequalities in health. Unregulated public-private interactions had skewed services to urban areas, and were generally only accessible to those who could pay. Publicly funded and/or provided services included few elements of the comprehensive SRH package outlined in the ICPD Programme of Action, mainly maternal health and family planning (Ravindran & de Pinho, 2005).

More recent articles have observed that globally GHIs have shifted the focus away from comprehensive SRH services towards infectious diseases with a particular emphasis on treatment rather than prevention, increasing demand and stimulating new markets for drugs, and bypassing existing public health services to provide such services through vertical programmes,[8] all of which have negative equity effects. They have contributed to the fragmentation of ICPD's comprehensive SRH agenda into narrow silos of "maternal health," "HIV/AIDS," and "other sexual and reproductive health" needs which receive more lip service and less investment or political commitment (WHO, 2009).

The large distance between the goal post of universal access to SRH services and the ground reality in the Asia-Pacific region is evident from a recent report on universal access to SRH services in the region. Of 21 countries studied, more than a fifth of all women in the reproductive age group had unmet need for contraception in a vast majority of countries studied. There were several countries where more than 50% of women delivered with no skilled help. Access to safe abortion services was poor, and unsafe abortions accounted for 10-16% of all maternal deaths. Barring a few exceptions, coverage by antiretroviral (ARV) therapy was below 50% of all people living with HIV, while coverage by ARV of pregnant women living with HIV was lower than 25% in the vast majority of countries studied. Adolescents had little access to sexuality education and fewer than 5% of adolescents got tested for HIV (Ravindran, 2012).

Twenty years after the ICPD, we seem to be not only far away from the goal post but appear to have lost our way somewhere along the line. Moving along the same path may not take us to our destination. It is time to step back and re-chart our future trajectory.

TOWARD A BRAVE NEW WORLD OF PROSPERITY, EQUITY, HARMONY, AND WELL-BEING

It is time to forge a new agenda for action towards achieving universal access to SRH services, one that strikes at the root causes of poverty, inequity, hunger, and disease. Movements for SRHR, poverty eradication, food sovereignty, and human rights need to forge alliances to stop the forces of neoliberal globalisation from devastating the world.
We do not have to look far for solutions. Clear guidelines have been outlined by many scholars and activists on the path we need to traverse. In this section, we draw extensively on such sources to present a roadmap of how to get from here to there—a sustainable economy where access to resources necessary for a healthy life would be a human right enjoyed by all.

[8]Vertical programmes are generally disease specific and promote targeted clinical interventions delivered by a specialised service with its own management structure. The 'pulse polio' intervention is a vertical programme, and so are family planning programmes in many countries that are not part of a comprehensive sexual and reproductive health programme.

We start with changes needed in global economic policies and in food systems, and then present an agenda for change within the health sector to make universal access to healthcare a reality.

Changes in national and global economies

The fundamental premise on which changes in the national and global economy would be based is that economic growth does not amount to development unless the proceeds of such growth are invested in poverty reduction and ultimately, eradication of absolute poverty. As enunciated in a UNDP report, this would mean directing resources "to the sectors in which the poor work (agriculture), areas in which they live (relatively backward regions), factors of production which they possess (unskilled labour) and outputs which they consume (food)" (Chhibber et al, 2009).

Public investment directed towards the poor, and not high growth rates, are a necessary condition for poverty reduction

The UNDP report (Chhibber et al, 2009) asserts that governments are able to take measures to reduce poverty even when their economies have a relatively low growth rate. For example, Indonesia experienced growth with equity and poverty reduction during the 1970s and 1980s through substantial public investments in the rural sector and in creating mechanisms that would improve farm prices (Chhibber et al, 2009). In Sri Lanka and Malaysia in the 1980s, annual poverty reductions of between 4-7% were achieved at a time when average annual growth in per capita incomes was only about 3%, by investing heavily on sectors that would benefit the poor (Chhibber et al, 2009). Public investment is thus a powerful tool for reallocation of public resources towards poverty reduction.

Conversely, cutting public investment to restrain fiscal deficit hurts poverty reduction and improvement in living standards of the population.

The concern with fiscal deficit is motivated by the neoliberal diktat to contain inflation at 3-5%. This is not based on any empirical evidence that higher than 5% or even 10% inflation can hurt economic growth. Several countries have experienced high growth rates alongside high rates of inflation. For example, China grew at almost 9% during 1990-2001 when its average rate of inflation was 8% and Indonesia's real GDP grew at the rate of 7.7% during the 1970s when its inflation rate was as high as 17%. This is not to say that inflationary pressures that have a destabilising effect on the economy need not be contained. The take-home lesson is that undue concern about inflation should not deter countries from making necessary public investments on poverty reduction and augmenting productive capacity (McKinley, 2004).

How would one generate the revenue needed for public investment? Income and wealth taxes, urban land taxes, and trade-related taxes are sources that need to be tapped better and could raise a significant amount of funds for public investment. In HICs, the ratio of income to consumption taxes is more than double, whereas the converse is true for LMICs (Ravindran & de Pinho, 2005). It does not seem to be true then that unless income and wealth taxes are maintained at low levels there will be no motivation for increasing incomes.

Cancel external debts of low and middle income countries

Even if enough public revenue is raised by an economy, its ability to invest this for the welfare of its people may be seriously compromised by the burden of debt servicing. According to a 2005 estimate, debt servicing liabilities far exceeded overseas development aid received by many LMICs. According to another, the developing world spent $13 on debt repayment for every $1 it received in grants. For the poorest countries (approximately 60), US$550 billion has been paid in both principal and interest over the last three decades, on US$540 billion of loans, and yet there is still a US$523 billion dollar debt burden (Shah, 2007).

There could never be a level playing field for economic interaction between countries unless the many promises of debt write-offs are honoured.

Legitimise and enable government regulations over international flow of finance and international trade

There is more than sufficient evidence on the detrimental consequences of financial liberalisation for a country's well-being. This has destabilised economies, made prices volatile, and impoverished millions. There is no reason why countries should not insist on regulating the movement of finance capital to minimise its negative effects and maximise benefits for the country. Vietnam and China have introduced controls to protect themselves against the volatility of external capital flows (McKinley, 2004).

Countries also need to adopt a trade strategy that benefits the creation of stable employment for the poorest and for women, and not adopt policies to attract FDI at the cost of disempowering its labour and maintaining low wage rates. "Footloose" capital (unregulated and free to move from country-to-country) should not be allowed to enter and exit as it pleases. What this implies is a more equal relationship between countries engaging in trade. HICs are not to be permitted to export their subsidised food to LMICs unless they open their doors for imports from LMICs.

Changes in systems of food production and agricultural polices

Since many of the drivers of food insecurity are related to neoliberal economic policies, countering these would promote food security and sovereignty. For example, public investments in agricultural research and infrastructure, subsidies for inputs and credit and price support measures to help small farmers, agrarian reform and agricultural policies that promote agro-ecological farming would vastly improve food security.

La Via Campesina is an international movement of peasants opposed to neoliberal globalisation's impact on the world's food system. In 1996, during the World Food Summit, La Via Campesina presented seven principles towards global food sovereignty (La Via Campesina, 2013). These seven principles are still relevant and important to include as part of the global agenda for change.

The resulting food production system based on these principles of food sovereignty would be sustainable, democratic and equitable[9]. It will put an end to hunger and malnutrition.

[9]La Via Campesina's principles rule out the second-green revolution trajectory to food security.

PRINCIPLES OF FOOD SOVEREIGNTY

The first principle is that food is a basic human right and that governments are obliged to provide constitutional guarantee for the right to food. This would require governments to prioritise investment in the agricultural sector to enhance food production.

The second principle calls for giving ownership and control of land that they work on, to landless and farming people and especially women. Owner farmers with security of ownership would have a greater motivation to invest resources in farming.

The third principle is sustainable management of natural resources in the process of food production, and conservation of biodiversity without being constrained by intellectual property rights. This means upholding communities' right to seeds, productive resources, a safe environment, and of access to the commons.

The fourth principle is for the reorganisation of food trade to ensure availability of affordable food for domestic consumption. It discourages food imports that could hurt local small farmers.

The fifth principle calls for opposition of control by multinational corporations over agricultural policies of national governments. Multilateral agencies such as the WTO, the World Bank and the IMF, which facilitate and privilege Multinational Corporations' control over agricultural production needs to be challenged by the global community.

The sixth principle is that food must not be used as a weapon to control people.

The right of small farmers to have a say in policies that affect them and a central role for women farmers in this constitutes the seventh principle.

Health sector changes for universal access

Economic policies that favour substantial increases in public investment on ending poverty and improving the conditions of the poor would by definition encourage public investment in health. To move from increased public investment in health towards universal access would require firm action by governments to regulate the private sector in health to be in consonance with national health goals. Governments need to intervene in the 'market' for healthcare services to offset the very unequal position of patient/consumer vis-à-vis the health provider through, for example, quality control measures to prevent provider-induced demand for unnecessary or irrational healthcare services.

Entry of international private players into the provision of healthcare services also needs to be regulated, with permission given to operate only if they will expand availability of services and access to affordable and good quality care. In this context, it is time to re-examine using the above criteria, the role played by GHIs and of the role of multilateral and bilateral donors and international NGOs in the promotion of the private sector in health in many LMICs.

Suitable prepayment mechanisms are needed to ensure that ability to pay does not deter access at the time of illness. The general consensus in this regard is that tax-based public financing of healthcare services would be a more likely to contribute to universal access than other mechanisms of financing health services. This is especially so if there is a progressive system of taxation of income and wealth and if these are the main contributors to tax revenue. Such a redistributive and inclusive mechanism would provide cross-subsidies for the poor from contributions of the better-off in society.

An important component of an action agenda for universal access would be to block individual for-profit voluntary private insurance. In societies with high income inequalities private insurance creates a two-tier system of care, with the rich using private healthcare services paid for through private insurance while the economically most vulnerable use "free at the point of service delivery" public healthcare services. This has the potential to erode the public health system through drain of human and other resources from the public to the private sector. Under private health insurance where providers are paid on a fee-for-service basis, the healthcare system tends to evolve towards high technology/high administrative costs/high exclusion path. This creates pressure on the public sector to also adopt high-tech care, skewing public investment towards tertiary and secondary care.

Universal access to healthcare services would not be possible unless drug and medical product costs are contained and the proceeds of scientific research become a global public good to benefit humankind. There is a need to challenge patent protection for monopolistic control and maximising profits and to challenge TRIPS in order to protect people's rather than corporations' interests.

Universal access to SRH needs to be seen within the context and larger goal of universal access to healthcare services. Approaches that focus only on one specific area, such as reproductive health or HIV and AIDS, may result in inefficient investment of resources in weak health systems (and may even result in their further weakening), and not achieve the desired goal.

Within the tax-funded healthcare system aimed at universal rather than targeted coverage, a comprehensive range of SRH services (see WHO, 2007) need to be made a part of the "essential services" package. If the range of SRH services provided is narrow, then there will not be adequate financial protection from catastrophic health expenditure. Important areas for immediate action include substantial investment in increasing availability of services overall and prioritising closing the gap across rural/urban locations and geographic regions of the country.

Consultation with communities about appropriate and acceptable healthcare services is essential to greater usage. In many instances negotiation and cooperation between state health service providers and community-based organisations can resolve the cultural and social barriers to access. For example, negotiation about acceptable methods of contraception can increase contraceptive use.

Universal access to SRH services cannot be achieved unless two formidable barriers are confronted and removed. These are:

- **Legislative restrictions on safe abortion services and policies that restrict the access of adolescents and young people to several SRH services** (such as sexuality education, contraceptive services, and safe abortion

services). Even where policies are in favour of safe abortion services and services for adolescent SRH, social norms prevent many women and girls from using these and health providers may themselves act as gatekeepers to prevent access to services.

- **Health system blindness to gender-power inequalities in society.** Women's limited decision-making power including on matters relating to their own health is an important determinant of contraceptive use and practice of safe sex. Restrictions on women's mobility, women's hesitation and lack of experience in travelling unescorted, and social norms against being examined by male providers are all factors discouraging use of SRH services in the limited number of instances where they are available and affordable.

CONCLUSION

Neoliberal globalisation and economic policies influenced by it underlie poverty, hunger and ill-health, and lack of healthcare access, including poor access to SRH services. To be an advocate for universal access to SRH services is to become an activist against neoliberal economic policies.

A combined movement against neoliberal globalisation would call for fundamental changes in the rules of the game in the global economy, especially the rules set by the WTO, IMF, the World Bank, and by global corporations. The time has come to publicly defy these forces and to advocate for the alternative path to development that would guarantee a life of dignity, equality, and well-being.

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ANNEX 1

Reproductive Health
Reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice, and to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of a healthy infant (WHO).

Reproductive Rights
Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (ICPD).

Sexual Health
Sexual health implies a positive approach to human sexuality and the purpose of sexual healthcare is the enhancement of life and personal relations as well as counselling and care related to reproduction and sexually transmitted diseases (adapted, UN).

Sexual Rights
Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; seek, receive, and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decision to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life (WHO working definition).

Source: Asian-Pacific Resource and Research Centre for Women (ARROW). (2009). Reclaiming and redefining rights. ICPD +15: Status of sexual and reproductive health and rights in Asia. Kuala Lumpur: ARROW.

ARROW is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building, and organisational development.

ARROW envisions an equal, just, and equitable world, where every woman enjoys her full sexual and reproductive rights. ARROW promotes and defends women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights.

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Asian-Pacific Resource & Research Centre for Women (ARROW)

1 & 2 Jalan Scott, Brickfields
50470 Kuala Lumpur, Malaysia

tel (603) 2273 9913/9914/9915
fax (603) 2273 9916
email arrow@arrow.org.my
web www.arrow.org.my
facebook The Asian-Pacific Resource & Research Centre for Women (ARROW)
twitter @ARROW_Women

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