RECLAIMING

REDEFINING RIGHTS

Thematic Studies Series 5: Poverty, Food Security, Sexual and Reproductive Health and Rights - Integrating and Reinforcing State Responsibilities, Integrating Societal Action

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CONTENTS

LIST OF BOXES

LIST OF TABLES

LIST OF FIGURES

GLOSSARY

ADB	Asian Development Bank
ARROW	Asian-Pacific Resource and Research Centre for Women
ART	Anti- Retro Viral Therapy
BPL	Below Poverty Line
BNPS	Bangladesh Nari Progati Sangha
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSO	Civil Society Organisation
CSW	Commission on the Status of Women
ESCAP	Economic and Social Commission for Asia and the Pacific
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
ICDS	Integrated Child Development Scheme
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
MDGs	Millennium Development Goals
NCDs	Non- communicable Diseases
NCMS	New Cooperative Medical Scheme
NGO	Non-Governmental Organisation
NREGA	Mahatma Gandhi National Rural Employment Guarantee Act
PDS	Public Distribution System
RUWSEC	Rural Women's Social Education Centre
SAAPE	South Asia Alliance for Poverty Eradication
SDG	Sustainable Development Goals
SDO	Sanayee Development Organization
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Diseases
TG	Transgender
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHF	Women's Health Foundation

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PART 1

POVERTY, FOOD SECURITY, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: INTEGRATING AND REINFORCING STATE RESPONSIBILITIES, INTEGRATING SOCIETAL ACTION

BY SHOBHA RAGHURAM

ABSTRACT

We explore the linkages of poverty, food security, and sexual and reproductive health and rights. We underscore the need to take a synoptic view regarding the vulnerability of women's lives in the Asia-Pacific region when assailed by poverty while simultaneously accounting these factors in SRHR.

We suggest ARROW action pathways borne from the world views of people affected at the grassroots where SRHR workers take into account the broader ramifications of poverty and develop strong linkages with broader development social movements.

We underscore the need for a world view which integrates all these aspects of human needs and political governance resulting in integrated national plans for equitable development.

We make recommendations for a way forward which will bring into focus a holistic understanding and therefore, foster social movements dealing with poverty eradication, food security, and SRHR to work with affected populations and governments in a synergistic fashion.

1. INTRODUCTION: THE MULTI-DIMENSIONALITY OF THE SOCIAL CRISIS

"Overcoming poverty is not a task of charity; it is an act of justice. Like Slavery and Apartheid, poverty is not natural. It is man-made and it can be overcome and eradicated by the actions of human beings. Sometimes it falls on a generation to be great. You can be that great generation. Let your greatness blossom."
- Nelson Mandela

"Poverty is the worst form of violence."
- Mahatma Gandhi

We locate the overall discussion of sexual and reproductive health and rights (SRHR) within the broader climate of poverty where people living the conditions of poverty are denied access to most social security support including health services, adequate food, and consequently, SRHR in particular.

"Reproductive rights are at once simple and revolutionary. Stated simply, reproductive rights provide women with the freedom to control their bodies and obtain needed health services. Yet respect for these rights has profound consequences. All women could maximize their chances of enjoying good health, accessing quality reproductive health-care, entering only into consensual sexual relationships and deciding the number and spacing of their children. The promotion of women's reproductive rights is thus a key step towards the creation of just societies that respect women's humanity and equality."[1]

We also suggest that the linkages between women's right to sustainable food securities and their right to universal health coverage are both rights that are part of the larger right to live a poverty-free existence. The Right to Liberty and Security, and the Right to Health straddle all citizenship rights which are enshrined in a nation's constitution. The condition of poverty is a loss of income, a scarcity of material needs, and a life denied essential rights. It is a condition that increases the vulnerability of the afflicted and their freedom to exercise citizenship rights. The question of patriarchy and power further exacerbate women's access and enjoyment of SRHR services, their sense of well-beingness, which must include SRHR. Given the nature of the unfair disadvantages that traditionally inherited societal hierarchies inflict on women's rights, we conclude that unless and until the grammar of development refuses, entirely, economic, political, gender, caste-based inequalities, the issues of SRHR will not become part of an enhanced citizenship, which is a fundamental condition of existence.

1.2 Universal ethical standards

Universal health care and coverage in the Asia Pacific region[2] must consider SRHR as a core component of its services just as SRHR must reorient its services and enforce its inclusion in all health care plans bearing in mind the nature of communities already facing the burdens of poverty and food insecurity especially in the Asia Pacific region. The fact that universal health coverage is yet to be operationalised in the region makes this issue the largest key factor for leaving out large sections of the populations from a condition of dignified well-beingness.[3]

This region imposes multiple burdens of poverty and attendant vulnerabilities on massive numbers of people –the scale of problems is intimidating and we suggest that unless the locals are addressed by way of seriously empowering changes in women's lives the national governments will not be forced to make sweeping policy changes that are required in combating large scale deprivations. If SRHR is not considered a set of rights and entitlements in the regime of other economic and political rights there will be no focus in national plans on these issues and consequently required budgets will also not be a reality. ESCAP reports that "[m]aternal mortality in Asia and the Pacific has been halved in the past two decades....

Regionally, 177,300 fewer mothers died in childbirth in 2008 than in 1990; however, there were still 136,995 maternal deaths in the region in 2008, nearly 40% of the world total. **The difference in the maternal mortality ratios between low-income and high-income countries was extreme: 517 maternal deaths per 100,000 live births in low-income countries, as compared to 10 in high-income countries**. Maternal mortality is closely linked with antenatal care – approximately 15 million women did not have a single visit for pregnancy-related care in 2008. Region-wide, there were 23 million births not attended by skilled health personnel in 2009; South and South-West Asia accounted for 20 million of them" (emphasis is mine).[4]

The international regime must respect and support national agendas for poverty eradication, state-led responsibilities for women's equality in education, health, and employment. All human development needs cannot be subsumed under the international and (growing) national cultures of profit maximisation-led trade growth. The politicised victories of world views that perpetuate poverty, class-dominated societies, gender blindness, patriarchal and caste-driven social relationships need to be countered by a unified perception that poverty is a condition that is illegal, immoral and unethical, and that there can be no justification for perpetuating a condition that intergenerationally condemns millions of future citizens. At the core of SRHR is this centrality of generational justice and respect for the lives and material needs of citizens as they build their social relationships at the most intimate, private realities, and at the most political and public levels.

1.3 Enhanced citizenship

Enhanced citizenship calls for positive conditions to be given and to be created in the external environment so that women and men live in a sense of well-beingness. Deepening poverty when combined with patriarchy pushes women's needs for SRHR services to the last instance of appeal for succour. The field accounts of the growing loss of self-esteem for people living on the fringes of the development story[5] that demonstrates the contradictions of social divides and emphasises the need for united political action at all levels, without forgetting the need for forging economic and political equality when doing SRHR work. The whole must not be forgotten at each instance of work in maternal health, food security, and education provisioning because each human being endures all the failures of this civilisation at every turn of public policy.

1.4 Poverty-a reality that keeps deepening

The condition of poverty has been one of the most introspected social realities in the grammar of development, growth, and progress. As we move into the 21st Century, we find that with spectacular wealth there has also been the increase in inequalities that deny the person living the burdens of poverty even the slightest semblance of dignity.
The prognoses for poverty levels in the Asia Pacific Region are alarming and dismal:

- 1.8 billion people below poverty line live on less than $2 a day.
- 903 million people struggling live on less than $1.25 a day.
- 2/3 (two thirds) of the world's poor live in the region.
- Between 1990 and 2009, Asia and the Pacific reduced the proportion of people living on less than $1.25 per day from 50% to 22% – or from 1.57 billion to 871 million people.

One may well ask the reasons for this given how Asia scores higher over so many other regions, especially on the highly visible performance of China and India in attaining high growth during the economic downturn of the last two years. It seems almost irreconcilable that India, for example, could post such growth figures and yet remain with some of the most dismal data on poverty, maternal

mortality, internal migration, declining sex ratio for girl children, rural poor agrarian distress, and a failing public health system which adds to the growing indebtedness of rural families. Is there any single answer as to why there are 1.8 billion people below poverty line living on less than $2 a day in 2012? Is there any single answer as to why India has been unable to feed the majority of its citizens[6] and that despite all government official discourse almost 70% of a billion population remain in dire poverty?

It is well-known that poverty is multi-dimensional as a condition but what is less known is the nature of the multiple burdens it imposes on the affected in access to public goods, in enjoyment of various services, and the manner in which it reinforces all negations, thus repeatedly lowering the dignity of the affected in public life.

The lack of political will for this class of problems is a global phenomenon and it is perpetuated by elites everywhere who stand to gain by keeping the world as divided as it is. SRHR is a sector of silent neglect where apart from maternity services and family planning there is little public focus on the various aspects of SRHR. It will be useful for the State and private development actors to keep in mind all aspects of SRHR as provided in the definitions below.

Box 1: Key Definitions[7]

"Reproductive Health: Reproductive Health implies that people are able to have a responsible, satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and to appropriate health care services that will enable women to go safely through pregnancy and childbirth, and provide couples with the best chance of having a healthy infant.[8]

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.[9]

Sexual Health: Sexual health implies a positive approach to human sexuality and the purpose of sexual health care should be the enhancement of life and personal relations, as well as counselling and care related to reproduction and sexually transmitted diseases. 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 to be free of coercion, discrimination and violence, to obtain the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services; seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decide 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."[10]

Source: Asian-Pacific Resource and Research Centre for Women (ARROW). (2012). Maternal Mortality and Morbidity in Asia (P.17). Kuala Lumpur, Malaysia: ARROW.

1.5. Women's status and condition

Women bear the largest set of debilitating conditions, given the nature of patriarchy, lack of access to health and education, and the denial of fair employment. Women in the informal sector do not enjoy equity status in labour rights in terms of wages, health care, and child support. Equity is defined as equal health, meaning:
1. Equal access to care;
2. Equal utilisation of health care; and
3. Equal access to health care according to need.

Hunger, child mortality, and maternal mortality remain high in the Asia-Pacific region, making it difficult for the countries in the region to achieve the Millennium Development Goals (MDGs) by 2015. Over three million children in the region died before their fifth birthday in 2010 alone.[11]

"The under-five mortality rate decreased from 86 deaths per 1,000 live births in 1990 to 49 in 2009. The infant mortality rate decreased from 63 deaths per 1,000 live births in 1900 to 38 in 2009. Still, too many children and infants in the region perish each year. Afghanistan has the highest under-five mortality rate of 199, followed by Cambodia (88), Pakistan (87), and Bhutan (79)."[12]

The burdens of poverty include high risks for the poor in both communicable and non-communicable diseases. "In Asia and the Pacific, an estimated 6.1 million people were living with HIV and almost 300,000 people died from AIDS-related causes in 2009.... New HIV infections are declining in the Asia-Pacific; 360,000 people were infected with HIV in 2009, a 20% decline in new infections in comparison with the 450,000 new infections in 2001. China, India, Indonesia, Malaysia, Myanmar, the Russian Federation, Thailand, and Viet Nam had more than 100,000 people living with HIV in 2009 – India alone had 2.4 million. Injecting drug users have a higher HIV prevalence than any other at-risk population has, while the reported rates of condom use for injecting drug users are still low – 75% of countries with available data showed condom use rates below 50%."[13]

Low public health spending in the wake of severe privatisation of health care in most countries in the developing south and the dismantling of primary health care services (except in the case of China),[14] is one of the reasons for unimpressive health indicators in India and other countries in the region where people living in poverty are more likely to succumb to morbidity conditions.

Non-communicable diseases are a major cause of lost life in Asian and Pacific countries. "For more than half of Asia-Pacific countries with available data in 2008, non-communicable diseases account for more than 50% of the years of life lost."[15] Other health hazards such as malaria affects millions of people in the Asia-Pacific region each year. In Asia and the Pacific, there were 5 million cases of malaria reported in 2009, and 4,000 malaria-related deaths. Papua New Guinea had the highest malaria incidence in 2009, with 20,137 cases per 100,000 population, followed by Solomon Islands (16,071), Timor-Leste (9,566), and Vanuatu (6,178).[16]

In all health burdens, women and girl children bear the brunt of being the most vulnerable and at high risk. Why do the scales of progress provide so little weightage in real terms to women's participation, enjoyment and fulfilment of all rights? Why do women bear the largest burdens of care-giving in the household and yet remain without attention when it comes to their own much needed care for their health rights, education, and their access to food, clothing, and shelter?

How do we explain why women remain left behind on indicators pertaining to human development despite the fact that they are at the forefront as contributors to a nation's sense of well-beingness which includes the overall health and education indicators, income, capability, quality of citizenship, food availability, and social securities ranging from employment rights, housing, sanitation, and all of the quality of life indicators?

What are the policy implications of the present context of unmet needs and the confluence of variables that have prevented the poor from living in a state of well-beingness? We underscore the need for reforms in the state services, the need to define the political ramifications of poverty and powerlessness, and the issue of strong and continued public action for securing the right to health.

The application of a trickledown theory to the social progress of women and their full enjoyment of all rights has not served any purpose in dramatically shifting the scales of growing inequalities for women within a broader arena of the growing poor. On the contrary, the reductionist politics causing the displacement of women's health needs has increased. We suggest that women's access to political power is critical among other strategies for achieving equality, propelling higher investments in public health care, universal health coverage given that the development discourse *vis-à-vis* state, civil society and markets have not achieved enough to fulfil the various internationally committed development goals.

1.6 Poverty, the agrarian crisis, food sovereignty

The World Food Summit of 1996 defined food security as existing “when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life.”[17]

Access to food, control over food sources, sustainable production and consumption, State protection by way of policy and subsidising food for poorer sections of society all remain as integral aspects of food sovereignty.

“Commonly, the concept of food security is defined as including both physical and economic access to food that meets people’s dietary needs as well as their food preferences. In many countries, health problems related to dietary excess are an ever increasing threat; in fact, malnutrition and food borne diarrhoea have become double burden.”[18]

A recent press coverage stated that Americans waste nearly half of their food, and this constitutes 40% of the garbage each year. “That adds up to an estimated $165 billion in food wasted annually, the Natural Resources Defence Council said in its report released Monday. The average family of four squanders $2,275 in food each year or about 20 pounds of food per person each month. That is 10 times as much food as a consumer in South Asia trashes each year, according to the Council.”[19]

“Circumstances of poverty and food insecurity have been particularly difficult on poor women and marginalised groups like the Dalits. Farming communities that can maximize sustainable use of natural resources accomplish it through successful consensus management, protection, utilization and promotion of their resources. Indigenous communities, fisheries and women play a vital role in conservation of biodiversity and medicinal herbs. In such a context, there is an urgent need of policy reform that incorporates the affected communities as stakeholders in matters linked to land, forest and genetic resources in today’s agricultural sector.”[20]

When gaps are significant in access, enjoyment and quality of food availability, it is critical that the states ensure food as part of the public goods domain. All basic needs frameworks need to take into account major consumption habits which keep hunger outside homes. Women and the elderly often suffer the backlash of the failure of nation states to provide subsidized food to the poor. Engendering the food security issue is a basic necessity for engineering social equality in consumption. Privatization of sustainable agriculture has forced consumption by the poor to mimic the volatility of inflation induced food prices; this is when governments leave their social security obligations, and markets enter and destroy the resilience of the poor.

Traditional knowledge of food protection becomes redundant when the commons are privatized and the transnationalisation of food replaces the cultivation of land by the dwellers. Food cultivation within the household’s land suffers demise, further risking the very survival of people at the fringes of development and growth led prosperity. Marginalised communities in the Asia Pacific region remain the most affected in land displacement, in the corporatization of commons, and the overall discriminatory violation of their civil rights.

1.7 A few observations on the paper

This paper has been constructed on the basis of what Sai Jyothirmai Racherla and I heard from the various CSO leaders with whom we had long conversations. These dialogues are reflected specifically in the second part of this report jointly authored with Sai Jyothirmai Racherla of ARROW. The extensive research and policy work already available in multilateral documents, in research papers on the issues covered here have been cited in the references but it is not our intention to dwell extensively into many of the serious research questions that remain.

Two papers that deserve highlighting are both ARROW papers by Dr. Sundari Ravindran on universal health coverage and the second on poverty and SRHR co- authored with Dr. Manju R. Nair. In large measure, the latter covers extensively existing data on the various aspects of poverty and SRHR, and the former on the needed universal health care. Sivananthi Thanenthiran, Executive Director of ARROW, supported this work because of her commitment to pursuing these questions from a political and humanistic perspective, and much is owed to her perseverance with a dialogue that began long ago.

My engagement with the South Asia Alliance for Poverty Eradication (SAAPE) and the extensive interactions with many of the members in this membership network have been a compelling resource for drawing upon the wealth of insights that people at the grassroots developed over years of work with communities living in hardship but never giving up. The Poverty Reports of SAAPE have been heavily resourced for this report. Last but not least, Sai Jyothirmai Racherla and I have tried to listen to people engaged on the field allowing them to decide on the overall political and social changes that are needed to bring greater convergence of values about the kind of developmental action and world views needed. Massive investments, wholehearted public support, and strong coalition bodies that can command the direction of development itself are needed for a future where the vulnerabilities of millions in this region are reduced and livelihoods are assured as part of respected citizenship commitments. I am grateful to ARROW for the opportunity to work on these issues with the ARROW team. Part II, “Narratives from the Field”, co-edited with Racherla has been presented to the public using the co-constructivist methodology in our discussions with all the specialists whom we had the privilege of dialoguing with. To them, we owe our gratitude.

1.8 Some Truths

We convey to the reader that in the last instance a few truths that have emerged are:

- That not all are poor, not all need social security and yet what the ‘haves’ do to the ‘have-nots’ has enormous consequences; what action those in the privileged groups take negatively implicates the growing poor. Rightful citizenship is at stake.
- That poverty debilitates agency at both the individual and the community level the longer it is allowed to continue and the deeper it is allowed to progress.
- That patriarchy destroys the agency of women and men cutting across their caste, class, gender, and age characteristics.
- That the face of poverty is visible in every woman, man and child when they seek their rights and receive instead the denials. The risks faced include maternal mortality, IMR, lowered life expectancy, poor care or no care and loss of dignity in ill health, lack of employment, poor food consumption, silent hunger, and morbidity caused by a host of illnesses and compounded by patriarchy.
- That the attendant loss of dignity for people living in poverty is a crime against humanity, and in the final instance unjustifiable under all circumstances.
- That no development action can be permissible if it destroys the integrity and dignity of a fellow citizen. Consulting and getting a consensus from the people living in the area is essential and necessary to avoid undemocratic development.
- That the rights and entitlements ensured in all ratified international treaties and national Constitutions are the bedrock on which are built the rights to a poverty free existence inclusive of sovereignty of food, and access to health care.

The following sections deal with the overpowering and all encompassing nature of poverty and induced vulnerabilities (Section 2), the critical importance of food security for ensuring a poverty-free existence (Section 3), the issues of women’s status as empowered citizens as being a fundamental condition for equity access and rights fulfilment (Section 4), and lastly, the concluding section (Section 5) suggests some standards in the recommendations which are non-negotiable in regard to a holistic perspective on poverty and its attendant impacts and burdens on the lives of marginalised people, dovetailing the various aspects of poverty’s burdens calls for a greater alliance both in political action as well as in world views. We assert in all the sections that all aspects of SRHR need to be integrated explicitly into these areas of existence and world views for bettering the quality of life for all citizens, and providing respectful and inclusive justice to all citizens. Retaining this vision results in holistic solution seeking and in a socially just building of equal societies.

2. POVERTY AND VULNERABILITY IN THE ASIA PACIFIC REGION

"Anywhere you have extreme poverty and no national health insurance, no promise of health care regardless of social standing, that's where you see the sharp limitations of market-based health care.... I critique market-based medicine not because I haven't seen its heights but because I've seen its depths."
- Paul Farmer, physician and medical anthropologist, Haiti

"The first task of the doctor is...political: the struggle against disease must begin with a war against bad government" & "Man will be totally and definitively cured only if he is first liberated..."
- Michel Foucault (The Birth of the Clinic: Archaeology of Medical Perception)

The Asia Pacific Region has posted progress in certain areas but on the whole remains with some serious social deficits which will hinder the overall achievements of governments in bringing social equality to their citizens and maintaining economically inclusive growth. On accounts of education and health for all, the goals of equitable social development remain highly distant because of the depth and the extent of poverty conditions, conditions which ensure intergenerational social injustice across caste, class, and gender, encircling the poor and vulnerable everywhere.

Box 2: Poverty in the Asia-Pacific region

- More than 4.2 billion people lived in the Asia-Pacific region in 2010, constituting 61% of the world's population.
- People living in extreme poverty in Asia and the Pacific declined from about 1.6 billion in 1990 to 0.9 billion in 2008. The proportion of people in extreme poverty was highest South and South-West Asia (36%), followed by South-East Asia (21%), East and North-East Asia (13%), and North and Central Asia (8.2%) – extreme poverty is defined as those living on less than PPP$1.25 per day. However, 753.5 million people in Asia and the Pacific are in extreme poverty today according to the ADB.[21]
- In 2009, 2.8 million infants and an additional 0.8 million children under 5 died in Asia and the Pacific. The under-five mortality rate decreased from 86 deaths per 1,000 live births in 1990 to 49 in 2009. The infant mortality rate decreased from 63 deaths per 1,000 live births in 1900 to 38 in 2009. Still, too many children and infants in the region perish each year. Afghanistan has the highest under-five mortality rate of 199, followed by Cambodia (88), Pakistan (87), and Bhutan (79).[22]

Social inclusiveness, the right to health services and equity access to compulsory and quality education, the right to reproductive, sexual health, and the right to political participation form a regime of democratic universal rights and yet adaptable to contours to different countries. The Asia Pacific region, despite limited progress, continues to fail in delivering the fundamental rights of social development.

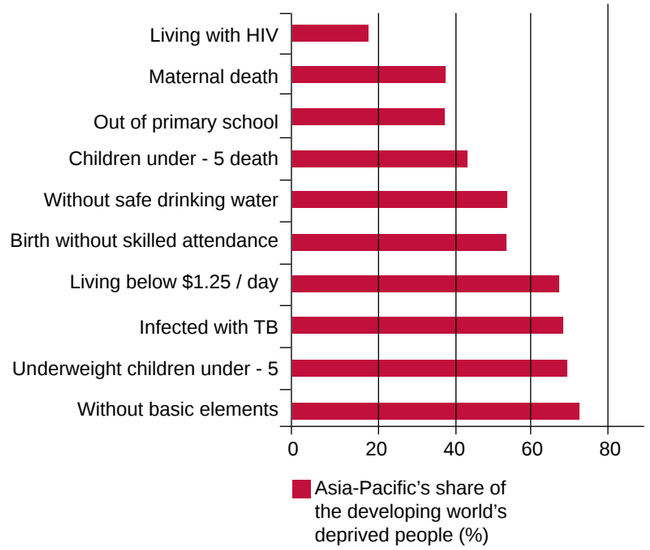
Article 25 of the Universal Declaration of Human Rights states:

1. Everyone has the right to a standard of living adequate for the health and Wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

The tables below demonstrate how the region's poor live in dire neglect of all entitlements which remain as significant aspects of the 'progress and development' trajectory. In many areas of social progress and human development advancement, there are vast tracts of communities where dire neglect and gross under development mark the lives of citizens, especially the elderly, women, and children. The pace of development is not fast enough and the compounded nature of the denials makes it virtually impossible for families to move out of poverty.

The cycle of deprivations are aggravated during armed conflict, natural disasters (30.4 million people were displaced in Asia and the Pacific in 2010 due to environmental disasters),[23] and national policies that destroy the resilience of people at local levels because of land privatisation, distortion of local livelihood systems due to development projects, and government/donor conditionalities (at the end of 2011, around 4.3 million people were internally displaced due to armed conflict, violence or human rights violations). 570 million people out of a total of 928 million went hungry in the Asia Pacific region in 2010 (geographically, more than 70% of malnourished children live in Asia, 26% in Africa and 4% in Latin America and the Caribbean).[24]

Figure 1. The Asia-Pacific share of the developing world's deprived people



(Source: Staff calculations based on United Nations' MDG Database and World Population Prospects 2010).[25]

Table 1. The Asia-Pacific share of the developing world's deprived people

Issues	Asia-Pacific's share of the developing world's deprived people (per cent)
Without basic elements	72
Underweight children under - 5	69
Infected with TB	68
Living below $1.25 / day	67
Without safe drinking water	54
Children under - 5 deaths	44
Out of primary school	38
Maternal deaths	38
Living with HIV	19

The much-touted not-too-distant meeting of the MDG for halving poverty by 2015 does not quite match up to the experienced reality of insufficient sanitation, lack of water, education, displacement-related poverty, and the denial of education to the poor, especially girl children. "In Asia and the Pacific, 466 million people lacked access to improved water sources and 1.86 billion lacked access to improved sanitation in 2010.... Region-wide access to improved water sources rose from 74% of the total population in 1990 to 89% in 2008 – 96% of the urban and 83% of the rural population had improved water sources. Access to improved sanitation rose from 42% to 54% of the total population during the same period – rural access to improved sanitation grew from 30% to 43% between 1990 and 2008.... Natural disasters killed an average of more than 70,000 people every year of the last decade in Asia and the Pacific totalling more than 200 million people during the last decade."[26]

The late 1980's and 1990's witnessed the extensive integration of the countries in the Asia Pacific region into the global economies led by the policy prescriptions of the Bretton Woods' Washington Consensus. Privatisation, deregulation and liberalisation policies meant that the role of the State in promoting and protecting the poor and the vulnerable sections of their populations took a downward turn. User financing, limiting the supply of subsidised food, the diminished role of the public sector in maintaining labour rights as per domestic policies, the reduction in production of indigenous drugs and export-led growth dominating over food self-sufficiency policies in the rural food production sector, all came to be realities that deepened poverty while fostering the consumption-oriented middle classes and the wealthy. Globalisation created dramatic changes in domestic economies spurting the service sector to contribute to a larger share of

the GDP of several countries, notably India, while lowering the predominant role of agriculture in a country's economic growth and social development opportunities.

The rural face of the Asia Pacific countries during the last decade has changed dramatically and mostly, not for the better. Rural poverty has deepened in India with the lowering of state investments in agriculture in the 90s, and a growth in the urban sector investments. The latter has resulted in the labouring poor relocating to the towns and thus, increasing both the urban poor as well as the female headed households in rural areas. Ethnic minorities, tribal communities, and rural poor living in highly inaccessible and remote areas have continued to live on the other side of globalisation and 'progress'. The region records some of the highest ever figures in transmigratory populations. These massive displacements due to lack of income in rural areas make the delivery of health and education services more difficult for state and non-state actors. Increasing privatisation of health and education add to the burdens of people living in poverty, particularly in developing access and enjoyment of their rights. With the exception of China, privatisation has increased out-of-pocket expenditures of the rural poor for both health and education.

"The elimination of ignorance, illiteracy, remedial poverty, preventable disease, and needless inequalities in opportunities must be seen as objectives that are valued for their own sake. They expand the freedom to lead the lives we have reason to value, and these elementary capabilities are of importance on their own. While they can and do contribute to economic growth and to other usual measures of economic performance, their value does not lie only in these instrumental contributions. Economic growth is valuable precisely because it assists to ameliorate deprivation, and to improve the capabilities and the quality of life of ordinary people."[27] Economic growth has not resulted in a corresponding increase in social investments for public health. Through the Comprehensive Health programme, China has, however, managed to secure much needed succour to the poor by way of financial assistance as well as free health care provisioning.[28] A staggering 96% of the Chinese population have full health coverage. Unless and until governments ensure meeting the goal of full health care coverage for their populations,[29] which means increased outlays among others, one cannot expect to see a drastic overhauling of the high distress conditions of the poor of the Asia Pacific region.

The multidimensionality of poverty does not restrict itself to rural and urban non-equitable development, increasing privatisation, and lowered or insufficient state expenditures on covering all below poverty line. It also occurs because of the fact that the welfare coverage is often exclusive of all other constituencies of the disadvantaged, who are vulnerable, for example, the millions who fully or partially constitute people living with differing abilities. 650 million people worldwide endure some form of physical impairment. The World Bank estimates that 20% of the world's poor have some form of disability and more women than men live with impairments facing various forms of violence, sexual, discrimination and income deprivation due to forced unemployment.[30] 60% of the globally disabled live in the Asia Pacific region.[31] "Poverty and marginalisation characterise the situation of majority of the persons with disabilities in the region."[32]

ESCAP considers them to be "among the poorest of the poor and the most marginalised in the society. Living mostly in the rural areas, they have difficulty accessing whatever facilities that are available for them because these facilities are usually located in the cities. They generally have limited access to education, employment, housing, transportation, health services and recreation, leading to their economic and social exclusion.

The International Labour Organization (ILO) states that the unemployment rate among persons with disabilities is usually double that of the general population and often as high as 80%. They frequently face various barriers such as negative attitudes of employers, lack of accessible facilities, and lack of vocational and technical training."[33]

Dr. Amartya Sen pointed out in his keynote address at the World Bank's conference on disability; the poverty line for disabled people should take into account the extra expenses incurred in exercising what purchasing power they do have. A study in the United Kingdom found that "the poverty rate for disabled people was 23.1% compared to 17.9% for non-disabled people, but when extra expenses associated with being disabled were considered, the poverty rate for people with disabilities shot up to 47.4%."[34] Afghanistan, Cambodia, Pakistan, Nepal, parts of India, Sri Lanka are countries with war conflict induced disabilities among the populations living in these zones of land mines, drones, insurgency etc.

Another expanding constituency of the vulnerable include people living with HIV/AIDS, 9-9.5 million transgender population risk being HIV+ in the Asia Pacific region as reported by the latest UNDP report, *Lost in Transition: Transgender People, Rights and HIV Vulnerability in the Asia-Pacific Region*. "Social exclusion, poverty and HIV infection contribute to what we call a 'stigma sickness slope' -- a downward spiral that is difficult to reverse," states the Editor of the report much of which is constructed on anecdotal evidence over the last 12 years.[35] The report brings home several shocking truths about

a highly violent and degrading situation faced by this constituency – rejection, emotional torture resulting from social rejection, poor and harmful health care by way of plastic surgeries carried out in unregulated make shift clinics, and lack of livelihood opportunities resulting in a 'ghetto-isation' of millions of transgenders. Mr. Manohar, Founder of Sangama Foundation, India, in his interview with ARROW explicitly states that there has been dire neglect and targeted elimination of transgenders and alternative sexualities communities, especially among the rural poor in the social perceptions of them being citizens. Many live in chronic poverty which includes unemployment, illiteracy, few skills, lack of housing (both urban and rural), disinheritance, rejection by both family and society, denial of health care and emotional support, physical weakness, and exposure to high risk behaviours as part of survival. Ravaged by hard informal sector employment, many resort to begging as they are denied food ration cards by repressive governmental authorities.

They are never invited by governments or donors when decisions are being made about investments for them. They are never asked what their priorities are like, what it is they want as support, and what of their capabilities they would like strengthening. A transgender partner once said to this writer, "Even poor communities are casteiest and reject us, because they don't have a frame in which to fit us except the frame of an 'aberration', an unnecessary mistake of history." Very drastic changes are required to reform societies that thrive on distorted perceptions of large classes of the excluded. Cutting beyond caste, class and gender, SRHR needs to be brought into all areas of the politics of care and citizenship issues to enable a serious capability building within mainstream institutions in respect of their weakness in understanding vulnerability and poverty. Indeed, the condition of poverty is an integrator in building a social movement for the unities of the vulnerable on basic needs, citizenship, voice, and participation.

Unless we are able to expand its very definition and its coverage to include all those denied rights for livelihood and citizenship, the role and responsibility of the state in a democracy will be unconstitutionally diluted. All privatisation efforts will reduce the public sector arenas of education, health, food, employment to becoming market driven, exclusive and therefore, narrow in its outreach and availability, especially in contexts of expanding and deepening poverty. Engaging in the highly complex world of deepening poverty where a larger number of constituencies remain entrapped, engulfed by social, political and developmental neglect and apathy, it remains to be seen if the extremity, the sorrow, and the injustice of poverty is ever experienced by the socially included, the policy makers in government and corporate leaders who are in a powerful positions to alter the poor employment opportunities faced by millions on the flipside of development. The communities of the excluded poor are diverse, rich in their cultural knowledge, fully aware of the history of their inherited discrimination that has left them to struggle alone. Needed is official recognition that immediately translates into entitlements, received promptly by citizens and not by 'beneficiaries'. What needs to be broken is the notion of a class of people who live the conditions and of others who decide on their behalf. If this divide continues, a long history of the state's and people's efforts at winning freedom, at building institutions, at unveiling human capabilities, and at negotiating with external interventions and external realities will be set aside.

The situation in the Asia Pacific region speaks volumes of the erosion of much public sector services, of increasing poverty – lack of income, lack of entitlements which are rights and not social handouts, and lack of inclusive social perceptions, of equity in employment, and of equity access to all public social security with respectful responses from bureaucrats who man these services. Trickle down theories of social benefits are being challenged by the numerous groups left out of development. The causal processes underpinning poverty and injustice, and resulting loss of real freedom for millions require massive social changes, structurally, in the delivery of services and an increase in bringing health and education into public sector purviews.

There is a commonality of scarcity issues as expressed by a large number of the speakers in the ARROW interviews. Yet, there is a serious lack of respect and understanding of the local when needed interventions of diverse approaches are involved. There are omissions of entire communities or partial acceptance which amounts to tokenism. Democracy needs full participation, not representational references. The instrumentalisation of the term, 'poverty', eliminates the people who live that condition. There is no other explanation for the continued social injustice in the region in a large number of the countries.

The people who remain supreme are excluded from being part of powerful partnerships which decide on who may be the beneficiaries. The health status of the excluded is insufficiently recognised in poverty and wealth indexes, revealing a morality where there is no convergence in concerns leading to efficient incremental delivery. Similarly, the primary condition of overall health has everything to do with the availability of food and sustainable consumption habits in the overall framework of livelihood and citizenship. In the next section, we probe and develop the profiling of the lack of democracy when hunger is created by flawed policies which increase gaps and cause man-made hunger in populations already facing the loss of sustainable development.

3. POVERTY AND HUNGER: RIGHT TO FOOD

"In India, amongst children in the age of 3 and below, 47% of children are underweight, 38% of the children have stunted growth, 18% of the children are severely malnourished and 48% of the children are anaemic.... Amongst children in the age group below 5 years, 6000 children die every day due to malnourishment or lack of critical nutrition in their food.... The total population of malnourished children in the world is approximately 14.6 crores. India houses nearly 5.7 crores of them i.e. more than one third. We are on our way to becoming a sick and malnourished country. In the history of the world, people have survived flood and famine, yet in India, 2 and a half lakh farmers have committed suicide, although no natural calamity befell them. Of a population of nearly 125 crores, around 125 people or so are determining the pace and the direction of economic policies. Questions are raised by people whose lands are flooded by dam waters, questions are raised on behalf of those whose lives were lost in communal riots, questions are raised by workers who have lost their jobs due to the rank profiteering of their capitalistic employers, or questions are raised on behalf of adivasis displaced from their lands, waters and forests..."
- Dr. Binayak Sen and Dr. Ilina Sen

"The mainstream definition of food security endorsed at Food Summits and other high level conferences refers to everybody having enough basic food to eat each day. But it does not talk about where the food comes from, who produces it, and under which conditions it has been grown. Addressing poverty and hunger successfully will not revolve around inherent rights to food, but about asserting people's food sovereignty in food production and distribution."
- SAAPE, 2006

"The treatment for malnutrition is food."
- Paul Farmer, Physician, Medical Anthropologist, Partners in Health

The condition of poverty is both material and non-material, often referred to as a condition that is inclusive of scarcity in the areas of both rights and entitlements. The *United Nations Millennium Declaration* resolved "to promote gender equality and the empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable."[36] The *1996 Rome Declaration on Food Security* and the *World Food Summit Plan of Action* recognized that although the availability of food has increased substantially during past decades, serious constraints in access to food, coupled with the continuing inability of households to purchase food, the instability of supply and demand, and natural and human-induced disasters, prevent many people from fulfilling their basic food needs.[37] Renewed commitments related to food security, poverty alleviation, and empowerment of women in the declarations of the *World Food Summit: Five Years Later*[38] and the *World Summit on Sustainable Development*[39] have been made.

Despite a large number of reiterations such as the above, there has been little progress made in protecting populations, both poor and vulnerable, from the issues of hunger, deprivation, and malnutrition. Despite attempts theoretically to ensure that there is a global recognition of the commitments that are necessary for a humanistic approach to food security guarantees by the state to their most vulnerable populations, few governments have taken serious steps to mitigate a colossal disaster already stalking the young, marginalised populations and socially excluded. Food wastage, imports replacing domestic cultivations result in food becoming locally inaccessible to the small producers themselves; rising inflationary prices move food out of the affordability range for the working poor, food prices have doubled in the last decade, ensuring the arrival of the new era where food is part of trade, dictating profit maximisation trends. "A recent FAO report estimates the global food import bill will increase $250 billion from 2010 to an astonishing $1.29 trillion in 2011."[40]

"The Asia-Pacific region is home to 578 million of the world's 925 million people who are malnourished, representing almost no change in the absolute number of hungry people in 20 years despite rapid economic growth in most countries. Of that total, 91% live in just six countries: India, China, Pakistan, Bangladesh, Indonesia, and the Philippines."[41] The UN Food Agency (FAO) said that food insecurity has increased in the Asia-Pacific region which is home to more than 60% of the world's over 1 billion hungry people. "Nearly 18% of the region's population was undernourished in 2009, compared to 16% in 2006 – the first time since the Green Revolution in the 1960s that the share of the hungry in the region has increased."[42] Liberalisation policies by governments have ensured that food has been brought from a regime of constitutional rights to one entirely dictated by markets.

The economic recession of 2008 had implications for the further liberalisation of agricultural production. Instead of a return to a more enhanced role of governments in guaranteeing good quality food availability at affordable prices combined with guaranteed food supply for those in severe poverty conditions the region witnessed poor performance, there is no performance or a more savage liberalisation of food. There has also been a deliberate attempt to replace traditional diets with market determined diets where traditional diets vanish leaving the poor more vulnerable to illnesses and poor health status.[43] "Large numbers of people in the Asia-Pacific were already undernourished prior to the recent price rises, relying on monotonous diets dominated by a few staples. Pushed into reducing their dietary diversity even further, many more millions are now suffering from hunger and deteriorating health. The most fundamental food crisis in the Asia-Pacific is one of poor diets, and this affects the obese just as much as the undernourished."[44] Traditional state funding for agricultural research changed during the structural adjustment policies implementation where the R&D corresponded to market-demand trading patterns and food consumption moved from direct cultivation to food purchase.[45]

"Remittances by migrant labour is being used to buy food instead of growing it."[46] "In the Asia-Pacific region, the bulk of agricultural R&D is still financed by governments, and China, Japan, and India account for more than 70 percent of this spending. Although regional expenditures grew by 3.4 percent per annum from 1981 to 2002, investments were very uneven. Most growth was due to China and India, where expenditures tripled and there was a shift from funding traditional areas of agricultural research to a greater focus on biotechnology. The 11 low-income countries in the region (excluding India) accounted for only 5 percent of the region's public agricultural R&D expenditures."[47]

In Indonesia, it is reported that during the decentralisation era between 1996 to 2002 national food insecure households remained stagnant in terms of food expenditure share. "There was no substantial improvement in the related indicators for national food insecure households (Part 3) during 1996 to 2002. This was shown by the stagnant proportion of food expenditure share (70 percent)... the proportion of food insecure households actually increased from 5.2% to 9.8%...Other indicators are the prevalence of underweight children under-five years of age, and an increase in the proportion of the population below the minimum level of dietary energy consumption (2,100 kcal/capita/day)."[48] Hunger, child mortality, and maternal mortality remain high in the Asia-Pacific region, making it difficult for the countries in the region to achieve the Millennium Development Goals (MDGs) by 2015.[49]

In South Asian countries, the story is similar. "However, more important from the perspective of poverty and food security, is the reduction in food production and per capita food availability during the decade of the 1990s. The rate of growth in food production dropped below the falling population growth rate."[50] "According to an official data provided in the Economic Survey 2004-05,[51] the gross area under food grains has declined sharply from 127.8 million hectares in 1990-91 to 123.8 million hectares in 1997-98 to 111.5 million hectares in 2002-03. This massive decline (12 million hectares in 8 years) in the gross area under food grains, when combined with the slower food production growth rate and rising food grain exports, had to inevitably translate into reduced per capita availability of food."[52] Sri Lanka, one of the first South Asian countries to adopt liberalisation policies, has high rural male suicides rates and food insufficiency that haunt some of the poorer districts of the country, partially destroyed by internal war.

Export led growth has also been demonstrated by Kabir in 2005 where the districts of Rajshahi division in Bangladesh, have food surplus which means that poor people of this region produce food for deficit regions and remain hungry. Poverty increased sharply during the 1990s in Pakistan; and in terms of caloric intake norms, the percentage of population living below the poverty line increased from 23.6% in 1993-94 to 32.6% in 1998-99. Food poverty incidence increased in Pakistan, and according to some estimates, about one-third of the households were living below the food poverty line and were not meeting nutritional requirements for healthy growth. The incidence of food poverty was higher in rural areas (35%) than in urban areas (26%).[53]

FAO reports that over three million children in the region died before their fifth birthday in 2010 alone. Hunger and malnutrition are responsible for the deaths of roughly 3.3 million children under the age of five each year. To feed the projected world population in 2050, sustainable food production will have to increase by 60% globally, and by 77% in developing countries.[54] The macro data profiles remain shocking and convey highly dismal pictures of the catastrophe of declining food standards and food sufficiency. Sustainable food security is defined as "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 without compromising the productive capacity of natural resources, integrity of biological systems, or environmental quality."[55]

"Rural women across Asia and the Pacific region play a critical role in supporting the three pillars of food security – food production, economic access to available food, and nutritional security – for the members of their households, in normal times as well as during periods of stress. The majority of households and communities in Asia and the Pacific manage their rural production systems based on socially accepted ender divisions of labour that affect food security achievements."[56] But, what is less known and recognized as a national crisis is that women face far more acutely the ravages of hunger within the household when hunger begins to visit the community.

Food Security is a long term goal for any developing country to reach. The crisis, however, lies in the fact that the magnitude of the problem places at risk large numbers of the very poor. The International Food Policy Research Institute (IFPRI)'s 2008 Global Hunger Index says that with over 200 million people insecure about their daily bread, India's situation is 'alarming' in terms of hunger and malnutrition. The first ever Indian Hunger Index, released along with the Global Hunger Index, found that not a single state in India fell in the 'low hunger' or 'moderate hunger' categories. India ranks 67 among 88 countries in the hunger index.[57]

Needed are State policies that promote pro-poor sustainable agriculture which seriously interrogate the callous and sub-human standards of women's consumption and agricultural labour standards progressively worsening as poverty progresses. Sufficiently effective decentralised operations which shape agricultural policies with farmers' associations, local administrative services, public distribution systems, community associations, food trading outlets interventions are necessary for the food chain to reflect the pathways of peoples' food choices in agriculture. Food pricing policies must be in place so that farmers are protected from volatile market fluctuation and uncontrolled export of food grains which are needed in the domestic markets. Hunger is man-made, forcing growers and the poor alike to adopt sub-human consumption habits or to accept hunger as an inevitable consequence of existence.[58]

The sharp rise in food prices during the economic recession has made food security an even more remote ideal. When the FAO, in several documents, has explicitly stated that "[g]irl children and women in poor households are included in the hunger vulnerable group in the region," it is surprising how most governments pay no attention in state budgets and social programmes to ensure that rural women are consulted on development plans that affect their health and livelihood status.[59] "In relative terms, countries in South Asia (such as Bangladesh, India, Nepal, and Pakistan) that are also low-income food deficit countries, are notable for their low performance in gender-related development indicators."[60]

In the backdrop of rural poverty in many parts of the Asia-Pacific being a growing phenomenon due to decline in agricultural investments by Governments and the privatisation of agriculture, women remain the most seriously affected. The rapid commercialisation of agricultural land has also been responsible for denying food security at the local level where community members can access the commons freely. "Indigenous communities, fisheries and women play a vital role in conservation of biodiversity and medicinal herbs. In such a context, there is an urgent need of policy reform that incorporates the affected communities as stakeholders in matters linked to land, forest and genetic resources in today's agricultural sector."[61] The ineffective nature of the public food distribution systems after the initiation of the structural adjustment policies has also been a source of hunger among both urban and rural poor. Indeed, it has been observed that "[f]or many, being female and living in rural Asia is doubly discriminatory."[62] In India, the Public Distribution System (PDS), the Integrated Child Development Scheme (ICDS), the School's Mid-day Meal Scheme, and NREGA have all met with limited success due to corruption, poor implementation, and an insensitive system which treats citizens as 'beneficiaries' undeserving of respect.

"Data confirm that countries with low and medium achievements in human development and gender development indices also tend to be low income food deficit countries, and have a larger share of women in agriculture.... It is imperative that gender defined constraints that affect agricultural productivity be systematically investigated in selected food deficit countries that record high risks of hunger in the region."[63]

Privatization of sustainable agriculture has forced consumption by the poor to mimic the volatility of inflation induced food prices. Where governments leave, markets enter to destroy the resilience of the poor and traditional knowledge on food protection, food cultivation within the household's land suffer a demise, further risking the very survival of people at the fringes of development and growth led prosperity. It should not be forgotten that 70% of the world's more than 250 million indigenous peoples live in Asia and the Pacific. Most of them are dependent on the forests.[64] The three pillars of food security –i.e. "Food security is built on three pillars: Food availability: sufficient quantities of food available on a consistent basis, Food access: having sufficient resources to obtain appropriate foods for a nutritious diet", Food use: appropriate use based on knowledge of basic nutrition and care, as well as adequate water and sanitation.[65]

These definitions of food security are useful for operationalising a sustainable food policy. However, they conceal the reality of food being part of the global trading flows that is detached from human development, and the politics of survival food becomes instrumental for profit-maximization. Growing indebtedness among the rural agricultural small producers and peasantry is a truth which forces rural poor to extend the condition to the spheres of health and education. The indeterminate use of pesticide and the loss of biodiversity have been major reasons for this situation of disempowerment. Indeed, many farmers' associations in the South Asia region prefer to use the term, 'food sovereignty' instead of 'food security'. "Food sovereignty is the right of people to define and choose their own food production and agriculture: to protect and regulate domestic agricultural production and trade in order to achieve sustainable development objectives; to determine the extent to which they want to be self-reliant; to restrict the dumping of products in their markets; and to provide local-based community fisheries the priority in managing the use of and the rights to adequate resources. Food sovereignty is the basic right of people linked to economic and social human rights. Food insecurity means that people do not get food despite its availability."[66]

Food Security for the poor is an entitlement which is part of redistributive justice and good governance. When gaps are significant in access, enjoyment and quality of food availability, it is critical that the state ensures food as part of the public goods domain. All basic needs frameworks need to take into account major consumption habits which kept hunger outside homes. Women and the elderly often suffer the backlash of the failure of nation states to provide subsidized food to the poor. Engendering the food security issue is a basic necessity for engineering social equality in consumption.

During the writing of this paper, a special high-level Commission in India revealed startling facts about the prevalence of malnutrition in one of India's most wealthy states, Karnataka.[67] 71,605 in August 2011 were the number of registered cases of malnourishment of children. In 2012, 61,564 were recorded in official government registers, mainly among 'backward' and very poor communities in rural areas. Withdrawal of much needed subsidies by the government over the years caused migration due to jobless growth and patterns of growth-led economics which have led to the unusual surge of the service sector that are all responsible for a rapid decline of the agricultural sector, and the massive gaps in consumption with the poor in dire hunger, especially women and children. When democracies cannot prevent hunger, the problem of a poorly functioning democracy with massive consumption deficits becomes evident leading us to return to the question of social justice and how well they are accessed by all in any society.

4. WOMEN IN LEADERSHIP: A QUESTION OF ENHANCED CITIZENSHIP

"Because they claim to be concerned with the welfare of whole societies, governments arrogate to themselves the right to pass off as mere abstract profit or loss the human unhappiness that their decisions provoke or their negligence permits. It is a duty of an international citizenship to always bring the testimony of people's suffering to the eyes and ears of governments, sufferings for which it's untrue that they are not responsible. The suffering of people must never be a mere silent residue of policy. It grounds an absolute right to stand up and speak to those who hold power."
- Michel Foucault

This paper in the preceding pages underscores the multi-dimensional nature of systemic poverty and its ramifications for governments and civil society organisations when dealing with SRHR issues compounded in contexts by hunger, malnutrition, inequality, and all outcomes of unsustainable development choices. Universal access to reproductive health services cannot be sustained and guaranteed unless there is political will in the countries where large communities face hunger and starvation to include these services and provide care on a consistent basis for all.

Given the lack of attention to both the growing inequality gaps in the Asia Pacific countries as well as the inability of the political ruling elites to recognise maternal mortality, dominant morbidity among the poor and ethnic minorities, high IMRs and declining status of girl children among others as critical matters deserving the highest degree of Parliamentary discussion we dwell on the question of political participation by women and elaborate on why this deserves much attention in the region.[68]

Full participation of women in the political discourse is needed to bring women centre stage and away from the household ambit of unpaid labour and patriarchy induced subordination. Their participation in the political arena at all levels is required for a drastic shift in the development story. Unless and until women from all walks of life in all their cultural and occupational diversity are present at all levels of decision-making in a country to shape the history of a country's development, the pace of gender parity and equality for women will not be quick enough to close the massive gaps in social development.

Repeatedly, on almost all counts of literacy, political participation, employment, health status, women's access to professions, and women's resistance to growing violence both domestic and public, it has been demonstrated that progress is being hindered on all counts of equal participation because gender equality is slow and often regresses thanks to rising fundamentalism, and rising violence against women and 'apathy' among those in power when it comes to women's rights and their condition. Collective of people of diverse gender identities and sexual orientation, sex-workers and those who are HIV+ speak of the callous treatment meted out to them in society at large. Barred from economic opportunities due to non-availabilities of loans and inability to qualify for public positions, they remain condemned to various other denials such as denial of property and inheritance rights, livelihoods, rental housing, medical care, pensions and various other state entitlements. Treated either as 'beneficiaries' or as objects of public derisiveness, they remain almost all their lives victimised by hostile societal malevolence and neglect.

Education as the first step: Of the 793 million illiterate adults worldwide, the Asia Pacific region had 518 million without access to the written word. 65% of the illiterate in the region were women. Twenty years ago, the figure was 64% for women! In Article 26, UDHR states "Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit."[69]

With the exception of Cambodia, India, Indonesia, the Lao People's Democratic Republic, Pakistan, and Tajikistan, the Asia-Pacific countries have achieved gender parity in primary school enrolment. However at the secondary level in 2007 the gender parity index is 0.79. Literacy rates among young Afghan women are disturbingly low: only 18% of women between 15 and 24 can read.[70]

The region as a whole could counts only 746 researchers per million inhabitants in 2007, well below the world average of 1,081. Women composed only 18% of the regional R&D work force in 2007 – lower than in Africa (at 33%), Latin American, the Caribbean (45%), and Europe (34%).

Withdrawing children from child labour (prevalent in the Asia Pacific region) and ensuring that girl children are retained in school till the age of 18 years across the Asia Pacific is critical for building the future where gender parity is a norm already evident in access to knowledge, skills, and informed participation in public life. The school is a public space where private domestic violence against girl children in invisible child labour gets shut out.[71] "In November 1989, the United Nations declared the *Convention on the Rights of the Child*, stressing that child labour is exploitative in Article 32 of the Convention.[72] According to the International Labour Organization, there is an estimated 218 million children aged 5 to 17 years worldwide, excluding child domestic labour.[73] Thus, ILO has also stressed on the abolition of child labour in the Worst Form of Child Labour Recommendations, 1999. School enrolment figures for girls in India have increased by 13% in nine years but these figures are deceptive, as drop-out rates are also high. We need to stop perpetuating a system of elite schools for the middle class and the wealthy, government schools for the lower income families, evening schools for working children, and finally, no schools for millions of poor working children. This paper hopefully is uncompromising in calling for a sea change in the present divided state of affairs that is the fate of India's children."[74]

In India, rampant is also the violation of the fundamental right to education of impaired students as guaranteed to them under Articles 14, 15, 21, and 38 of the Constitution of India read with the provisions of the U.N. Convention on the Rights of the Child (1989). Devaluation of girl children is commonplace due to son preference and growing demands on limited resources within the household. Millions of girl children are growing up facing the savage nature of poverty everyday. Despite many countries, for example, India, is having legal provisions preventing early marriage, thousands of girl children are still married off before reaching 16 years of age in rural India and sent away due to hunger and other limited incomes.

The mid-day meals schemes for children in disadvantaged circumstances are provided in schools, and the proximity of these schools to communities to enable excluded communities to send their children and to provide supportive assistance to ensure school retention and health care are being given to these children who need to be the priority of state efforts. The campaign for integrated public schools is important to support. It is believed that such schools will become a major part of societies preparing for a socially inclusive social compact which will promise gender, caste, and class parity with equal opportunities. Reorientation of curricula to include basic data on social development, the constitution and legal entitlements for citizens are necessary in every school, in every country. Legal advocacy is not something that can be acquired at an older age and education is a huge space for integration, especially for overcoming the gaps and divides in societies.

Women's participation in Labour: "In Asia and the Pacific, 47% of employed women were engaged in the agricultural sector in 2008, compared with 38% of men. The proportion of women employed in industry has remained relatively constant in the last 20 years, at slightly less than 20% of employed women." Employment is higher for men than women. Male employment-to-population in the region was 76, while the female ratio was 51. Notably, 6 of the 10 countries in South and South-West Asia had a male employment-to-population ratio of more than double the female ratio.[75]

Women's Health: Maternal mortality in Asia and the Pacific has been halved in the past two decades but it still remains, in 2008, 40% of the world's total. "The difference in the maternal mortality ratios between low-income and high-income countries was extreme: 517 maternal deaths per 100,000 live births in low-income countries, as compared to 10 in high-income countries. Bangladesh still has one of the highest maternal mortality rates in the world. It is estimated that about 14% of maternal deaths are due to violence against women, while 12,000 to 15,000 women die every year due to maternal health complications." [76]Lack of attention throughout pregnancy, lack of visits for ante-natal checkups, poverty, and its attendant deprivations,[77] and neglect are often the main factors for the prevalent high rates. Many government hospitals display callousness towards women in child birth as often evidenced in media reports.

Women and HIV-AIDS: "Women account for 50% of people living with HIV. Globally, young women aged 15-24, are most vulnerable to HIV with infection rates twice as high as in young men, and accounting for 22% of all new HIV infections. HIV is the leading cause of death of women of reproductive age. In the absence of HIV, maternal mortality worldwide would be 20% lower."[78] In Asia, the proportion of women living with HIV compared to men increased from 20% in 1990 to 34% in 2002. Since then it has stabilized at about 35%. It is estimated that at least 50 million women in Asia are at risk of acquiring HIV from their male intimate partners who engage in high risk behaviours, including paid sex, injecting drug use, and unsafe male to male sex. Sex work is the key driver of HIV in Asia Pacific; the median reported coverage of HIV prevention services for sex workers in countries in the region, however, was only 40%.

Women and Early Marriage: "Current estimates show that approximately 82 million girls between 10–17 years will be married before they reach 18 years. Of the 331 million girls aged 10–19 in developing countries (excluding China), 163 million will be married before they are 20.[79] "Although there is little international consensus on what a rights-based agenda is, what is needed here requires a commitment to married girls and women who have been voiceless simply because it is their due as human beings."[80] 58% of the women attained motherhood between the ages of 13-19 years and 37% of births occurred within two years of the latest birth. The mean age for marriage among girls in India is as early as 17.68 years, according to the 1991 Census data. The overwhelming demand to bear sons is very prevalent cutting across class and

caste.[81] Adolescent girls in South Asia are pressed into early marriages even when they suffer from nutritional deficiency. Health services available for non-maternity health needs of women are even less. Even where services are available, they may not be utilised due to deep-seated prejudice against women's needs.[82]

Women in Marginalisation: Economic marginalisation and social marginalisation are far more predominant among women in poor communities. "Women from marginalised communities suffer more – especially so called Dalits, other backward classes and tribes, poor, single, old, adolescent, physically challenged and sex workers."[83] Women in Afghanistan, Bangladesh, India, Papua New Guinea, the Islamic Republic of Iran, and Sri Lanka have very little access and ownership to land. Equal rights to property remain stalled in many cases across the region due to a lack of social support in patriarchal society for encouraging and ensuring the implementation of transferring property to women.

Despite all evidence pointing to great gender disparity, so entrenched that it seems insurmountable, there is little effort for investing resources in getting close to the heart of what this form of social exclusion really entails. It is no surprise that there is zero acceptability of sex workers, and of third gender individuals. Their repeated failures at accessing credit facilities, accommodation, jobs, admission to memberships for sports facilities etc., over time demonstrates a truth which we may not wish to see – mainstream society succeeds in almost obliterating the differences that make us what we are – a humanity that has not deserved the fruits of development. Rights and entitlements are not a privilege, they are mandatory.

Violence against Women: As per the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), accepted by South Asian States, women have the right to the highest attainable standard of physical, mental and reproductive health. Such rights have a direct relation to the women's right to life and liberty. "According to the decennial Indian census, the sex ratio in the 0-6 age group in India went from 104.0 males per 100 females in 1981, to 105.8 in 1991, to 107.8 in 2001, to 109.4 in 2011. The ratio is significantly higher in certain states such as Punjab and Haryana (126.1 and 122.0, as of 2001).[84]

"Prevalence of violence against women by their male partners remains high in Asia-Pacific and national surveys find the incidence varying from two in three women in Papua New Guinea; one in four in Viet Nam; and one in ten in the Philippines. Domestic violence extracts billions of dollars from national economies, in part through greater health burdens on healthcare systems and lower productivity," says the Asia Pacific Human Development Report. According to a World Bank study quoted in the Report, it is estimated that 5% of the disease burden for women between the ages of 15 to 44 in developing countries is from domestic violence and rape alone"[87]

A majority of those interviewed by ARROW underscored rising violence against women and stated that there is added patriarchal endorsement by religious fundamentalist groups. Despite the key global milestones achieved in addressing violence against women: the Declaration of Violence against Women adopted by the General Assembly in 1993; the appointment of a Special Rapporteur on Violence against Women in 1994; the Beijing Platform for Action in 1995; the adoption of Security Council Resolution 1325 in 2000; and the General Assembly Resolution on "Intensification of efforts to eliminate all forms of Violence against Women" in 2006,[88] there has been insufficient accurate data on violence against women as much of it goes unreported, particularly domestic violence, sexual abuse of children, sexual harassment at the work place, and violence against women among people in highly vulnerable contexts (mentioned in Part 2) and those in sectarian remote rural groups.[89]

Worldwide, there are serious gaps in exercising the rule of law when it comes to violence against women. According to the UN Secretary-General,[90] in "89 countries had some legislation on domestic violence, and a growing number of countries had instituted national plans of action. Marital rape is a prosecutable offence in at least 104 States, and 90 countries have laws on sexual harassment. However, in too many countries gaps remain. In 102 countries there are no specific legal provisions against domestic violence, and marital rape is not a prosecutable offence in at least 53 nations."

In India, the National Bureau of Crime recorded official figures of 2,13,585 registered cases in 2010 included Rape, Kidnapping & Abduction, Dowry Death, Torture, Molestation, Sexual Harassment, Importation of Girls, Sati Prevention Act; Immoral Traffic (Prevention) Act, 1956; Indecent Representation of Women (Prohibition) Act, 1986; and Dowry Prohibition Act, 1961. "The crime against women has increased by 4.8% over 2009 and by 29.6% over 2006."[91] The overall India figure in 2010 for total number of registered crimes is 23,25,575.

Political Power: Women are under-represented in national and local politics in almost all Asian and Pacific countries. Women occupied 30% or more seats in their national parliaments in just two Asian and Pacific countries, Nepal and New Zealand, in 2010. In China, "[a]mong chief leaders, men occupy 83.7% and women occupy 16.3% in urban area, and in rural area, men occupy 97.5% and women occupy 2.5% only."[92] "While India shares the 105th position with West African country, Cote d'Ivoire, it is ranked 85 places below Nepal and 53 places behind Pakistan. Even China at 60th spot and Bangladesh at 65 are well above India, according to the IPU data that are based on information provided by Parliaments by December 31, last year. Only Sri Lanka and Myanmar are the neighbouring countries which are placed below India at 129 and 134 spots in the list, respectively."[93]

Acquiring Political Power: A route for concerted mobilising for social change

The profiles on various aspects of women's lives in the Asia Pacific Region glimpsed at above only reinforce the drastic nature of social discord, torture, and inhuman status that women endure, all too silently, lasting for several decades, generation to generation. It is a matter of powerlessness by way of which enslavement of women continues. Development of a critical mass of political power is necessary to shift the balance of scales in favour of women acquiring their rightful position in society.

Despite large numbers of women's movements struggling for women's rights, women's presence in the political sphere of elected governments remains bleak. Women in the Asia Pacific region at the most local levels have asked foundational questions such as, "What does it mean to have political equality and to have political rights?" Everybody has the vote but so few exercise it in terms of the long term nature of citizenship participation. The vote determines the political fate of the society and yet there are several determinations and there are several reasons for societies deciding on the levels of inequality they are willing to accept. The figure of 33% (India) as a minimum for reservations will appear as arbitrary as any other figure, unless, one is willing to settle for full equality of 50%.The democratization of policy-making has itself not become a reality.

Empowerment is not just an innate potential that is brought into realisation. The empowerment of one subjugated group does mean the disempowerment of another elite group. Are we white-washing a more serious, endemic problem? Does the constitutional guarantee of political presence in Parliament mean that it can be realised given the present state of affairs? In the Afghanistan case, despite a high percentage of women's participation in Parliament, little has happened to alter the chronic condition of women living in poverty and conflict situations.

Does the guarantee of women's active and informed participation, however, pave the way for an acceleration of the emancipation of women? Yes, we believe so if this is time-bound and backed-up by supportive programs. Laws without teeth cannot be reasonably effective. The distribution of power and inequality need counter laws which affect the larger economies and policies whose repressive tactics are felt deeply by the vulnerable.

All the problems of gender inequality, historical discrimination of deprivation status, and of being condemned to 'backward' castes from birth need to be raised as issues in electoral debates and this is a firm route for keeping an issue alive in the public consciousness. We have seen how the mooting of various rights advancing bills has provoked visceral reactions in the upper castes and in men because their deeply hidden assumptions of domination as a way of existence get touched. When naked self-interests are involved, women's movements have found that it is very difficult to convince powers that be that the endemic problems of an unequal social life do not warrant further procrastination. The laws of self-interest make social catharsis a difficult matter, insurmountable almost to overcome.

Social catharsis calls for beliefs and practices to be governed by the premise of full equality, not a premise that accepts inequality and yet attempts to 'alleviate' distress. Reservations are no magic bullet because social change calls for deep transformative processes being unleashed at various levels, from beliefs to community perceptions to institutional reforms. At every level, women's organizations have found that they have had to encounter raw self-interests of dominant communities.

In India, the reservation of 33% seats for women in Parliament and the state assemblies is just the beginning in women's determination towards changing national policies which affect employment for women, education and health budgets, agricultural policies that are pro- poor and the overall investments that break caste, class and gender divides. Political parties are used to gaining political mileage by using women as token representational forces which finally breeds a patriarchal political system. When it comes to legislation favouring women, the male establishment drags its feet as is evidenced in India.

Rape Laws, Anti-Dowry Bill, Maintenance Act, Child Protection Bill, etc have taken years of campaigning by women's groups, huge time lags from the time of placing the issues with the public till the chain of social change, has touched enough social collectives to warrant elected representatives to guarantee passage and then implementation which is time consuming, often reducing the victims of abuse to further abuse.

Most of the Asia Pacific countries have enjoyed over or almost sixty years of independence from colonialism but the usurpation of women's rights to determine a socially inclusive society has remained a distant goal. Time bound programmes to accelerate women's entry into politics and leadership in public

policy is an investment that has few contributors. Massive illiteracy for women, poor overall HDR and GDI rankings ensure women's earned income share to be a paltry amount. As administration managers, as professional and technical workers, as farmers, as entrepreneurs, etc., their incomes remain negligible with wide disparities in overall wealth.

As homemakers, their contributions to the household incomes and to the GDP of the nation remains devalued, reducing women's work to free labour. Indeed, the burden of welfare shifts to the family from the state and in the household to women. Hence, the political participation of women is a priority that cannot be underestimated. Without the knowledge of their experiences of work at all levels, all public passages of legislation and social change will remain without the learning of a gender-lens-driven change.

Progressive laws need firm implementation and this suffers from lags and procrastination of the political will. The vital catalyst is missing and this can only be equal political space for women in Parliament. No changes overnight can be wrought if men continue to rule by proxy. Decentralisation of power and finances is needed for integrated action to happen at the local level and reform at the national levels. The political class passed the 73rd Amendment in India, for instance, thinking that jockeying for power at that low level was not important.

However, in some states, the Bill brought about great changes for women members of Parliament, cutting across the party lines when they joined forces with elected leaders at the local level to bring about changes which revolutionised women's spaces in the development story. (The reserved seats for women are on a rotational basis and do not preclude women from contesting other general seats raising fears of too much political space going to them.) The right to equal pay for equal work, access to land and food resources, right to abortion, maternity benefits, and counselling, have not been without their struggles and remain largely unfulfilled. The political parties that have given lip service to women's causes have sidelined women in their own parties.

Box 3: Women and labour force

"In some regions, women provide 70 percent of agricultural labour, produce more than 90 percent of the food, and yet are nowhere represented in budget deliberations."

"In Sri Lanka, food took up to a quarter of migrant women workers' wages in 2008, so women since then have reduced their meals from three to two times a day and/or reduced the quality of their diet in response to declining wages and dramatic increases in the costs of basic necessities."[94]

Needed is the creation of a solid electoral power constituency among women. Women are the single largest 'backward group' in the country cutting across caste and class lines. Political empowerment of women, strongly and democratically delineated for the first time in the country, signals the entry of large numbers of women into local-level politics. Social dimensions of gender equality injected into the political governance of the country will reproduce intergenerational equal justice systems. Women are inhibited from entering state and national politics because of factors such as distance, domestic burdens, lack of family and community support, and lack of confidence resulting from a lifetime of inherited neglect and prejudice.

Political parties are failing to create an enabling condition. There is an increasing criminalisation and corruption in the social whole monetises of the electoral process. Patriarchy is reproduced in Parliament when it comes to gender concerns. The quality of parliamentary participatory democracy has reflected the absence of a co-equal participatory democracy.

Is it any surprise that the factors that reproduce poverty, resulting in large scale and deepening hunger, nutrition deficient food, and poor SRHR services for those outside equity transactions, rarely feature in Parliamentary deliberations? This bias percolates sharply into social formations ensuring that as long as constitutional guarantees are side stepped as 'gender concerns' and therefore, as soft options, the iron grid of powerlessness reduces the availability of a much needed poverty free social reality.

However, in the last instance, it may be noted that the cluster of critical variables that form the whole of SRHR will need special sensitivity to know that even fairly equal societies will need that extra step to understand what happens to women's lives at the intersection of the political and the personal.

Capability Building for politics and public discourse have been conducted right across several countries in the Asia Pacific region, notably in India, Nepal, and Sri Lanka. These have included sharing of power and information, optimising participation in grassroots democracy, confidence building, developing leadership qualities in civic and political rights and responsibilities, the meaning and scope of development, of village as an integrated unit, decentralized administration, working of the development machinery, political sensitization, political literacy, awareness of political systems, fostering of community and social values to build value-based politics, mock sessions of the gram-panchayat: community, class and caste-based biases, financial accountability, need for planning, gender and burden of domestic responsibilities and in transformative politics, determining how democracy can create spaces for the widest possible participation of all.

Unless and until women are in the forefront of decision making at all political levels, there will only be incremental change in women's lives as they try to overturn the present realities of bearing the burdens of poverty, lack of food rights, and equity in SRHR matters. The rights and entitlements sphere of a democracy can be enlarged with increased participation of women in politics. In sum, what many women are asking for are constitutional guarantees and their sovereign rights to function and identify as citizens.

There are no simple linear solutions. We have to force the pace of change so that the indivisibility of poverty and gender parity is recognised and structurally, the barriers are removed. Development Justice must be seamless and inclusive. Those who have been denied rights need to be on the political platform to create that guarantee of rights and entitlements.

How to bring this into effect? In the concluding section, we attempt to develop a praxeological model of recommendations stemming from the issues and the critiques built around the major problems articulated in this paper. The recommendations to governments and civil society organisations have drawn heavily from the interviews conducted by Sai Jyothirmai Racherla of ARROW and myself. These have been provided in Part II, "Narratives from the Field".

The concluding section of this report and Part II, together, provide strong field-based recommendations that respond to the need for structural changes, refusing superficial responses which remain short term.

We recall the message that has been consistent in this report: sustainable development, poverty eradication, gender equity, and health equity are long term goals which cannot be postponed. They are intimately connected to collective social will for a genuine democratic framework of governance. Without a political will and normativeness that form the bedrock of social change, it will not be possible to reach any of the goals that have been set in internationally agreed declarations. Hence, we make no concession on the first set of public and normative policy provided in the last section because they alone can guarantee the meeting of the recommendations suggested for each issue.

5. ISSUES AND RECOMMENDATIONS: POVERTY, FOOD SECURITY, GENDER, CITIZENSHIP AND SRHR - BUILDING DURABLE AND SUSTAINABLE ALLIANCES

"I would define politics as the composition of a common world."
- Bruno Latour

" The policies that are key to bringing about change are those that emphasize the empowerment of women as decision-makers in the interest of social justice; sustain and enhance the livelihoods of the poor; respect the rights of indigenous people to the benefits of own knowledge; respect diversities of race, ethnicity, gender, sexuality and faith. These are precisely the ones that continue to be ignored."
- Peggy Antrobus, founding member and former general coordinator of Development Alternatives with Women for a New Era (DAWN), Barbados

"In order to establish the right relationship to the present – to things, to others, to oneself one must stay close to events, experience them, and be willing to be affected by them and to affect them."
- Michel Foucault in Choices

Lack of gender parity and socially non-inclusive development constructs in contexts of progressive and deepening poverty, have hindered the needed progress that is humanising and socially just.
If during the last sixty years and more of the emergence of the modern state where the welfare needs especially health, education, housing and shelter, and food security for the vulnerable are part and parcel of state obligations and commitments continue to remain still the most needed with the least priority, by and large, it is clear that systemic and structural changes are required. The time has come for some serious introspection and for some drastic shifts in public policy. Has the experience of minimising the role of the state during the reform period been beneficial to the poor?

What was the response of civil society in issues of public health and in auditing the accountability of the state as it promoted health not as a public good but as a 'market driven well'? How is the decentralising of health policy to be achieved so that it works closely in overall poverty eradication efforts? "It is clear that the gruelling data of existing poverty in the country has completely influenced the profile of ill health.

Chen and Das Gupta (1996)[95] contend that health and poverty may be presumed to share a 'synergistic and bi-directional relationship, wherein poverty exacerbates ill health and ill health diminishes labour productivity...the close linkage between ill health and economic poverty is generally accepted, but we know much less about the reverse direction in the health-poverty relationship'."[96]

The dangers of not taking into account the complexity and the interconnected nature of social existence will be a challenging and critical area of work as poverty, health and social development closely interconnect influencing the overall arena of social equality. The Asia Pacific region represents one of the singularly greatest challenges for all those struggling to connect the personal, the political, and the grassroots approach in understanding the lives of the affected at the level of the community, and nation. As pointed out, so large are the gaps that the most singular challenge will be to attempt to build a critical engagement which will help bring the SRHR movement and its goals into the central work of the poverty eradication efforts, national, local, and regional.

Achieving equity in this region is a journey fraught with difficulty as there is little political will to achieve the goals of SRHR in equal access to care, equal utilisation of health care. SRHR needs to be understood and valued as a platform for surfacing all those unmet needs that all other citizens require for survival. The role of the state and its commitment towards achieving 'health for all' has become distant with time thanks to sweeping liberalization reforms worldwide.

"The policy implications of the present context of unmet needs and the confluence of variables have prevented the poor from living in a state of well being. We underscore the issue of strong and continued public action for securing the right to health."[97] Therefore, it is crucial to do some foundational thinking of reversing negative trends by constructive critique-based future action.

Issues and Recommendations
The issues stated below are drawn from the overall study, the frame of reference being the introduction and the ensuing sections and most importantly Part II of this study. This important section is divided into the broader rubric of the overarching standards that are needed to bring about social change guided by democratic values, equity and gender sensitive considerations.

The recommendations to governments and civil society organisations echo almost all the recommendations of the interviewees, bringing them full circle, an enquiry that was guided by the wisdom and voices of several leaders who have dedicated their lives to the causes that this paper explores and hopes to further in real social change.

A. Public Policy & Normative Standards

1. People in decision making and powerful positions often give responses which reproduce similar biases, reproduce world views which create an hierarchisation of world views, of the perception of needs in society, replacing one set of values through another set, values which favour the markets, distort the values of those who have suffered discrimination and rejection in both material and non-material terms. It is important for all development theories to ensure that they do not deform the sense of a common social value and purposes and these theories of change must come from people living in poverty and most vulnerable constituencies as outlined in study.

2. Fragmented perceptions of the social good result in fragmented relationships within the household, within the community, and within the country. Hence, an integrated public policy needs to be drawn up which are inclusive of basic needs, and sexual and reproductive rights and health care.

3. The idea of the public goods framework offers hope to the poor in a country to receive protection from the State in terms of basic services, fulfilment of basic needs and all other citizenship rights. Hence, it is important for the platform of poverty eradication, be that in the areas of health, education, and right to food to ensure that there is a close interaction with all SRHR goals.

4. Growing privatization restricts and curtails the role of state in guaranteeing health, education, food, employment, and shelter. Poverty and its attendant set of inequalities grow reducing the access and enjoyment of all rights related to basic needs and citizenship rights as guaranteed in the Constitution. The SRHR platform must hold primary the politics of working in such conditions of denial of basic rights and respond, therefore, with sensitivity to these contexts.

5. Divisive worlds are created in an already fragmented society where the poor risk indebtedness of an overwhelming kind just to receive health care. In this context, is it any surprise that women who are at the bottom of the ladder for receiving state protection *vis-à-vis* services, health and education, food, and equal employment suffer the consequences of privatisation, deregulation and the marketisation of health care? The SRHR platform can be developed on the lines of it being a non-exclusionary significant part of the overall development agenda for poverty eradication. Given the nature of large numbers of people left out of development recognition - women in poverty, transgender people, and people living with differing disabilities, children and the elderly just to name a few constituencies.

6. The bare truth about inequality is that the most vulnerable remain the most denied. The weight of scarcity conditions include the multiplications of burdens for those without the capabilities of health, education, access to food, labour participation on equal and fair terms, political participation, and the enjoyment of citizenship. The idea and the reality of full citizenship is an area of work that can be shared by SRHR and poverty eradication social movements.

7. The Issue of Scale: Everyone needs food, employment, education, and health coverage but millions of citizens across countries, below and just above the poverty line, cannot pay for them and do not have the skills for employment. SRHR coverage criss-crosses these rights and unites the rights and the entitlements perspectives, this expands the scale of advocacy and broadens the overall struggle for emancipation.

8. In order for services to be effective, they need to begin at the local level. Public policy is a macro issue that needs to percolate at all levels. The international regime reforms all processes from food to health to education when national governments are willing to make the necessary changes. The issue of empowered public action at the local level needs to be taken to the global level after successes at reform of the national level. This has proven to be impossible. So powerful are vested interests that many civil society actors give up on up scaling their work for covering larger population bases and do not engage at the national and international level. The funds required are massive and most governments are weak and politically not willing to demand sovereignty of a kind which will empower the poor, especially women.

9. Gender ethics and development ethics are the present lack of values in society which have been outlined by many speakers in the ARROW interviews. We feel this also leads to a lack of an inner compulsion for solutions. It maybe useful to set within the organisation, gender audit standards. All goals need to be redefined from these standards. It is not only a means and ends question. It has to do with "self and other" definitions in social relationships.

10. Equity: Civil society organisations (CSOs) state that growth led economies, today, are extinguishing "vulnerable-led economics." What is SRHR platforms' gendered criterion for distributive justice? All CSOs must be able to take a holistic position and insist on equal

wages in their area and in their constituencies; land reforms, just ownership, formal equality and actual status need to be measured, understood and the gaps must be closed. Access and enjoyment are equally important. Every organisation must publically be able to keep their records on this; they must be able to show evidence that they consider equity as a principle to be crucial in improving the position of women economically, politically, socially, and culturally. The general iniquitous natures of gender relations force women and all vulnerable groups to bear the costs and lose the benefits.

11. All institutional development, and annual plans for implementation working in the area of poverty eradication must include the non-negotiables of SRHR just as those in the SRHR platform need a keen understanding of how they may include these perspectives in the agendas of wider anti-poverty struggles. **The idea of 'well-being as social change" provides seamless territory for integrative planning.** It is easy to write and 'include' gender/alternative sexuality group dimensions in the analysis of society and in annual plans for donors, collaborators and the public, and also take positions but it is another matter when one has to 'instrumentalise' and embed these rights and needs in everyday work.

12. We underscore the manner in which inequalities reproduce power relations. Deep poverty creates further vulnerabilities and women, when poor, endure the hardships of a callous existence where their dignities are violated all the time. The very people who provide nourishment and care to society today remain invisible in all decision making positions and have no standing in the command of wealth, structures, and politics. There are so many narratives of the way women are side-lined even within the progressive, established NGOs and religious institutions that observe gender equality in their perceptions, and actions, are often unable to really live out the issues of gender equality. If the SRHR platform begins this work, the greatest beneficiaries will be everyone, not men or women but socially excluded groups can come together as united and freed communities. The will is there but it needs much concrete work before one can see the tangible results. The gender sensitive platform of SRHR is ideally suited for raising issues of women's freedom and agency. If this is not urgently done there will be little hope that another 60 years from now things would have changed for the millions of women who are now missing, and at risk from birth to death.

13. The Beijing Platform for Action and the ICPD strongly remain inclusive documents as the basis of a framework for greater cooperation, a cooperation that can lead to enhanced citizenship for all outside the sustainable development story. SRHR is emancipating and equalising if fully implemented, and brings to the table, values which remain central to the social justice agenda of poverty eradication.

14. There needs to be a strengthening of public associations at the grassroots that remain in history and voice that is a representation of the larger will. The nature of partnerships needs to be driven by a higher order of developmental values and the needed pragmatic steps to live harmoniously on this earth, where severe imbalances and disparities, require pragmatic solutions.

15. Gender disparity in both health and education are evidenced clearly in all data that is available. This includes both access and enjoyment by women of education and health access. Our paper on education and child labour refers to these issues in education, especially among girl children and dalits. Organisations need to work on social exclusion in these critical areas along with other CSOs and governments to ensure that entitlements, access and enjoyment are without gender and caste biases. Cooperation and conflict mark all work with the States but it is in the social welfare sector where large funds of governments are spent and these must include the participation of CSOs. SRHR activists need to be alert to ensure inclusive planning in state driven social sector work because it is an area where influence is needed. Often between different agencies and line ministries SRHR related perspectives get lost.

16. Multilateral parties engaged with national governments must be involved with CSOs of the SRHR platforms in helping to support the up-scaling of successful efforts at alliance building in the Asia Pacific region. China's remarkable universalisation of health care deserves great attention in the region in terms of government budgeting, the manner in which local healthcare services are being provided, the policies on drugs in public healthcare and the public private partnership. The responsibility and the nature of joint commitment of aid institutions to the multiple crises in society can only be postulated on value-drivenness and not value-neutrality. Given the heightened interest in India on the side of the Indian government to bring in the universalisation of healthcare, the time is opportune for the coming together of major social movements and smaller coalitions to work with the government on an integrated health and development service delivery operations in the country.

17. Most of the formations in civil societies across the region are issue-based while some broader social movements have chosen to walk the journey of membership bodies, loose networks or platforms which support unions in the informal and formal sectors so that they have clarity on the resistance, the campaigns, on building a membership base etc. Distributive justice issues, women's wages, labour conditions, recuperating the commons by community, and the engendering of all land reforms to ensure gender justice in group rights are some of the issues they work on. The cluster of issues that SRHR has come to be identified with touch upon a large number of survival issues. Economic rights are common to all citizens and often, as in the case of members of alternative sexualities, it is their identity that forces them to be income poor.

B. Recommendations to Governments:

1. Guarantee a basic minimum primary healthcare for all till the universalisation of health becomes a reality.

2. Bring healthcare services to the people, rather than people going for the services. For example, community birthing services.

3. Start planning from BELOW. Women need to be actively involved in all planning processes.

4. Focus on discrimination against women, which is the fundamental root cause of the failure of public services; the lack of respect for women's labour within the family; and the growing violence against women including by state authorities in charge of rule of law.

5. Ensure women's rights to sustainable development and livelihood in all planning process in the agriculture, environment and labour ministries.

6. Ensure that gender sensitive planning processes are a primary non-negotiable. Gender analysis is critical in health research and interventions. Discrimination based on gender has many poor outcomes for girls, adolescent girls and eventually women. Awareness needs to be generated on issues of gender, and girls, adolescent girls and women cannot be ignored in health interventions. For example, diarrhoea affects both girls and boys, and yet, girls are more affected, including resulting in mortality. The dimensions of gender have to be examined carefully at household and health system levels.

7. Ensure interaction between community and health systems. It is the notion that doctors know everything and communities know nothing that needs change. A powerful strategy would be to increase and encourage local community participation. All government health mission staff need to be trained to work with communities of health givers.

8. Make compulsory placement of young doctors in rural areas for a certain period of time. This policy ensures that health personnel are present in rural areas to cater to the rural people's health needs. Young doctors often do not want to go and work in rural areas resulting in the critical deficit of doctors in rural areas; very few young doctors work in rural areas, even when they themselves come from poor places - the State policy will ensure that every doctor spends time working with poor communities before being promoted.

9. Ensure that health and access to food are rights! Governments need to recognise country priorities and work seriously at eliminating an increase in setbacks to general health which is preventive in nature. For instance, the very high rates of NCDs cause premature deaths in Fiji and in the Pacific. The increasing rates of heart attacks and reproductive cancers – breast, ovarian – in the general population is just beginning to recognise the importance of living a healthy life and the right to health and access to food is just beginning to take root.

10. The blurring of lines of citizen and corporations needs study. The case of United States where corporate personhood is the legal concept that a corporation may sue and be sued in court in the same way as natural persons. This provides a legal recognition that corporations, as groups of people, may hold and exercise certain rights under the common law and this sort of development will be detrimental to protect the rights and interests of citizens.

11. Changes in the mindsets of UNFPA are required. UNFPA needs to take a strong leadership role on issues of SRHR at the national and the regional level. UNFPA has to be proactive in steering and supporting the provision of rights-based SRHR information and services at the national level.

12. The corporate social responsibility approach needs to be studied to bring resource support for the initiatives but this must not mean increased privatisation of state duties.

13. Bring to fore and mainstream the rights of women and their entitlements to health and reproductive rights in all the work carried out by women's groups and NGOs when there is cooperation with government.

14. Ensure entitlements in economy and politics for women to be realised; a legitimate space and support for women to pursue education, and access to economic and political opportunities is critical to move the agenda of women forward.

15. Women deserve equal share in natural resources. Whatever resources are generated from the natural resources, a percentage of that revenue has to be contributed towards women's development; investments in public education, right to food and right to their reproductive health.

16. Budget analysis from gender perspective needs to be implemented, in addition to, the actual implementation of laws and policies promoting women's empowerment.

17. Include in all budgets and planning exercises SRHR goals.

18. Ensure access to free, safe, effective, affordable, and acceptable methods of fertility regulation of their choice.

19. Provide appropriate health care services for pregnancy, childbirth and other related services such as food security and employment.

20. Provide all SRHR services for all vulnerable populations needing additional support and care inclusive of counselling.

21. Provide to populations below poverty line access to broader social security services such as housing, ration cards, employment, participation in political processes, and voter cards.

22. Ensure state policies that promote pro-poor sustainable agriculture and ensure subsidy in highly destitute populations. Food subsidies must reach the people without a downscaling of quality grains.

23. Sufficiently well-oiled decentralised operations which connect agricultural policies with farmers' associations, local administrative services, pubic distribution systems, community associations, and food trading outlets - the food chain must reflect the pathways of food choices in agriculture.

24. All basic needs frameworks need to take into account major consumption habits which keep hunger inside homes.

25. Women and the elderly often suffer the backlash of failure of nation states to provide subsidized food to the poor. Engendering the food security issue is a basic necessity for engineering social equality in consumption.

26. Privatization of sustainable agriculture has forced consumption by the poor to mimic the volatility of inflation induced food prices. Food pricing policies need to be in place so that farmers are protected from volatile market fluctuation and uncontrolled export of food grains which are needed in the domestic markets.

27. The two Covenants of 1966 – UN covenant on civil and political rights and the UN covenant on economic, social and cultural rights span the tangible essence and the intangible rights of human beings. These can be the basis for reviewing the policy focus of SRHR when building alliances with social movements in the areas of human rights, sustainable development, and GLBT, transgender and HIV+.

28. The entire human rights and governance community received only 1% of all development assistance. Much higher financial investments are crucial for opening up the SRHR and poverty joint platforms and up-scaling more integrated work to solving the present lags in achieving the ICPD, MDG goals.

29. Multilateral parties engaged with national governments must be involved with CSOs of the SRHR platforms in helping to support the up-scaling of successful efforts at alliance building in the Asia Pacific region. China's remarkable universalisation of health care deserves great attention in the region in terms of government budgeting, the manner in which local healthcare services are being provided, the policies on drugs in public healthcare and the public private partnership. The responsibility and the nature of joint commitment of aid institutions to the multiple crises in society can only be postulated on value-drivenness and not value-neutrality. Given the heightened interest in India on the side of the Indian government to bring in the universalisation of healthcare, the time is opportune for the coming together of major social movements and smaller coalitions to work with the government on an integrated health and development service delivery operations in the country.

C. Recommendations to Civil Society Organisations:

1. Civil society has to work closer together. Organisations such as SAAPE and many other active networks have to come together and start working, CSOs have to start taking action not just talk about the issues; Civil society strategies need to be implemented; Workable initiatives/ strategies by civil societies need to be scaled up by governments.

2. Groups of civil society in each country in the region can come up with plans and also work towards regional policy and input for the region on various interrelated issues.

3. Apply pressure on donors and seek donor accountability on the outcome of their work in respective countries.

4. Start planning from BELOW. Women need to be actively involved in the all planning processes.

5. There is a need to focus on discrimination against women, which is the fundamental root cause.

6. Women and research organisations must use pilot studies and evidence to show governments that focus on the limited and efficient use of can bring great and significant difference to the health and well-being of the poorest families. Evidence shows that it is not expensive and resource intensive to save lives. Research organisations must carefully analyse the causes for the poorest women's anaemia and diarrhoea, this can benefit their health.

7. Gender analysis is critical in health research and interventions. Discrimination based on gender has many poor outcomes for girls, adolescent girls and eventually women. Awareness needs to be generated on issues of gender, and girls, adolescent girls and women cannot be ignored in health interventions. For example, diarrhoea affects both girls and boys, however, girls are mostly affected, including resulting in mortality. The dimensions of gender have to be examined carefully at household and health system level.

8. Encourage interaction between community and health systems. It is the notion that doctors know everything and communities know nothing that needs to be dispelled.

9. When organising the working class, addressing SRHR issues, the relationship between men and women, and the issues of violence are necessary as these issues are critical and everyday life is governed by these circumstances. Domestic violence has to be brought out into the open as well as the underpinnings of continued violence need attention in joint meetings.

10. Nutritional well-being and Reproductive Health are what labour movements are fighting for. Well-being, dignity, and bodily integrity are critical issues around which mobilisation should be done; addressing these issues are part of the goal.

11. The donor agenda which is now more focused on monitoring and evaluation, forgets that we are dealing with people, human beings with diversity. All interventions are number driven, target approaches dominate - "reaching so many people within so many years." There is a need for a shift in this approach to include a human-rights based approach with respect for people, going beyond quantitative targets alone.

12. When it comes to programme interventions, the standard and uniform strategy with little room for diversity and needs and rights of people should be set aside.

13. The need to reduce stigma and violence towards sexual minorities is a priority, followed by ensuring their economic rights are fulfilled and protected.

14. Integration of sexual minorities within broader social movements is critical. The need to include class issue analysis and other intersectionality analyses are to be included while working with sexual minorities.

15. Constitutional rights have to take precedence and dominate the discourses to protect everyone including sexual minorities.

16. Important to enter into male dominated spheres to discuss SRH – men as partners! The work that is underway is largely on SRH with very little formal connection to issues of poverty and food security. At the present moment, it is necessary to establish basic awareness levels for all facets of SRH - FP, sexual health, reproductive health, gender/sexual violence, services and commodities and their uptake. Doing a stock-taking of where we are at compared to the active SRH agenda of the 1940s-1970s. For example, levels of knowledge on FP methods, services and commodities with communities are helpful. Addressing health professional's attitudes, knowledge and practices towards offering FP services and procurement is another useful action.

17. Organisations that work on poverty are quite few and mostly male dominated – efforts on addressing women and poverty have largely been based on micro-finance projects – handicraft and shops (something like cottage entrepreneurship) – getting women to earn a livelihood. The focus is not sufficient to drive towards the directions to adequately address women in poverty, and to fundamentally understand the root causes that are leading to the destitution of women.

18. There is very little (research, M & E activities, etc) being done to evaluate what is being paid for by money earned by poor women. From what is covered in the media, money earned subsidises the family income towards consumption,

education and medical bills. The efforts adopted by the organisations is largely geared towards the benefit of the family as a whole inclusive of the woman – “when the family benefits, the woman benefits as well approach” – and not the other way around; when the woman earns, she becomes empowered and her choices and decisions will improve standards of living for the whole family! Critical to foster original research on women’s labour and the generation of funds by poor women’s labour.

19. There are high rates of NCDs causing premature deaths in Fiji and in the Pacific. The increasing rates of heart attacks and reproductive cancers – breast, ovarian – in the general population, is leading to the recognition of the importance of living a healthy life. The ‘right to health and access to food’ beliefs are necessary to ensure that local issues are lobbied based on local priorities.

20. There are very few organisations that base their work purely on SRH and rights! SRHR is often a small component in mainstream women’s organisations. Poverty issues are also included as small components in the attempt to address issues within a larger agenda. There is nothing written on the experience of NGOs tackling SRHR and poverty issues, simultaneously. Hence, documentation is needed of good practices which help all organisations to chart ways that fit with local realities but can achieve universal goals as in the ICPD.

21. The current development work is not going to bring any change unless a holistic development agenda is pursued, by getting groups out of poverty and by instituting systems that work for the 99% not just the 1%.

22. The blurring of lines between citizens and corporations needs attention. The case of United States where corporate personhood is the legal concept that a corporation may sue and be sued in court in the same way as natural persons. This provides a legal recognition that corporations, as groups of people, may hold and exercise certain rights under the common law and this sort of developments will be detrimental to protect the rights and interests of citizens. Clear distinctions need to be drawn.

23. The quality of health, education, safety, and welfare of people requires engagement of CSOs with local government officials, private sector and communities.

24. Early marriage is a major issue in poor areas in East Java, India. Fathers want to marry their daughters as soon as they are 11-12 years of age. Child Marriages need to come under the Rule of Law and civil society organisations must make this a priority area in their meetings with communities.

25. Peer education and trainings among young women and girls need to be carried out as these can go a long way in improving the lives of women and young girls.

26. Corporate social responsibility approach needs to be studied to bring resource support for the initiatives. However, this approach has to be treated with caution but it is not impossible.

27. The rights of women and their entitlements to health and reproductive rights should be mainstreamed in all the work carried out by women’s groups and NGOs.

28. Enable women to decide and exercise control over their fertility, the number of children they actually want to have, and address issues of reproductive health and morbidity, so that women can actively engage in productive work, participate in economic and political arena and move ahead to claim their agency.

29. Budget analysis from gender perspective needs to be implemented, in addition to,the actual implementation of laws and policies promoting women empowerment.

30. CSOs need to build strong secular policy frameworks and negotiate WITH religious and other faith groups and convince the need for convergence on basic entitlements.

31. Secure the needed food chain: sufficiently well-oiled decentralised operations which connect agricultural policies with farmers’ associations, local administrative services, pubic distribution systems, community associations, and food trading outlets must be built up as networks - the food chain must reflect the pathways of food choices in agriculture.

32. Gaps are there in data and it is necessary to get a better grip on the gender divides which stare at us in almost all walks of life everyday. The macro level data may not sometimes give society an idea of how women are being specifically affected. Hence, each organisation must have a profile of the situation of people living in poverty with a specific profile of gender development. The issue of gender disparity and discrimination needs to be applied across all vulnerability groups.

33. The growing feminisation of poverty: The SRHR platform needs to further intervene with case studies in this area of work from a SRHR perspective. How can this be understood at the micro-level and acted upon? Household dynamics are a critical area of observation and social change. The impact of poverty on gender discrimination is further aggravated in scarcity conditions. Gender based patterns of consumption and expenditure reveal the feminisation of poverty. Poverty and discrimination against women in patriarchy hurt seriously the well-being of women and girl children.

34. SRHR activists need to be alert to ensure inclusive planning in state driven social sector work because it is an area where influence is needed. Often between different agencies and line ministries, SRHR-related perspectives get lost. Gender disparity in both health and education are evidenced clearly in all data that is available. This includes both access and enjoyment by women of education and health access. Organisations need to work on social exclusion in these critical areas along with other CSOs and government to ensure that entitlements, access and enjoyment are without gender and caste biases. Cooperation and conflict mark all work with the States but it is in the social welfare sector where large funds of government are spent and these must include the participation of CSOs.

35. Feminisation of Poverty: Gender and migration need also to be tracked given at the macro level the large shifts that are occurring in severe social injustice caused by distress led migration. Female-headed households are on the rise and women bear the brunt of it in the Care domains. CSOs must bring this into their work and alert the country on what is really happening. Communications and media are crucial in this work.

36. Trainings needs to be strengthened with strong world views - the work by Sen and Nussbaum[98] on the uneasy relations between individual and group rights in the context of gender, affirmative action, and the capability index is helpful for drawing up simple charts of integration of needs and perceptions within diverse communities. The gender inequality index of the UNDP is also worth using along with HDI indicators for baselines of common measures.[99]

37. The two Covenants of 1966 – UN covenant on civil and political rights, and the UN covenant on economic, social and cultural rights span the tangible essence and the intangible rights of human beings can be the basis for reviewing the policy focus of SRHR when building alliances with social movements in the areas of human rights, sustainable development, and GLBT, transgender and HIV+.

38. SRHR platforms can contribute substantially to the quality of democracy by engaging on promoting citizenship rights and participation among the vulnerable groups. Organising meetings between affected groups and locally elected officials is important for amplifying the SRHR agenda inclusion and influence in local administrative decision making.

39. Demand for increase in financing. It is legitimate and needs to be done. The entire human rights and governance community received only 1% of all development assistance. Much higher financial investments are crucial for opening up the SRHR and poverty joint platforms and up-scaling more integrated work to solving the present lags in achieving the ICPD, MDG goals.

40. Strengthen public associations at the grassroots level that remain in history as the voice and the representation of the larger will. The nature of partnerships needs to be driven by a higher order of developmental values and the needed pragmatic steps to live harmoniously on this earth, where severe imbalances and disparities, require pragmatic solutions.

6. CONCLUSION

Lastly, “power is not a centralised monolithic force with an inexorable and repressive grip on its subjects. It is diffused, heterogeneous and a productive phenomenon. There are the sub-cultures of authority, discipline and control.”[100] How do we stop re-enforcing the same iniquitous power relations in human development? Only alliance building, which is committed to transparent relations with the affected for the causes that are shared, can succeed in bringing social transformation which is lasting and which profoundly affects people as individuals and as members of their communities.

Deeply social and existential problems do not deserve instrumentalist and poor quality technical solutions. In the last instance, the SRHR platform because of the rights to care, health, gender parity and identity brings poverty eradication efforts, and chances for collective well-beingness for wider constituencies of the socially excluded. We have attempted to locate the inextricability of poverty, SRHR, food security, and a nature of citizenship which responds and participates in the equity governance of all these issues. Building durable and sustainable alliances while working through these issues guarantee their realisation for millions left outside of development rights and entitlements.

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PART 2

POVERTY, FOOD SECURITY, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS:

INTEGRATING AND REINFORCING STATE RESPONSIBILITIES, INTEGRATING SOCIETAL ACTION: NARRATIVES FROM THE FIELD

BY SHOBHA RAGHURAM AND SAI JYOTHIRMAI RACHERLA

SEPTEMBER 2012

ARROW, Malaysia
The Asian-Pacific Resource and Research Centre for Women (ARROW) is a regional non-profit women's organisation working to promote and defend women's rights and needs particularly in the areas of health and sexuality, and reaffirms their agency to claim these rights.

PREFACE

In this rare experiential mode of sharing, nine senior and much respected development activists and academicians provide self-portraits of their work, ideas, struggle and activism in the areas of poverty and/or food security, and/or sexual and reproductive health rights. They describe their work in civil society which has bearing on the issues that Part I of this paper elucidates. They reflect whether there are organisations working on poverty issues in their countries, in particular and Pacific countries, in general, and whether there is sufficient focus on how poverty affects women. Moreover, they relate to us whether the context of the right to health is linked with the right to adequate food. Here in this text, they share with us their involvement in social movements including the SRHR movements and reflect on whether this has led them to also determine the agenda on combating poverty.

The broad format for the dialogue (see Annex 1) was circulated by Sai Jyothirmai Racherla to all the interviewees and used with their consent. The Skype conversations conducted with the authors (in India and Malaysia) and the interviewees in their home countries sometimes lasted almost an hour, and these conversations were intense and involved relying on a co-constructivist approach which would provide a platform for serious partnership dialogues, well after this publication.

Many were trusting and open enough to explain the dilemmas faced by SRHR organisations when they work on issues of poverty eradication and vice versa. Many spontaneously provided us a list of recommendations based on their field work, their extensive engagement with their own government, international agencies, and other alliance networks for the furthering of the agenda for an integrated perspective and activism. Some of our 'authors' wrote to us in response to the notes prepared by Sai Jyothirmai Racherla, thus, 'thickening' the text with their additional observations.

Last but not least, it should be underscored that Racherla and I have tried to listen to people engaged in the field allowing them to dictate the terms on the overall political and social changes that are needed to bring greater convergence of values in the kind of developmental action and worldviews needed. The recommendations suggest massive investments in grassroots efforts, State commitments for universal health coverage, bottom-up planning, strong gender equity concerns to be fruitful, and wholehearted public involvement and support to be solicited.

A major priority is alliance with strong coalition bodies that can command the direction of development itself which is needed for a future where the vulnerabilities of millions in this region need to be reduced. Livelihoods need to be assured as part of respected citizenship commitments.
We are grateful to ARROW for the opportunity to work on these issues with the ARROW team. "Narratives from the Field", co-edited with Sai Jyothirmai Racherla has been presented to the public using the co-constructivist methodology in our discussions with all the specialists whom we had the privilege of dialoguing with.

To them we owe our gratitude. Sivananthi Thanenthiran, Director of ARROW, supported this work because of her commitment to pursuing these questions from a political and humanistic perspective, and much is owed to her perseverance with a dialogue that began long ago. My engagement with the South Asia Alliance for Poverty Eradication (SAAPE) and the extensive interactions with many of the members in this membership network have been a compelling resource for me to draw on the wealth of insights that people at the grassroots developed over years of work with communities living in hardship but never giving up.

REACHING FULL DEMOCRATIC RIGHTS

The situation in the Asia Pacific region speaks volumes of the erosion of much public sector services, of increasing poverty – lack of income, lack of entitlements which are rights and not social handouts, and lack of inclusive social perceptions, of equity in employment, and of equity access to all public social security with responses from respective bureaucrats who manage these services. Trickle-down theories on social benefits are being challenged by the numerous groups left out of development. The causal processes underpinning poverty and injustice, which result in the loss of real freedom for millions, require massive social changes, structurally, in the delivery of services and an increase in bringing health and education into public sector purviews.

There is a commonality of scarcity issues as expressed by a large number of the speakers in the ARROW interviews. Yet, interventions involve a serious lack of respect and understanding of the local, the needed diverse approaches. There are omissions of entire communities or partial acceptance which amounts to tokenism. Democracy needs full participation, not representational references. The instrumentalisation of the term, 'poverty', eliminates the people who live that condition. There is no other explanation for the continued social injustice in the region in a large number of the countries. The people, who remain supreme are excluded in unequal partnerships and power equations, decide on who may be the beneficiaries. The health status of the excluded is insufficiently recognised in poverty and wealth indexes, revealing a morality where there is no convergence in concerns leading to efficient incremental delivery.[1]

The interviews reflect serious anxieties in civil society about the state of social development, nationally and internationally. We have stated in the earlier section that very drastic changes are required to reform societies that thrive on distorted perceptions about large classes of the excluded. The conversations ahead of the reader call for the need to go beyond caste, class and gender. It is recommended that SRHR needs to be brought into all areas of the politics of care and citizenship issues to enable a serious capability building within mainstream institutions in respect of their weakness in understanding vulnerability and poverty. Indeed, the condition of poverty is an integrator in building a social movement for the unities of the vulnerable on basic needs, citizenship, voice, and participation. Unless we are able to expand the very definition and its coverage to include all those denied rights for livelihood and citizenship, the role and responsibility of the State in a democracy will be unconstitutionally diluted. All privatisation efforts will reduce the public sector arenas of education, health, food, and employment to becoming market driven and exclusive, therefore narrowing its outreach and availability, especially in contexts of expanding and deepening poverty.

Engaging in the highly complex world of deepening poverty where a larger number of constituencies remain entrapped, engulfed by social, political and developmental neglect, and apathy, it remains to be seen if the extremity, the sorrow and the injustice of poverty is ever experienced by the socially included, the policy makers in government, and corporate leaders. The latter is in a position with the government to alter the poor employment opportunities being faced by millions on the flipside of development.

The communities of the excluded poor are diverse, rich in their cultural knowledge, fully aware of the history of their inherited discrimination that has left them to struggle alone. Needed is official recognition that translates into entitlements immediately, received promptly by citizens and not by 'beneficiaries'. What needs to be broken is the notion of a class of people who live the conditions and of others who decide on their behalf. If this divide continues, a long history of the State's and people's efforts at winning freedom, building institutions, unveiling human capabilities and negotiating with external interventions and external realities will be set aside.

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1. AFGHANISTAN

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Afghanistan, with its history of at least two decades of armed conflict, war, and insecurity, resulting in a widespread poverty, has impacted the lives and well-being of all people of Afghanistan, especially women. While in the recent times we see certain developments for women such as the provision of gender equality in the new constitution and women holding 27.7% seats in the national parliament, these developments have not been translated into real changes in women's lives. Women in Afghanistan face serious challenges in terms of overall development in areas of education, health, employment, and the exercise of basic human rights, freedom, and protection from violence.

This contextual question above in relation to Afghanistan was put forward by Dr. Shobha Raghuram, and Mr. Dalili notes: Afghanistan is different from other Asian countries. In recent times, the constitution has provided a lot of opportunities for women such as 33% political participation and other provisions, however, women in Afghanistan live the worst lives ever compared to women in other parts of the world. More than 80% of Afghan women live in rural areas and suffer from violence, poverty, lack of food security, diseases, and women live under strong traditional customs and practices affecting them, disproportionately.

Norms of patriarchy, early marriages of girls, high fertility, and frequent births devastate women's lives, their health and well-being. Most women have a high fertility of at least 6-10 children. The women's lives in Afghanistan are impacted by religious extremisms and this is evident when Mr. Dalili cited the example of the recent shooting of an Afghani woman by extremist groups as they accused her of adultery in a village in Parowan province. "When men do anything, it is not a problem, but women are closely watched for the smallest error they make."[2]

"The main cause of conflict is poverty. There was big hope with the change in government that the lives of people would improve. However, this is a matter of shame for the government and civil society organisations alike in Afghanistan, where poverty has actually risen in the recent years. Almost 65% of people are living below poverty line in Afghanistan. It is a shame that billions of dollars in the form of AID

Table 2. Afghanistan : Key Poverty, Food Security, and SRHR indicators

INDICATOR	DATA
General Indicators	
Total Population (in millions)	32.4
Life Expectancy at Birth (2011)	48.7
Human Development Index(Rank and Value) 2011	172(0.398)
Inequality Adjusted Human Development Index	-
Income Gini Coefficient (2000-2011)	-
Population below income poverty line PPP$1.25 a day (%)	-
Gender Inequality Index	141 (0.707)
Women Empowerment and Sexual and Reproductive Health and Rights Indicators	
Maternal Mortality Ratio	460
Adolescent Fertility Rate (women aged 15-19)	118.7
Contraceptive Prevalence Rate, any Method (% of marriedwomen ages 15-49) 15–49)	18.6
Unmet need for Contraception	-
Median age of marriage(25-49	-
Violence against Women legislation	Law on Elimination of Violence Against Women 2009
Seats in National Parliament (% Female)	27.6
Labour Force Participation Rate (%) Female-Male (2009)	33.1- 84.5
Population with at leastSecondary education (% ages 25 and older) Female-male 2010	5.8- 34.0
Health Expenditure Indicators	
GDP per Capita PPP$	1,321
Total Expenditure on Health as percentage of GDP	7.4
Food Security and Nutrition Indicators	
Aneamia Prevalence in pregnant women(Proportion of the population Population with anaemia with Hb<110 g/L)	61.0
Under- Five Mortality Rate %	19.9
Population under 5 suffering from stunting (%)- wasting (%)	59.3 - 32.9

Source: World Contraceptive Use 2011; Respective Demographic and Health Survey using Statcompiler; Global Hunger Index Database; Human Development Report 2011; Trends in Maternal Mortality: 1990 to 2010. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. WHO 2012; UN Secretary General's Database on VAW; UN Data; Worldwide Prevalence of Anaemia (1993-2005)

has come to Afghanistan, but little has changed or improved. The current scenario is such that people do not have money, families are not able to survive, and take care of their basic needs. As a result, people are joining the extremist and militant groups. At the same time, women are not allowed to be seen openly, and this seriously limits their access to health services including reproductive health.

One of ways families address poverty is getting their daughters married young, early, and underage in exchange for economic gains (as low as 8000 Afghan currency). 60-70% of girls get married at a very young age, before sixteen, as a result of poverty."[3]

On the issue of education, especially primary education, there are high declining rates of education, poor public investments in the health sector and high out-of-pocket expenditures in health. Mr. Dalili commented: "From the time the government changed, they have introduced an open education system for both men and women. More women and girls in cities, the capital city and districts go to schools. In rural areas, the situation is such that when the security goes up, schools are closed. In some areas, schools are opened for boys and closed for girls.

For health, there are three groups/stakeholders providing services in the health sector: the donors, civil society, and the government. Basic health services provision is implemented by the civil society, while the governments control the finances. NGOs are implementing health services provision for at least 80% of the population. Donors such as World Bank, ADP support these programmes, however, when the donors withdraw in 2014, the situation is unknown."

"Sanayee Development Organization **(**SDO) is actively engaged in poverty reduction, food security, and sexual and reproductive health in 11 provinces of Afghanistan. The focus areas of our work are agri-business support, vocational skills enhancement, and expanding market linkage opportunities. SDO is partnering with the government of Afghanistan to deliver basic health services, with strong emphasis on mother/child health in Ghazni province of Afghanistan."

Civil society organizations, mainly NGOs, have a vast scope of work in Afghanistan. There are several organizations that specifically focus on issues related to women empowerment and poverty reduction. However, in view of the deep rooted poverty in the country, especially among women, the role of civil society organizations is meagre. The evidence of progress in poverty reduction over the past eleven years, despite the engagement of civil society, has been disappointing. Women continue to suffer poverty and other forms of violence in this country of 30 million.

We believe the link between the right to health and the right to food is stronger on paper. Afghanistan has had relatively stronger progress in health services delivery. Broadening access to health services for up to 85% of the population, have reduced maternal and child mortality; indeed it is the main indicator for increased HDI over the last decade but in a way it compensates the violations of the right to food. The donor community's preference to fund health services delivery programmes has been the main cause of this unequal progress. Limited progress and investment in the economic sector (e.g. agriculture, horticulture, infrastructure) has left a major portion of the society deprived of adequate food - a situation that is likely to deteriorate post-2014 Afghanistan.

Sanayee Development Organization (SDO) is busy with the poverty issues alongside other civil society groups to advocate and work together. We do not have sufficient focus on how poverty affects women. The situation of Afghanistan is different than the other parts of the world. The men are mostly responsible to support their family members. Secondly, here in Afghanistan, women are facing many other issues, specifically violence against them, and every day there is a new story about how the women suffered for specific reasons. In a year, large numbers of women are burning themselves because of big problems that they face. Also in Afghanistan, the sexual issue is different and no one can reflect it in the bigger picture."

Some experiences in working with women in poverty and vulnerability conditions, and the entry points in reaching out to the women:

Box 4: About Sanayee Development Organization (SDO)

SDO endeavours to address poverty and vulnerability of its target population through innovative approaches and means. Our entry points on district and provincial levels have been individuals, households, women action groups, associations, and Shuras (traditional councils). Some of our project-based experiences are as follows:

Vocational skills training: we have trained more than 7000 unskilled male and female, and underemployed women (64%) and men in market-oriented vocational skills since 2008.

Agri-business development services: Rural enterprise development, value chain addition, and improved production quality have been the focus of our work in the newly emerging sector of Saffron in Herat province. We have facilitated 3800 households (55% women) to produce high quality saffron and undertake its marketing.

Expanding marketing opportunities: By supporting rural enterprises, we have helped expand the marketing opportunities for saffron and carpet in domestic and international markets. Our efforts have directly affected saffron producers and carpet weavers to generate more and sustainable income.
Horticulture and Livestock Development: We have trained farmers help groups, farmers field schools, and cooperatives to improve management and leadership skills of these respective groups - the aim is also to improve the productivity of farmers and their marketing options.

Community-based disaster risk reduction: By supporting women action groups (CBDRM groups), we have endeavoured to improve the resilience capacity and mechanisms of the target groups against natural and man-made disasters.

Youth associations: We have established male and female youth associations to serve as the hubs for curbing several social problems in their areas. The self-sustaining associations have been trained and supported to take their own initiatives to address acute and long term problems such as illiteracy, access to health services, lack of awareness on rights issues, especially women and child rights, and poverty. Campaigns and grass root level advocacy are core areas of their activities.

Social safety nets: Partnering with the government of Afghanistan, we have identified and supported the most at-risk households of two districts of Kabul province to survive the winter haul of 2011. The programme covered a total of 1200 households (4800 individuals on average) in two separate phases.

Question: Do you think that the campaigns against poverty free societies and the right to food need to build closer linkages to SRHR and if so, what do you think would be the way this can be done?
"This can certainly bring a focus of the state institutions of Afghanistan that is almost overshadowed by insecurity, political stability, and corruption. Poverty is almost overlooked in decisions made in the latest three. Thus, we believe campaigns can help to make poverty reduction and right to food at the core of the decision making in policy level."

Question: Has the failure by State to address issues of poverty affected investments for health care for the poor?
"Free health care is the constitutional right of the population. As mentioned earlier, health care is almost treated separate from the overall poverty policies."

Question: Do you see visible trends in SRHR service availabilities for the poor? Please describe the linkages you consider to be crucial?
"SRHR service availability is improving. However, some social norms, stigma, and myths prohibit a majority of the disadvantage population to utilize the services. For instance, women exercise limited influence in deciding the number of children that they conceive. The entry points to work for women rights are to advocate for them. As at the moment, the CS group is active for the deferent right of women and we have strong networks to work with. Yes, there will be possibilities to work with SRHR and mostly, advocacy for different issues women are facing."
We asked, "In an ideal situation, the role of state is to provide universal health care, and with donor support which is not a sustainable development strategy. Are there organisations and institutions developed that can look at eradicating poverty, examining the health systems and addressing women in poverty?"
To this, Mr. Dalili responded: "Health systems in the country are relatively well developed , there are provincial hospitals at the provincial level, and at the district level, there are hospitals that provide comprehensive health services and basic health services. There is a big cadre of community health workers, mostly women, providing services, especially for maternity services. The concern again remains on the situation when the big donors, USAID, and World Bank leave and withdraw support. Afghanistan has achieved some good progress such as freedom of the media, a good constitution, schools especially private schools, but we still have a long way to go in addressing issues of poverty to enable people to have better lives."

On the issue of food security, the situation of declining agricultural crop production, and the availability of food for people who are not employed in Afghanistan, Mr. Dalili notes: "The issue of food production and agriculture is a big problem in Afghanistan. There is no policy, strategy planned on this issue...at this moment there is no answer, and there is no subsidised food supply for the poor and people facing food insecurity. In such scenarios, people have no alternative but to beg. In situations where there is lack of food at the household level, people, helplessly, have to take negative actions such as joining extremist groups, be involved in hijacking of people, and women opt for prostitution in such circumstances, to overcome poverty in the families, and at least, have food at the household level."

Mr. Dalili underscored the good practice in Islam called the zakat, in which rich people contribute money to the poor. For instance, if a family has 10kg of rice, 1kg is given away to the poor. This is one way food is distributed by the rich so that the poor have access to food.

On the role of civil society actors in agriculture and food production, and how communities and organisations are organising themselves on the issue of food security, Mr. Dalili notes: "Over the years, agriculture production has declined and in the recent years, with donor investment from OXFAM, ACTION AID, EU...there is some progress in food production. Civil society has no concrete plans and is not strong in the country. They are also established to generate employment and make money. Mr. Dalili talked about the use of media to promote agriculture through programmes in television on agriculture and development.

RECOMMENDATIONS AND WAY FORWARD

In terms of strategies for the AP region, to build alliances, and have greater political commitment to food security, the right to citizenship protection from poverty and lack of entitlements and rights, Mr. Dalili recommends:

1. Civil society has to work closer together. Organisations such as SAAPE and many other active networks have to come together and start working, CSOs have to start taking action not just words.

2. Civil society strategies need to be implemented; good workable initiatives by civil societies need to be scaled up by governments.

3. Groups of civil society in each country within the region can come up with plans and also work towards regional policy and input for the region on various interrelated issues.

4. There needs to be pressure on donors and (donor accountability) on the outcome of their work in respective countries.

5. Each country is unique and general blanket solutions are not possible. However, we can learn from the experiences of other countries.

Working in such vulnerable and uncertain conditions, especially post 2014, I draw hope and strength to work further on community peace building; Community mobilisation with support from other organisations is required.

Ms. Rokeya Kabir

2. BANGLADESH

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Question: Please describe your work in civil society which has some bearing on the issues of poverty, food security, and sexual and reproductive health. Do you feel that for organisations working on poverty issues in Bangladesh there is sufficient focus on how poverty affects women in particular? And, in that context, is the right to health linked with the right to adequate food? Has your involvement in the SRHR movements led you to also determine the agenda on combating poverty? Please explain the dilemmas faced by SRHR organisations when they work on issues of poverty eradication.

On the issue of poverty and lack of food security – in Bangladesh, and in a context where civil society is actively engaged in delivery of social services, the positioning of Bangladesh Nari Progati Sangha (BNPS) is unique in many ways. BNPS was set up in 1986 by a group of committed professionals and activist women, who advocated for alternative development processes, emphasising on the rights of marginalized, minority and deprived people of Bangladesh, particularly women, using a bottom-up approach linking the communities to the national level policy/decision-making.

BNPS is also able to link the grassroots movement of women to become a part of regional and an international women's movement. BNPS is working towards the creation of a platform for marginalized

Table 3. Bangladesh: Key Poverty, Food Security and SRHR indicators

INDICATOR	DATA
General Indicators	
Total Population (in millions)	150.5
Life Expectancy at Birth (2011)	68.9
Human Development Index(Rank and Value) 2011	146(0.500)
Inequality Adjusted Human Development Index	0.363 –change in rank = (5)
Income Gini Coefficient (2000-2011)	31.0
Population below income poverty line PPP$1.25 a day (%)	49.6
Gender Inequality Index	112 (0.550)
Women Empowerment and Sexual and Reproductive Health and Rights Indicators	
Maternal Mortality Ratio	240
Adolescent Fertility Rate (women aged 15-19)	78.9
Contraceptive Prevalence Rate, any Method (% of marriedwomen ages 15-49) 15–49)	55.8
Unmet need for Contraception	16.8
Median age of marriage(25-49	15 years
Violence against Women legislation	Domestic Violence Act 2010
Seats in National Parliament (% Female)	18.6
Labour Force Participation Rate (%) Female-Male (2009)	58.7- 82.5
Population with at least Secondary education (% ages 25 and older) Female-male 2010	30.8 - 39.3
Health Expenditure Indicators	
GDP per Capita PPP$	1,416
Total Expenditure on Health as percentage of GDP	3.4
Food Security and Nutrition Indicators	
Aneamia Prevalence in pregnant women(Proportion of the population Population with anaemia with Hb<110 g/L)	47.0
Under- Five Mortality Rate %	5.2
Population under 5 suffering from stunting (%)- wasting (%)	43.2 - 41.3

Source: World Contraceptive Use 2011; Respective Demographic and Health Survey using Statcompiler; Global Hunger Index Database; Human Development Report 2011; Trends in Maternal Mortality: 1990 to 2010. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. WHO 2012; UN Secretary General's Database on VAW; UN Data; Worldwide Prevalence of Anaemia (1993-2005)

groups of women and minority groups to raise and articulate their voice and to claim entitlements. It is working towards a society free from all sorts of discrimination against women, religious and ethnic minorities, and other marginalized groups where they enjoy equal rights and status in all spheres of life from family to state.[4]

It is working towards establishing an enabling environment for the disadvantaged people, particularly women, to be able to get organized, exert demand, and ensure access to their rights and quality services for social, political and economic empowerment.

Ms. Rokeya Kabir being one of the first activists in Bangladesh to forge the crucial link between grassroots women and the national and international women's movements notes: BNPS did not work for health, initially, but began as an organisation working for the rights of marginalised and disadvantaged people. Poverty eradication has been a major area of work. According to Ms. Kabir, it is the basic premise, the entry point - if people do not have rights - it is difficult to come out of poverty and vice-versa
.
Ms. Kabir is of the opinion that women have to come out of the notion that women's primary role is reproductive and they need to make free themselves from "reproductive burden" as having more children than they actually want which impoverishes women's health, time and their overall empowerment. The conventional logic of more children are needed, such as a few will die due to reasons of poverty, and children are assets as they can start working from 7-8 years and adding to the family income, and work as insurance for their old age in absence of any kind of public support and policy, have been a traditional one and does not apply in today's context.

Women need to have choices to decide on the number of children they want to have, and work towards their own empowerment. The reproductive age of women (15-50 years) is critical both for reproductive and productive work. If a woman is burdened to produce more children than she actually wants, she is compromising her own development, empowerment and productivity, and this leads to poverty in all dimensions for women. If women can make the best of their productive and reproductive years by making their reproductive choice and avoid unwanted pregnancies, then they can focus on their productive dimensions, get educated, be economically independent, and participate in economics, social and political facets of lives and become empowered. This kind of awareness raising and education and information is being provided by BNPS in urban-poor, rural, remote and conservative areas in Bangladesh and women through information are able to make decisions about their own bodies and are seeking contraception to space and limit their pregnancies and have the number of children they actually want.

On the issue of bringing women to involve into broader development agenda, in the context of Bangladesh where general perception in national and international level the development work is focused mainly on micro-credit, and the preference to leave issues of sexual and reproductive health to second and third generations, and the priority toward issues of SRHR in the hierarchy of needs, Rokeya notes: "There is a big debate around issues of micro-credit, and whether this addresses issues of women empowerment or poverty eradication. Women, however, need micro-credit because the mainstream banking system does not work for women. The development agenda is focused on simple survival strategy and does not focus on issues of rights, education, entitlement as equal citizen etc. Micro-credit programmes operated by some NGOs/ organisations provide credit and help women through the micro-credit programme. As a result, some kind of capacity building activities take place, but engaging with political and social forces is only happening in sporadic areas."

On the issue of bringing synergy to link and bring together organisations, help NGOs to work on rights-based issues, and to keep in mind the right to basic entitlements and how this kind of synergy can be built, Rokeya notes: There is a need to look at all dominant discourses and broader social movements and see the intersections. The gender perspective has to be mainstreamed, actively, in the Asian region; gender has to be integrated in all development discourses.

Women's reproductive burden, her responsibilities in care economy, mostly unpaid, need to be addressed, and women's capacities need to be developed so that they develop professionally. Women cannot be victims of circumstances, as they may remain in the lower ladder of economic or political system. There is an urgent need to look at these factors and explore the inter-relatedness of reproductive rights, political rights, and economic rights."

Ms. Kabir further notes that we need to put together our minds to look at the linkages of women's low paid and mostly, unpaid labour and how it relates to macro-economics, how women provide their labour for subsistence economy, the global crises, and its impact on women, and how women's low paid and unpaid labour is subsidising the economy and this is how the economy is sustained in poor developing countries. Even some well-meaning people say, there is a need to revive our age old norms of communities, the cultural aspect, and this is nothing but slavery of women, and we neither should nor glorify women's unpaid labour. This is against the fundamental rights and we need to mainstream such discourse that look at women as equal.

On the issue of rising religious extremism, Ms. Kabir notes: "Situations in countries such as Afghanistan where many women want the USA to stay as when they leave, the prevailing feudal system will be impeding on women's basic rights. At the same time, there are situations where powerful countries in the name of being strategic are patronising religious forces in Bangladesh. The 'war on terror' needs to be reframed, and we need to address the root causes of terror such as poverty, injustice, deprivation, and not to boost war economy for the interest of weapon producers."

Ms. Rokeya Kabir notes: "We need to think of new ways – impose ceiling on capital accumulation by few people, have regulations on how much land people can keep, and release the excess resources back to the communities for their health, education, safe water and energy. We have to look at ways to redistribute the wealth to eradicate poverty. The States cannot subsidise the wealthy on the backs of the poor, there needs to be tighter taxation on the wealthy, and have standards and regulations in place to protect the poor."

Question: At the local level, on the issues of SRHR, access to food, right to quality food - and how the public distribution system (PDS) should work, and what should the State be providing? What is your opinion on decentralisation and

solutions coming from the local level, and the state rescinding on upholding basic human rights and how local organisations can leverage at the national level policy debates, get involved in campaigns?
To this question, Ms. Rokeya Kabir shared some of the BNPS project interventions, where pilot interventions have been taken up in 10 constituencies on the issue of health and education. The methodology includes assessment of situation in the grassroots, community organising and mobilisation, bringing together stakeholders – doctors, lawyers, women, local governments – to meet together locally with BNPS providing data and evidence on the situation in terms of how many women are dying due to childbirth, numbers of child marriage, VAW, etc. These local discussions and sharing of evidence go up to the university level. Public hearings are organised to pressurise local politicians to address the issue locally. Then these issues brought to the notice of Parliamentary Standing Committees.

At the same time, advocacy and lobby work is carried out at the national level, and organisation of national level seminars involving policy makers, media and academicians occurs to address issues at national level. This is one of the strategies that BNPS puts to work – a bottom-up approach and is looking at a replication and scaled up version of this approach at the national level. In addition, emphasis is also on grassroots level awareness and linking up with political processes.

On the issue of having a fairly good government sensitive to issues of development, and politically correctness, such governments can contribute to positive changes such as in legislation, and implementation of poverty eradication programmes, Ms. Kabir notes: “The problem currently in Bangladesh is largely with implementation. Bangladesh has significant constitutional provision and statutory laws guaranteeing human and fundamental rights and women’s equal rights. However, the issue is the poor quality of governance and non-implementation of these national policies and laws. The political parties are not consolidated and has to depend on bureaucracy, which is not very helpful for the poor.

There is a need for reforms within bureaucracy. There is a difference of opinion and gaps in understanding between civil society and political forces. Bureaucracy blames civil society on pilfering money and often plays a blame game. There is currently a new law to restrict the liberty of NGOs. NGOs are facing many problems in Bangladesh, despite the government being politically supportive of NGOs to an extent but practically, many issues of bureaucratic bottlenecks need to be addressed.”

Question: Issues around women, which people talked 20 years ago seem to be relevant even today with no significant improvements, even the macro data presents a depressing picture on indicators of gender equality and equity. Is there hope to bring about change and claiming agency of women in SRHR?
To this, Ms. Kabir shares feelings of both yes and no. In Bangladesh, she also sees abject poverty despite steady progress in GDP, number of people coming out of poverty. In recent times, she sees a lot of deprivation occurring which could be avoided The gap between the rich and poor has dramatically increased in recent times. The different dimensions of poverty among deprived excluded groups are increasing and need proper and effective attention. There is a need for the people in the movement to see how the deprived, marginalised excluded groups are able to claim their entitlements and rights.

Rich people have gathered so much capital in a short period of time, grabbing public money and land through corruption, and political influence on government/state that are creating a real challenge for people, NGOs as they are constrained by resources to implement any programme. There is an urgent need to address the macro-economic changes, the power that markets have gained recently, and their negative impact on the rights and entitlements of women, and marginalised groups. There is an urgent need to address this situation in the coming days and years, and strategise the way forward.

RECOMMENDATIONS AND WAY FORWARD

1. To bring to fore and mainstream, the rights of women and their entitlements to health and reproductive rights in all the work carried out by women groups and NGOs.

2. There is a need to ensure entitlements in economics and in politics for women to be realised; a legitimate space and support for women to pursue education, and access to economic and political opportunities is critical to move the agenda of women forward.

3. Women deserve equal share in natural resources. Whatever resources are generated from the natural resources, a percentage of that revenue has to be contributed towards women development; investments in public education, right to food and right to their reproductive health.

4. Enable women to decide and exercise control over her fertility, the number of children she actually wants to have, addressing issues of reproductive health and morbidity, so that women can actively engage in productive work, participate in economic and political arena and move ahead to claim their agency.

5. Budget analysis from gender perspective needs to be implemented, in addition to, the actual implementation of laws and policies promoting women empowerment.

Dr.Zhang Kaining

3. CHINA

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On the subject of coming from a country that has made great progress on the forefront of poverty, and describing work related to sexual and reproductive health and rights (SRHR) in China, Dr. Zhang Kaining mentions his work on the development and health issues of women, both as the Founder and Director of Yunnan Health and Development Research Association and his academic affiliation with the Kunming Medial University[5] as the professor in social medicine and health management and administration.

At the same time, he says his training was in public health and not poverty alleviation. He talks about the changes in population and development discourses since 1994 after the International Conference on Population and Development (ICPD) at the international level, and its impact on sexual and reproductive health and rights in China, in terms of reforming health as well as perspectives around population and development.

According to Dr. Zhang, the reform and opening-up of China has led to remarkable progress in all aspects of social development, and also greatly enhanced the effort to move towards the ICPD goals.

Work on issues of sexual and reproductive health have been improving, at the same time, poverty alleviation is also something that his organisation and other NGOs has been linked with while working on health, reproductive health, family planning, contraceptive use, STD/ HIV/ AIDS prevention and education.

Question: With regards to the public health system, the philosophies of people like Paul Farmer from the Harvard School, whose perspectives on public health system and reforms are integral and take into account provision of better health services as well as work on issues of alleviating poverty, which is the root cause exacerbating diseases and the criticality of insights and inputs from the academic work, especially while lobbying at the national level, what are the specific problems that poor communities face? And, is the health system decentralised in China?
To this question, Dr Zhang responds by saying that he has been involved in health care for more than 20 years. The work of his team is rooted in grassroots experiences. Looking at the history of health care in China, in the 1950s and 1960s, China suffered with poverty, food insecurity and poor health care service delivery for the poor.

In the 1970s and early 1980s, some primary health care was provided in China. In rural areas there were the barefoot doctor system under which the health service providers were trained to meet the health needs of rural population. Many urban physicians were sent to the rural areas, and utilizations of traditional medicine including herbs, acupuncture and massage were highlighted.Health insurance was provided and majority of the rural population were covered by the cooperative medical scheme.

During this time, Dr. Zhang worked in rural villages as well. The allocation of the limited national health resources had had greater focus on the health and well-being of rural population. This ensured villagers have primary health care with low costs at the commune level. The communes owned land and at the same time, provided health care through the cooperative medical system which operated mainly at the village level staffed by barefoot doctors with basic health care training. Generally to say, this system was effective to meet the basic health needs of rural population.

Between early 1950s to beginning of 1980s, improvements were seen in health indicators of the population, and the public health system was centralised and this system was able to control infectious diseases through immunisation and other public health measures. In the late 1980s, the Chinese government changed its national policy and the country moved from a socialist planned economy to a market oriented model. While incomes of the huge number of the majority of poor people increased dramatically, economic inequity became larger. As a result of the reforms of China's economy and a general effort in decentralization in social development regarding the role of Beijing's central government in China's regional and local affairs, this reduced the cooperative medical scheme coverage in rural areas remarkably, from as much as 90% coverage to less than 10% and nearly everyone had to pay.

This situation also resulted in the disparities between provinces/regions as well as between rural and urban areas as a result of government's lack of initiative to redistribute health care from wealth to poor provinces/regions where most of the poor people needing health care lived in deprived conditions.

Between 1980-90, the whole country moved further into a market oriented economy model, there was more food, more freedom, and more and more people became richer. At the same time, some poor people, especially older women could not pay for health care and others, resulting in increased inequality and coverage of primary health care which declined.

Since later 1990s, there has been a debate of the unfair situation that women and poor people are in, and there is a significant change in the health policy. Since 2002, government has begun paying rural population for all under the new CMS.[6] This new health insurance system, the New Cooperative Medical Scheme (NCMS), in rural areas, aims to improve the health of rural population, reduce poverty due to illness, and provide financial risk protection for people with catastrophic illness. The government is confident that providing health care to large rural populations is possible, and there is enough money. Dr. Zhang specifically mentioned, poor people never abuse money (services provided by the Government).

Table 4. China: Key Poverty, Food Security, and SRHR indicators

INDICATOR	DATA
General Indicators	
Total Population (in millions)	1,347.6
Life Expectancy at Birth (2011)	73.5
Human Development Index(Rank and Value) 2011	101 (0.687)
Inequality Adjusted Human Development Index	0.534 Change in rank= (-1)
Income Gini Coefficient (2000-2011)	41.5
Population below income poverty line PPP$1.25 a day (%)	15.9
Gender Inequality Index	35 (0.209)
Women Empowerment and Sexual and Reproductive Health and Rights Indicators	
Maternal Mortality Ratio	37
Adolescent Fertility Rate (women aged 15-19)	8.4
Contraceptive Prevalence Rate, any Method (% of marriedwomen ages 15-49) 15–49)	84.6
Unmet need for Contraception	2.3
Median age of marriage(25-49)	-
Violence against Women legislation	Law on the Protection of the Rights and Interests of Women, as amended in 2005
Seats in National Parliament (% Female)	21.3
Labour Force Participation Rate (%) Female-Male (2009)	67.4 - 79.7
Population with at least Secondary education (% ages 25 and older) Female-male 2010	54.8 - 70.4
Health Expenditure Indicators	
GDP per Capita PPP$	6,828
Total Expenditure on Health as percentage of GDP	4.6
Food Security and Nutrition Indicators	
Aneamia Prevalence in pregnant women(Proportion of the population Population with anaemia with Hb<110 g/L)	28.9
Under-Five Mortality Rate %	1.9
Population under 5 suffering from stunting (%)- wasting (%)	21.8-6.8

Source: World Contraceptive Use 2011; Respective Demographic and Health Survey using Statcompiler; Global Hunger Index Database; Human Development Report 2011; Trends in Maternal Mortality: 1990 to 2010. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. WHO 2012; UN Secretary General's Database on VAW; UN Data; Worldwide Prevalence of Anaemia (1993-2005)

Question: Drawing parallels with the Indian situation - where the structural adjustment programme initiated in India completely left out access to health care and quality health services for the poor, most poor households have negligible access to food as most of the locally produced food is exported. While it is required by the State to protect the interests of poor, to reverse negative policies, and ensure ethical normative are sustained,[8] the reality, however, is about profit maximization within the public service delivery. As a result, the poor and vulnerable people lose the battle. In the context of China based on what Dr. Zhang has mentioned, there is a sense of extreme respect for poor rural people as shown by the conceptualization and implementation of the New Cooperative Medical Scheme (NCMS), What was the common basket of health problems poor women and children get covered within the NCMS?
To this question, Dr. Zhang responded: "Before 1980, rural China also had a high infant mortality and maternal mortality ratio (IMR and MMR), a huge level of inequality and inequity existed between the rich and the poor. Indeed, women in urban areas enjoyed more health care and the highest MMR was among the people in the poorest quintile. In addition,

high levels of malnutrition existed in the rural areas. In the 1980s, campaigns and programmes were also initiated around public health and maternal health supported by international organizations such as UNFPA/ UNICEF in collaboration with the government.

In the 1990s, WHO and the World Bank collaborated a research project in Yunnan province on maternal and child health for poorest families with the hypothesis that there exists clear inequity and poor women suffer the most, and that we can use modest money to save poor women and their children, and that little money and good health systems can save lives of women and children. This study was carried out in 3 counties and 3 years later, data and results showed that little money can save lives while participatory methods work effectively. The government was given this evidence and this evidence informed the national policy."

In addition, Dr. Zhang also talked about the "Green Channel" referral mechanism to safeguard maternal and child health established nationally and in all the counties within the health care system to cater for the poorest segments of population and subsidize poverty stricken rural women with hospitalized care when needed and with such programmes initiated step by step, things have improved greatly in terms of maternal and neonatal health, although there is still a long way to go in a few of the most remote and poor villages.

Question: On the issue of poverty and number of people living below poverty line in China and the government initiated reforms to respond to poor people's health needs such as direct cash transfers or supply of medical equipment and food subsidies.
To this Dr. Zhang responded by saying there has been an allocation in the government budget to cater to the needs of poorest people. The new CMS, which basically is the rural health insurance system, aims to address the serious situation of health service utilisation in rural China. The challenge now is about migrant people's health who hardly get government subsidies. He further notes the huge migrant population of 200 million in China and the challenge to address the health needs of migrants, their health and equity matters.

Question: On issues of population control and the Chinese government's argument that a growing population would lead to among others insufficient food for the growing population.
To this, Dr. Zhang responded: "Since 1994, after the Cairo conference, and with a number of Chinese academics studying abroad and seeking Ph.Ds in foreign countries, there is a change that increasing number of people, professionals, policymakers in China are talking about women's rights, SRHR. At the national level, there is a strong family planning system and many government health staff in the country do not talk of population control anymore. There are lots of trainings at provincial and county level.

While the general policy states one child only, this policy differs from place to place. For instance, in Yunan province, it is 2 children per rural family, for ethnic minorities, they can have up to 3 children. There is now a great debate in the country, people are openly criticising the one child policy and asking the government to look at examples from other countries such as India which approaches population in a different manner.

Indeed, many of demographers and population experts are now coming to India to study the Indian population policy and experiences. At the same time, there are some new tendencies and interesting developments, in cities such as Shanghai and Beijing, this generation of young people do not want any children. The national policy now allows couples to have 2 children if the husband and wife are from families of one child only, however couples still prefer only one child."

Dr. Zhang further mentioned that people in China are worried about the future of population in China with an increasing older population. There are policies for older and elderly people above 60 such as free buses and free coaches.

RECOMMENDATIONS AND WAY FORWARD

Building on his experience of working in China and extrapolating this experience to the Asia-Pacific region and charting the way forward, Dr. Zhang finds the following recommendations as relevant:

1. Drawing on the experience of his country, Dr. Zhang strongly recommends for women and research organisations to use pilot studies and evidence to show government's that focused, limited and efficient use of resources can bring great and significant difference to the health and well being of poorest families, especially the poorest women. Evidence shows that it is not expensive and resource intensive to save lives. If research organisations can carefully analyse the causes for the poorest women focus on maternal care, and children's health focusing on a few kinds of illness such as anaemia and diarrhoea, this can benefit their health greatly.

2. Gender analysis is critical in health research and interventions. Discrimination based on gender has many depriving outcomes for girls, adolescent girls and eventually women. Awareness needs to be generated on issues of gender, and girls, adolescent girls and women cannot be ignored in health interventions. For example, diarrhoea affects both girls and boys. However, girls are mostly ignored and affected, including resulting in mortality. The dimensions of gender have to be examined carefully at household and health system level.

3. It is important that in all countries, there should be interaction between community and health system. It is the notion that doctors know everything and communities know nothing, a powerful strategy would be to increase and encourage local community participation.

4. Dr. Zhang also talks about compulsory placement of young doctors in rural areas for a certain period of time. This policy ensures that health personnel are present in rural areas to cater to the rural people health needs. He mentions young doctors at this point do not want to go and work in rural areas resulting in the critical deficit of doctors in rural areas, very few young doctors work in rural areas, even when they themselves come from poor places as their hometowns– the State policy ensures every doctor spends time in grassroots, poor communities before being promoted.

5. He further notes that gender training and young people, especially doctors' placement in rural areas, in the long run will ensure professionals empathise with the poor and their changed perceptions.

Dr. Zhang concludes his talk by saying there has been strong social reform in China. Major changes in economic reforms will take place, and people are asking for more and more reforms. He also sees a trend of people going back to traditional ways of life, emphasising values of life, although some people still are seeking for more money.

Ultimately, it is our obligation towards society.

Ms. Avelina Rokoduru

4: FIJI

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Ms. Avelina Rokoduru, who is from the Fiji islands, could not directly discuss with us due to poor Skype connections. She was kind enough to write to us to share some of her feelings and glimpses into their work in Fiji.

“My work with civil society is mostly to do with SRH for all – women, males, youths and LGBTQI. We are also trying to enter into male dominated spheres to discuss SRH – with men as partners! The work that we currently do is largely on SRH with very little formal connection to issues of poverty and food security. At the present moment, we are trying to establish basic levels of knowledge, attitudes and practices for all facets of SRH – family planning, sexual health, reproductive health, gender-based and sexual violence, services and commodities and their uptake. The kind of work we do is something like a ‘stock take’ of where we are at compared to the active SRH agenda of the 1940s-1970s. E.g. levels of knowledge on FP methods, services and commodities with communities and, we also address health professional’s attitudes, knowledge and practices towards offering FP services and procurement.

There are a few organisations that work on poverty and are mostly male-dominated – efforts on addressing women and poverty have largely been based on micro-finance projects – handicraft, bakeries, and shops (something like cottage entrepreneurship) – to enable women to earn money. In my opinion, the focus is not sufficiently focused and targeted to drive solutions to adequately address women in poverty.

Table 5. Fiji: Key Poverty, Food Security, and SRHR indicators

INDICATOR	DATA
General Indicators	
Total Population (in millions)	0.9
Life Expectancy at Birth (2011)	69.2
Human Development Index(Rank and Value) 2011	100 (0.688)
Inequality Adjusted Human Development Index	-
Income Gini Coefficient (2000-2011)	-
Population below income poverty line PPP$1.25 a day (%)	-
Gender Inequality Index	-
Women Empowerment and Sexual and Reproductive Health and Rights Indicators	
Maternal Mortality Ratio	26
Adolescent Fertility Rate (women aged 15-19)	
Contraceptive Prevalence Rate, any Method (% of marriedwomen ages 15-49) 15–49)	45.2
Unmet need for Contraception	2.3
Median age of marriage(25-49	-
Violence against Women legislation	Domestic Violence Decree 2009
Seats in National Parliament (% Female)	21.3
Labour Force Participation Rate (%) Female-Male (2009)	38.7- 78.4
Population with at least Secondary education (% ages 25 and older) Female-male 2010	86.6- 88.6
Health Expenditure Indicators	
GDP per Capita PPP$	4,526
Total Expenditure on Health as percentage of GDP	3.4
Food Security and Nutrition Indicators	
Aneamia Prevalence in pregnant women(Proportion of the population Population with anaemia with Hb<110 g/L)	55.6
Under- Five Mortality Rate %	1.8
Population under 5 suffering from stunting (%)- wasting (%)	

Source: World Contraceptive Use 2011; Respective Demographic and Health Survey using Statcompiler; Global Hunger Index Database; Human Development Report 2011; Trends in Maternal Mortality: 1990 to 2010. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. WHO 2012; UN Secretary General's Database on VAW; UN Data; Worldwide Prevalence of Anaemia (1993-2005)

There is very little research and M&E activities, being conducted to evaluate what is being paid for through money earned by these women. From what is covered in the media, money earned subsidises the family income towards consumption, education and medical bills.

As a personal opinion, the approach and effort adopted by the organisations is largely geared towards the benefit of the family as a whole, inclusive of the woman; i.e. when the family benefits, the woman benefits as well – and not the other way around; when the woman earns, she becomes empowered and her choices and decisions will improve standards of living for the whole family!"

"We have not started talking rights yet regarding health and access to food! We have very high rates of NCDs causing premature deaths in Fiji and in the Pacific. The awareness that there are increasing rates of heart attacks and reproductive cancers – breast, ovarian – in the general population has also taken root. There is the recognition of the importance of living a healthy life and that there are rights pertaining to health and access to food for each person.

Towards a more integrated future, she states - "We are still trying to establish the extent of SRH knowledge, practices, attitudes and issues in the general population across the Pacific. We are organising a key indicators workshop in September and the Centre is hoping to introduce issues of poverty and food security into the discussion.

There are very few organisations that base their work purely on SRH and rights. SRHR is often a tiny component of programmes in mainstream women's organisations." Rokuduru concluded by adding that there was nothing recorded or research conducted on the experience of NGOs tackling SRH and poverty issues, simultaneously in Fiji.

Dr. T . K. Sundari Ravindran

Mr. Manohar Elavarthi

5: INDIA

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T. K. Sundari Ravindran is a researcher and activist based in Trivandrum, India. She has a Masters in Mathematics and Ph.D in Applied Economics from Jawaharlal Nehru University, India. She is the founder and Secretary of Rural Women's Social Education Centre (RUWSEC), India, a rural women's organization working on reproductive health and rights issues since 1981. She is currently Professor at the Achutha Menon Centre for Health Science Studies in Trivandrum, Kerala, where she teaches in their Masters Programme on Public Health. Sundari has worked with the World Health Organization in Geneva, and its Regional Offices for SE Asia and the Western Pacific in putting together a number of publications. She was formerly co-editor of the international journal, *Reproductive Health Matters.* On the biographical question of how Dr. Sundari started to work on issues of population and development and the history of how she got involved and interested in this area of work, Dr. Sundari mentioned, 33 years ago, she started work as an adult educator.

During her student life, she was involved in left-wing student political activities. These experiences provided her roots to reaching the communities. As an adult educator, working with dalit women, she often came across questions from Dalit women who were literacy teachers on how to prevent or terminate a pregnancy - this work was also the background for establishing RUWSEC. With the publishing of "Our bodies ourselves" in 1979/80, this became a major resource for Dr. Sundari to respond to the questions. Dr. Sundari started organising small meetings with women literacy teachers to learn from Our Bodies Ourselves, which then led to community meetings focusing on reproduction and other issues - one activity lead to another and in 1981, RUWSEC[9] was established. She further noted how she made forays into communities and worked with fishing groups in Chennai, student politics, went into adult education, facilitated Dalit women's leadership in mobilising action on wages etc.

Through these, the one common message she discerned from the women she worked with was - *we need to control our lives and our bodies and these struggles are not different struggles, but interlinked. In order to do the one, we need to do the other. In order to be able to organise the community,*

Table 6. India: Key Poverty, Food Security and SRHR indicators

INDICATOR	DATA
General Indicators	
Total Population (in millions)	1,241.5
Life Expectancy at Birth (2011)	65.4
Human Development Index(Rank and Value) 2011	134 (0.547)
Inequality Adjusted Human Development Index	0.392 change in rank= (1)
Income Gini Coefficient (2000-2011)	36.8
Population below income poverty line PPP$1.25 a day (%)	
Gender Inequality Index	129 (0.617)
Women Empowerment and Sexual and Reproductive Health and Rights Indicators	
Maternal Mortality Ratio	200
Adolescent Fertility Rate (women aged 15-19)	
Contraceptive Prevalence Rate, any Method (% of marriedwomen ages 15-49) 15–49)	86.3
Unmet need for Contraception	9.8
Median age of marriage(25-49	17.4 years
Violence against Women legislation	Protection of Women from Domestic Violence Act 2006
Seats in National Parliament (% Female)	10.7
Labour Force Participation Rate (%) Female-Male (2009)	32.8- 81.1
Population with at least Secondary education (% ages 25 and older) Female-male 2010	26.6 - 50.4
Health Expenditure Indicators	
GDP per Capita PPP$	3,296
Total Expenditure on Health as percentage of GDP	4.2
Food Security and Nutrition Indicators	
Aneamia Prevalence in pregnant women(Proportion of the population Population with anaemia with Hb<110 g/L)	49.7
Under- Five Mortality Rate %	6.6
Population under 5 suffering from stunting (%)- wasting (%)	47.9 - 43.5

Source: World Contraceptive Use 2011; Respective Demographic and Health Survey using Statcompiler; Global Hunger Index Database; Human Development Report 2011; Trends in Maternal Mortality: 1990 to 2010. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. WHO 2012; UN Secretary General's Database on VAW; UN Data; Worldwide Prevalence of Anaemia (1993-2005)

we need to have greater control over our bodies and our lives and assert our freedom of movement.

Dr Sundari mentioned that when RUWSEC was started, the imagination was that the organisation would build dalit women's leadership so that when a revolutionary movement swept across the country-side, there would be rural women leaders who were well equipped to take on a leadership role. She expressed disappointment that this had not happened although three decades had passed since RUWSEC was started.

Dr. Sundari mentioned RUWSEC was successful in building leadership within communities, the importance of local leadership was emphasised in RUWSEC's work. She noted that there is hardly any presence of left-thinking in the areas where RUWSEC works

Dr. Sundari stated that the situation in the local self-government levels is very encouraging in Kerala where the left is engaged with gender at the local self-government levels; there occurs decentralised planning exercises, status study in every village, and village plan in every panchayat as well as gender training for panchayat women at local level.
Question: On the dilemmas of SRHR organisations to impress upon broader social movements such as poverty, right to food etc.

Dr. Sundari noted: "RUWSEC was founded and established by dalit women. RUWSEC was in fact asked to train dalit human rights activists working with adolescents, on issues of sexuality. Recruiting adolescents for dalit movement also meant that they were trained on issues of sexuality, to deal with the practical issues of relationships between young boys and girls when they come together. Training was provided on responsible sexuality and how to work with adolescents. Sexuality is integral to the work of the movements and there has been local support and recognition for SRHR as important in the social movements and RUWSEC's leadership is recognised among local leaders of the dalit movement."

Question: On the engagement with women, rural women, agriculture and social service for rural women and the connections with SRHR.
Dr. Sundari commented that there is a close connection with agriculture, pertaining to conditions of Reproductive Tract Infections and Uterine Prolapse. Squatting and doing work for women becomes difficult, and the women are not getting access to nutritional supplies, as well as the function of Public Distribution System (PDS) etc are included as... all these are inter-connected scenarios. She questioned as to how one can work on one aspect without working on the other. Dr. Sundari also noted the work on social determinants of health, gender based violence, and organising for better working conditions in which Dr. Sundari did not see a dichotomy.

Question: On the issue of visionaries such as Dr. Sundari, who look at the holistic vision integrating the hardships of women, but social services are provided in silos with different line departments responsible for different social services based on the reductionist logic, and lack of centrally abiding vision and lack of inclusion, and the way to break the silence and operationalise such programmes.
Dr. Sundari responded: "When people work in departments and we talk to them of holistic vision we lose it, we frighten them away, we need to find a way to give the message in discrete capsules. For instance, give concrete examples of what it means to adopt a holistic approach i.e. when you do X, do it in such and such a way, take on board Y as well, etc. There is a need for carefully approaching the issue."
Observations from Dr. Shobha: Observations were quite valuable and this is THE way to approach.

There is a need to put in place certain ethical standards, which are universal and then break them into functionalities. This is in line with what Dr. Zhang Kaining (China) mentioned in his interview – with the State's presence in local bodies they are able to have a State that understands the need for effective service delivery at local and national levels. In India, with massive corruption, this is the only way we can work – larger structural transformation is required.

Question: On the entry points to address the current rather grim situation of the impact of structural adjustment programmes (SAP), highly privatised education and health.
Dr. Sundari observed: "It is important to look closely at the BIG picture. For example, the state of Tamil Nadu provides nutrition and health. About 20kg of free white rice is provided to households, and this is actually results in the complete elimination of core cereals from the diet, people are eating "white rice" 3 times a day and are themselves beginning to question. This is because only eating "white rice" in comparison to *ragi* costs Rs. 35 seems cheaper than wheat which costs Rs.50 if bought from the market. These trends are raising many issues of food and nutrition security; in fact, this policy is having a negative consequence on food and nutrition security of the population.

Dr. Sundari noted the potential of such interventions to predispose people to an early onset of diabetes. "We are increasingly moving towards the "Thin Fat India"[10] with such diets. Such diets may give rise to diabetes; predispose people to the onset of type 2 diabetes."

In India, diabetes is no longer an affluent lifestyle disorder, but a condition that is affecting poor landless people. Unfortunately, the government is contributing to this. For the government, what is their interest? Why is the government giving only "white rice"? Why not subsidise food such as ragi? There is a sense of status associated with white rice-populist measure and part of vote bank strategy for the government.

In India, there is a need to study this pattern and there is a need to gather evidence, studies that look at the nutritional profiles and disease profiles of people before and after subsidy, or compare people in states where such subsidies are provided to people where such subsidies are not provided. Changing diet patterns take a toll on women and men. Given the poor status of people, lack of a proper health system, and increased cost of drugs, it is difficult to imagine how poor people will manage the complications of diabetes.

Question: Focusing on the entire state of vulnerability and the risk that people are put through, Dr. Shobha refers to Karnataka expert social services group, which looks at the example of Tamil Nadu, and notes they are getting food for free and Karnataka does not. The substandard nature of grains, that Below Poverty Line (BPL) families get and in light of this, we need mechanisms for addressing issues for poor population, the gold standards on what the deliverables should be, the nature of women oppression – poverty, vulnerability, and the need for reflections on how SRH campaigns need to include food security in a more explicit manner.
To the question above, Dr. Sundari answered that not enough studies have been conducted that look at poverty, food security, and SRHR.
Dr. Sundari points to the level of anaemia among women, which is cutting across class, more than 50% of women are nutritionally anaemic in India and this needs to be investigated further, whether the condition is nutrition related, or other systemic disease related.

Why are women anaemic? It has serious consequences for SRH, and there needs to be an understanding on where this is coming from? Everyone who is taking poor diet, could cause iron deficiency. Other factors such as poor nutrition, poor body weight has implications on reproductive health. Dr. Sundari mentioned the cases of maternal deaths in Barwani among tribal women. These women have Hb levels below 4 grams. “No one can save such women with such low Hb levels. What is causing this? Is it plain hunger?” 60% of maternal deaths are in tribal areas. Anaemia is a major reason.

Question: Dr. Shobha noted large number of complexities, and the work to be done is not easy. For example in Rajasthan, the nature of lives in tribal areas that women face - what is it that they really want? Simply, water. Women sit on cow dung during menstruation due to lack of water for 4-5 days every month. We are calling for a drastic overhaul. What are some visible trends in provision of RH services, and campaigns to be promoted for RH services?
To this Dr. Sundari remarked: “With regards to campaigns on reproductive health services, the current focus is mostly on maternal health. While maternal health is doing comparatively well, on other SRH services, we have a long way to go. There are no standards, no protocols for RH care, no good information on RH services in the country. There is a deficiency within the feminist space, how important and not important is reproductive health. If people focus on maternal health, then nothing happens at the abortion front.”

Nothing is made available in the State such as Tamil Nadu, with a well functioning health system around comprehensive sexual and reproductive health issues - work is mostly around maternal health services. Dr. Sundari did an analysis on the availability of safe abortion services within NRHM, and the findings point to the fact that this is poor. There is hardly any training that has happened.

RECOMMENDATIONS AND WAY FORWARD

Citing no differences with the opinion on the zero access, and zero willingness on the government side, Dr. Shobha noted that in such a situation, the only solution would be decentralisation and finding local solutions. At the same time, Dr. Shobha noted the need for advocacy across movements - across women’s group to bring the SRHR message and across the right to food group to bring the SRHR message. The dalit movement is great and calls for a mutual exchange of experiences around social conditions and discrimination, and these kind of things should happen at state and national level. To this, Dr. Sundari explained that she is more of a local player, and would leave the state and the nation to other players.

On the SRHR message for labouring poor and informed unions Dr. Sundari notes two critical messages:

1. If you want to organise the working class address - SRHR issues, relationship between men and women, issues of violence - as these issues are critical and everyday life is governed by these circumstances. If there is no sense of control over personal life, it is difficult to control the larger aspects of life;
2. Nutritional well-being and Reproductive Health, after all, what are labour movements fighting for - It is on the wellbeing, dignity, and bodily integrity. If we want to mobilise, we need to address issues which are part of the goal.

Dr. Sundari pointed to certain ways in which positive changes are being steered. Referring to her course on SRHR, Dr. Sundari observed greater awareness, openness, engagement and the willingness of people, especially men to work on the issue. “People are listening”, and Dr. Sundari no longer has to convince people on what the issues are. Engaging with men is seen as a very important way to move forward.

Dr. Sundari shared her experience of working with young medicos, shaping their perspectives and perceptions, and pondered whether this avenue can be worked out; it will be one way forward. The engendering of medical education, and working with public health students with a compulsory course on gender is showing results. Dr. Sundari is seeing results from her conversations with the alumni on what they have gained from gender and medical education. She mostly hears two things: a) changed attitude towards abortion (previously, the perception was women are being irresponsible), and b) greater empathy for reproductive health needs of women.

6: INDIA

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Question: Please describe your work in civil society which has some bearing on the issues of poverty, food security, and sexual and reproductive health.

Box 5: About Sangama
Sangama was founded in 1999 to work on issues of sexual orientation and gender identity rights, information and education. The initial funding for Sangama was through a two-year individual fellowship from MacArthur Foundation to Manohar. Over a period of time, Sangama developed into a full-fledged documentation/drop-in/resource/crisis intervention centre, and a space for activism on sexual orientation and gender identity issues, sex workers issues and rights in Bangalore."[11]

Manohar's noted: "'Class factor' plays a very important role in the lives of people of diverse sexual orientations and gender identities, and sex workers. In fact, it is the sexual/gender identity that forces persons into situations of dire poverty." Manohar described that wherever and whenever a person's sexual orientation and gender identity come to the fore, they are denied basic survival, rights and entitlements such as right to food, employment, housing and education, and this social exclusion pushes them further into the vicious cycle of poverty."

On the issue of sex workers, Manohar observed: "Sex workers are marginalised, have less skills and being sex workers, they get further discriminated." He cited the example of a common problem faced by sex workers, in which as a result of discrimination, sex workers have to shift houses constantly, they pay high rents, they are denied or do not have identity documents, denied various opportunities that are available to other poor people, (such as housing, ration card [food grains as subsidised cost provided by the government]), face stigma, HIV risk, police and *goonda* violence and are denied their basic entitlements.

Question: Do you think that the campaigns against poverty-free societies and the right to food need to build closer linkages to SRHR and if so, what do you think would be the way this can be done?
"Sangama works around campaigns for transgender communities - this includes and integrates larger networks of right to food campaign, right to pension campaign, Wada Na Todo campaign, to fight for the economic rights of Transgender (TG) communities, their access to loans, education, employment, housing, and health rights and services."

Manohar called attention to some positive changes in the attitude of the government in recent times. A new order had been passed - which is currently only on paper and includes entitlements for transgender (TG) communities such as a nominal pension of Rs. 400/ month for all TG people above 40 years of age; it also includes the allocation of 1% of seats in schools and colleges; loans for TG communities if they form groups; trainings to seek jobs, housing, voter ID etc. However, this order needs to be implemented and the issue is in the process of being taken up in the court to implement this state order.

On the evidence that people are denied their citizenship rights and entitlements owing to their sexuality/gender identity, Manohar noted: "There is a lot of evidence available to confirm this." With respect to the public health services, Manohar clarified: "Everyone gets condoms, treatment for STIs. this health service, however, is marred with stigma and discrimination."

Manohar cited a recent report, "Chasing numbers and betraying people**.**"[12] This report documents how people of diverse sexual orientations and gender identities, and sex workers are seen as vectors of diseases, they are seen as objects and not as human beings with rights and agency. "Even when it comes to ART services, people of diverse sexual orientations and gender identities are insensitively left out, on the grounds that ART delivery needs caretakers and sexual minorities often do not have caretakers. When in situations they are provided with ART, there is not enough nutrition as the government only provides for medicine and no other support, such as for nutrition, is provided."

Manohar emphasised that "[t]he approach is to provide condoms for HIV+ people and that is all and these communities are left to fend for themselves (*attitude being - let them die, the faster the better*)."

Question: Has the failure by the State to address issues of poverty affected also investments for health care for the poor? Do you see visible trends in SRHR service availabilities for the poor? Please describe the linkages you consider to be crucial.
"Privatisation, sole focus on HIV, and lack of focus on overall reproductive health needs of people as impeding factors in the current health system. The public health system with its siloed approach and the sole provision of only condoms and STI treatment for HIV positive people is a waste of resources. There is no focus on other critical and complementary issues such as sensitisation trainings for police, government and the integration of people of diverse sexual orientations and gender identities, and sex workers into the mainstream society. Wherever there are strong collectives, strong community based organisations (CBOs), they are able to exert pressure on local hospitals to provide services and ART treatment for LGBTIQ persons as well.

Manohar also mentioned the psychological problems people of diverse sexual orientations and gender identities, and sex workers face, leading to alcoholism. There exists discrimination and violence and a total lack of respect to privacy and confidentiality aspects of HIV+ people. The way data is collected is by setting up testing camps for HIV+ people – everyone in the community knows who the HIV+ people are.

Question: On the government's lack of respect for people coming for state run health services, and the way funds are allocated where there is no room for the affected communities to decide how funds are allocated and for what purposes.
Manohar commented: "The situation is such that health interventions are numbers driven, target approaches dominated – *reaching so many people within so many years*. The donor agenda which is now more focused on monitoring and evaluation, and forgets that we are dealing with people, human beings with diversity."

Manohar cited the need to take diversity into context while designing interventions. He mentioned diverse settings for sex workers, such as, a brothel based setting is different from street based setting and technically, interventions would also differ. However, when it comes to programme interventions, everything is a standard, uniform strategy with no room for diversity and needs and rights of people. There are significant funds to reach out to people from the donors, however, the top-down approach impedes the realisation of positive results. Manohar brought to light the plight of volunteers, who do not have any contract, are given very little money; the money they are paid is so little that it violates labour laws.

Question: How are larger social movements such as peasant movements, displacement, workers, women, and dalits, relating to people of diverse sexual orientations and gender identities, and sex workers?
To this question, Manohar notesd: "After the Delhi High Court Decision to decriminalise consensual sex between adults of same sex (IPC Section 377), the situation of transgender communities is seen as getting better." He mentioned the Wada Na Todo Campaign,which held a session on transgender under "women in special circumstances"; there are lots of movements recognising transgender communities, however, concrete integration is not happening. There is a lot of stigma and violence, this needs to reduced first, followed by economic rights...it is very early to discuss concrete integration. Manohar mentioned the Pension Parishad,[13] an initiative to ensure universal pension in India and the campaign includes pension for all transgender communities, sexual minorities and sex workers..

Question: On the integration and action at the macro level on health, education, decent employment and the integration of sex workers and TG communities within larger unions.
Manohar noted that "the situation is difficult and the kind of groups currently present are small and are formed to deliver HIV related services and information. This is a slow process and larger movements need to give space for sexual minorities, sex workers. The movement of food security encourages people from marginalised communities to join." "While going to court is one strategy, it is not useful for sex workers as in national/international discourse on sex work the lines between sex work and trafficking are blur."

Question: Please share with us your perceptions on the challenges for the SRHR movements in engaging with poverty and sustainable development social movements. What would you recommend as critical for the movement in terms of growing food insecurity and poverty in the Asia Pacific region?
Manohar is actively working towards setting up a political party and becoming politically active to champion the issue of people of diverse sexual orientations and gender identities, sex workers, women, dalits, adivasis, religious minorities, workers, poor and all marginalised sections of society. He sees a critical need for the LGBTIQ persons and sex workers to engage in politics.

"People need to get united politically, get their voices together, create a space where different groups with different ideologies can negotiate a space, and make the difference." His turn to politics comes from the experiences of atrocities on people of diverse sexual orientations and gender identities, and sex workers by the State and police, resulting in violent attacks by the State on NGOs and the affected communities recently in Karnataka, India. In his opinion, violence was used as a tool, since people did not have political power (as they are not organised in a manner to influence electoral politics) , and after this incident he was strongly inspired to take up the political path in his struggle for the betterment of lives of sexual minorities.

On the issue of regional and international developments on people of diverse sexual orientations and gender identities, and sex workers,

Manohar noted that Brazil seems to make definite progress with regards to the issue. Nepal is making good progress in Asia – the landmark 2007 Supreme Court Decision, aimed at securing rights for Nepal's Lesbian, Gay, Bisexual, Transgender and Intersex population, and the addition of a new category on citizenship documentation essential to access a range of health and legal services. The society in Thailand is more inclusive as well. In countries such as Bangladesh, Sri Lanka, and Pakistan, transgender communities face difficulties. Overall, the work around larger LGBTIQ Groups, focuses more on provision of condoms, HIV prevention and treatment. The movement has not actively taken up economic rights of people, and the funding streams are very narrow. "The poor are more vulnerable, class issue analysis is missing in this whole exercise. It is more of an identity issue and the lack of acknowledgement that it is the identity which makes people poor."

Manohar observed that people of diverse sexual orientations and gender identities discourse, internationally, are mostly dominated by rich elite people, men, and the English speaking people, while the representation of the poor and women is low. "Intersectional analysis is missing." A single identity issue is doing more damage to the cause of people of diverse sexual orientations and gender identities, and sex workers. There is a need to understand the multiple intersections of discrimination, such as that of class, caste disability.

Question: On the double/triple and multiple exclusion process by which social divides are further reinforced, what are some of the integrators?
To this, Manohar responded by stating that the constitutional rights have to take precedence and dominate the discourses to protect everyone including LGBTIQ persons and sex workers. Manohar described his dream, his vision as an integrator is to create a political platform through active involvement in politics. He envisions this political platform for all marginalised groups, people holding different ideologies (feminist, Ambedkarite, left, socialist, ecologist etc), all persons to come together to function, move and operate the political platform/party through democratic decision making process.

Manohar's vision is to keep democracy intact. He envisions a methodology where everyone respects each other, something in the line of new democracies, where through proportional electoral system there is no majoritorian (FPTP) vote such as in Brazil, and where the government brings together all alliances and the whole society participates. He envisions a system to keep people together, and help people work together, for at the moment, we are divided. Finally, a two-party system domination is not going to work for the gaps in societies.

RECOMMENDATIONS AND WAY FORWARD

The best way to work is to take the complexity into consideration because everyone feels excluded in certain social settings, for instance, an elite upper class woman may feel secure in her class setting, but she may be oppressed in the aspects and setting of religion being a Hindu woman etc. If such complexities are understood, this will be a better way to move forward.

1. Health interventions need to shift their approach from number driven and target oriented approaches to interventions founded on a human rights approach with respect for people.

2. Health interventions need to take into account the diverse contexts and lives of persons. A blanket approach would not serve the needs of all persons.

3. There is a need to reduce stigma and violence towards people of diverse sexual orientations and gender identities, and sex workers.

4. Integration of LGBTIQ persons and sex workers within broader social movements is critical.

5. The need to include class issue analysis and other intersectional analysis while working with sexual minorities.

6. Constitutional rights have to take precedence and dominate the discourses to protect and fulfil the rights of all persons.

Ms. Ninuk Widyantoro

7 : INDONESIA

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Question: Please describe your work in civil society which has some bearing on the issues of poverty, food security, and sexual and reproductive health. Do you feel that for organisations working on poverty issues in Indonesia there is sufficient focus on how poverty affects women in particular? And, in that context, is the right to health linked with the right to adequate food? Has your involvement in the SRHR movements led you to also determine the agenda on combating poverty? Please explain the dilemmas faced by SRHR organisations when they work on issues of poverty eradication.

Ms. Widyantoro explains: "My work in the Women's Health Foundation does not specifically focus on poverty alleviation, but we always set up our community empowerment programme/project in poor communities. Other than our advocacy programme to change the law, the programme now assists the Ministry of Health in drafting Government Regulation to implement safe abortion services, our other programme is focussed on community empowerment on SRHR, and most of our works are in poor or problematic areas.

I think there are strong links between poverty and SRHR. Poverty will strongly affect women/people SRHR, since these people are lacking knowledge and useful information that can protect them against many different hazards. Lack of good quality food will only push them into confronting even poorer quality of health type of hazards causing a poor quality of the child if the woman gets pregnant. Facing an unwanted pregnancy because they either lack knowledge about how to prevent a pregnancy or they could not afford to buy any contraception, or they don't know how to access the right services will then give more burdens to the women.

"Poverty is actually a human enemy, and it will produce a weak generation. It makes me so sad to think about this. In a poor community, women will always be the poo rest of the poor. Pregnancy, whether it is wanted or unwanted, will be a threat to her health and her life."

"I always believe that SRHR education program is just one effort to minimize poverty and not directly eradicate poverty. We need to join with other programmes in order to really help these poor communities. In the last ARROW Regional Conference (May 2012), I just realized that actually SRHR can be regarded as a cross-cutting issue

Table 7. Indonesia: Key Poverty, Food Security and SRHR indicators

INDICATOR	DATA
General Indicators	
Total Population (in millions)	242.3
Life Expectancy at Birth (2011)	69.4
Human Development Index(Rank and Value) 2011	124 (0.617)
Inequality Adjusted Human Development Index	.504 change in rank= (8)
Income Gini Coefficient (2000-2011)	
Population below income poverty line PPP$1.25 a day (%)	18.7
Gender Inequality Index	100 (0.505)
Women Empowerment and Sexual and Reproductive Health and Rights Indicators	
Maternal Mortality Ratio	220
Adolescent Fertility Rate (women aged 15-19)	45.1
Contraceptive Prevalence Rate, any Method (% of marriedwomen ages 15-49) 15–49)	61.4
Unmet need for Contraception	9.1
Median age of marriage(25-49	19.8
Violence against Women legislation	Law No. 23 of 2004 regarding Elimination of Household Violence
Seats in National Parliament (% Female)	18.0
Labour Force Participation Rate (%) Female-Male (2009)	
Population with at least Secondary education (% ages 25 and older) Female-male 2010	
Health Expenditure Indicators	
GDP per Capita PPP$	4,199
Total Expenditure on Health as percentage of GDP	2.4
Food Security and Nutrition Indicators	
Aneamia Prevalence in pregnant women(Proportion of the population Population with anaemia with Hb<110 g/L)	44.3
Under- Five Mortality Rate %	3.9
Population under 5 suffering from stunting (%)- wasting (%)	40.1 - 19.6

Source: World Contraceptive Use 2011; Respective Demographic and Health Survey using Statcompiler; Global Hunger Index Database; Human Development Report 2011; Trends in Maternal Mortality: 1990 to 2010. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. WHO 2012; UN Secretary General's Database on VAW; UN Data; Worldwide Prevalence of Anaemia (1993-2005)

with Poverty and Food Security, with Migration, with Environment, with Clean Water etc. because in whatever issue, it will put women in the centre of burdens and hazards especially because of their being women, especially because their reproductive systems are such and, plus, the social construction which positioned them in a complex and difficult situation."

Ibu Ninuk (referring to Ms. Widyantoro) added that so far they don't have any firm plans to really link their SRHR programmes with an agenda focused on combating poverty. "We have the idea in mind, but we still have not found a reliable partner to do it. Last year, there was an offer to assist a program on helping women raise their income by giving them a credit to start a small business and the company who do this asked us to empower these women by educating them about SRHR. Unfortunately, the company is a cigarette company, and in principle, we are against cigarettes, so we turned down the offer. Actually, we do not see any dilemmas to work on poverty issues: I think we just do not know yet how to start, the methodology and funds is also a big barrier. I have to admit that I myself am now keen to think about it, even though we still have to face a great challenge to achieve SRHR for all."

Question: Please describe your experiences in working with women in poverty and vulnerability conditions and what were your entry points? (These could be country specific given the extreme variations often within countries). Do you think that the campaigns against poverty-free societies and the right to food need to build closer linkages to SRHR and if so, what do you think would be the way this can be done? Has the failure by State to address issues of poverty affected also investments for health care for the poor? Do you see visible trends in SRHR service availabilities for the poor? Please describe the linkages you consider to be crucial. As a NGO working in SRHR area, we get used to starting by introducing a number of principles as follows:
Ms. Widyantoro asserts that "(k)nowing your body, your reproductive organs, functions and the systems to protect yourself against unnecessary burdens and hazards – physical, mental and also social".... This is how we begin. Then, we introduce the mapping of our body, give the names of the reproductive organs, their functions and the system using simple tools that can easily be reproduced. Our messages include – When no one will or can protect you, you have to try hard to protect yourself, and the first step is your own health, then that of people around you.

Actually, we are the ones who can make a good plan of our life. We have the right to stay healthy and to achieve a good quality of life. In this, we introduce many different rights that each person should have – Human Rights, SRHR etc.
We also discussed about sexuality and in my 30 years of experience working in this field and also teaching in many different countries including Islamic countries such as Iran or in a Catholic/Christian teaching country such as Timor Leste, I have never been rejected after I explain what is actually discussed in sexuality education.

The Government never sees the close linkages between poverty and SRHR. In my opinion, this is a very difficult situation to be addressed. In our experience, many decision makers or medical professionals themselves lack in understanding and do not have a complete knowledge about what they mean by SRHR. Women's Health Foundation keeps records of how the poor have the knowledge of doctors and midwives regarding SRHR. If the decision makers do not understand about this issue holistically, what can you expect them to do?

The only Government programme to protect the poor is setting up a Health Insurance scheme, although through experience, the access has not always been easy. Working for a long time in this effort, sometimes I am amazed that no one in power can believe that education (although not formal) can change people's lives. Since Cairo, I have witnessed a lot of money being invested to train medical professionals, to buy medical equipment, to build buildings, but very, very little has been put aside for human investment like education, training peer educators, counselling, and training – all efforts to make people respect other people. It seems they do not like the idea of empowering people, especially women.

Yes, I think now is the right time to do the linkages. In my opinion, this time we have to work more with young people, the owners of the future generation, empower them before they get trapped by poverty and SRHR related burdens and hazards. To do this, we have to sit with NGOs who already have experience in working in the poverty alleviation programme. The new chair of Women's Health Foundation once had this idea, but we cancelled it because of limited funds.

We should also discuss this with higher ranks of decision makers in the MOH, Ministry of Women Empowerment, and Ministry of Social Affairs. In the Indonesia case, it will be more possible if we work with local government. We can choose Governor or Head of Districts who have a caring attitude towards their people. So far, Women's Health Foundation has been successful in working with them. In my opinion, if we want to start these initiatives, it will require sitting down with Local Governors or Head of Districts, private sectors in the area and related Ministries as witnesses to take up the pilot programme and see if it works. In my opinion, it will be more of a bottom-up approach since the Indonesian Government has failed in so many ways in bringing up the quality of health, education, safety and welfare to their people.

Health professionals need to be trained around the principles. Health professionals think they know better, we need to spend more time with young people, maintain good relationship with the Ministry of Health, have a soft attitude, for instance, when Ibu Widyantoro asked the Ministry, with a rationale, if she could have young people from the government to train them along with young people from civil society, she was able to get young government staff for training."

Ms. Widyantoro) is of the opinion that the understanding of the real situation is increasing and increasingly, governments are seeing the value of civil society and working with the civil society. Ms. Widyantoro has now completed 4 trainings on SRHR including the government staff and she sees hope. In Indonesia, the New Minister of Health (only one month old), is positive about the contribution of CSO movement, and is willing to see and talk with Ms. Widyantoro 's group on SRHR related matters.

Auto- biographical narratives

She explicitly stated that she is not a poverty expert and at the same time, works on issues of SRHR among poor communities. Her management of work both at the rural community level and her advocacy at the national level comes from her experience which started when she was quite young. She is a psychologist by profession and came across clients in the city who could afford her services. After 3-4 years of her work, Ibu Ms. Widyantoro felt uncomfortable working at her clinic which caters to people who are rich enough. Her heart was in the rural areas where women had no comprehensive SRH services and she wanted to go back to the communities.

One day, she came across the UNFPA representative who had some fund for programmatic work in Indonesia and asked Ms. Widyantoro what she would do. She said she would want to work in the villages, so that more people can access information and services. Ms. Widyantoro was of the feeling that she owes to the community, to the rural women, who are deprived of basic health needs and services. In clinic level counselling, empowering takes place one by one, but the community level work will help her to serve more people, in fact, she thinks the poor are her “Guru” who have pushed her to work more and do more to improve their lives.

On the maintenance of any baseline work, which would enable to measure change and see impact, any anecdotal information, any successful practices to share, any specific interventions that have made progress, Ms. Widyantoro noted that she kept a record of clients, and performed simple surveys. She also had worked on a paper on unwanted pregnancy to convince doctors, medical professionals, and policy makers, based on evidence. She emphasized that keeping records is part of her work.

On the kind of illness that poor women come for services, Ms. Widyantoro noted that in the 1980-1990, she had to do all the work providing counselling and SRH information by herself, since the 1990s, she has been training more people, peer educators on SRH information, methods, and counselling. She has also developed simple forms which provide information on sexuality, and health.

She shared interesting accounts of how women in rural Muslim communities asked her questions around orgasm, sexuality, pleasure, how to satisfy partners, and if it is normal to have an orgasm, how to describe orgasm, and whether a white discharge is normal? She noted that there are many SRH issues that need to be addressed, taboos around syphilis, STIs etc.

When Ms. Widyantoro communicated the situation in the rural areas to the Ministry officials, they noted that such services around STI and RTI screening, prevention, treatment and management were not available. In one village in Sumatra, after they learnt about SRHR information, and STD signs and symptoms, the community women noted that they had the symptoms mentioned by Ms. Widyantoro , but there was no place to go, no laboratory for tests, nothing to check and diagnose. After advocacy with the governments, one year later, the government established a clinic. There is no exact method to make things work. Methods are different, and constantly working in the communities will help to solve problems.

The above practices and understanding being fundamentally true, and putting the reality of people to be at the centre of discourse, participatory learning, will help achieve goals for the poor. With respect to issues around good quality of food being available in the communities, and the reflections on the supermarketisation of foods in Indonesia, Ms. Widyantoro made known her restlessness on the matter. Being a psychologist, when she talked of connecting and integrating poverty alleviation with SRHR, she would look at the issue through the Maslow’s hierarchy of needs framework (attached below).

Field Learnings

In her opinion, people have to address the basic survival needs of food, water first, to attain further levels of other needs such as good sex, enjoyable sex free from infections.

We have to put in place the basic needs for poor people; even to fulfil the first need is very difficult. It is not enough to just live, living a good quality life is important. Food, especially balanced food, it is impossible for poor people to consume in the Indonesian context. Women during menstruation, pregnancy need better intake of food and nutrients, for better reproductive health outcomes.

Government has not been able to provide basic needs for people. Women and girls lack good nutritious food, and there is prevalence of anaemia during pregnancy. The first three months are critical for brain development and nutritious diet is important for this. It is a crime on the part of government to not address the basic needs of people.

Question: In the tribal community settings 20 years ago, in India, there was more self-sufficiency at the community level, growing food in small pieces of land which would cater to the needs of community people, tribal people and helped them live dignified lives – on whether things are changing with the privatization of commons in Indonesia?
Ms. Widyantoro observed that in Jakarta, super and hypermarkets rob the traditional markets. Even if people are poor, if they have some land holding, they will be able to grow their own food for basic survival, but the Indonesian government does not think about equality or people and the only thing, now and lately, that the government is talking about is health insurance, but this will not solve problems, accessing insurance is not easy, manipulations take place, people who really do not need an insurance free of cost are getting this. Ms. Widyantoro states that she has stepped down from her organisation to give space for younger people. She further noted that the interview with Dr. Shobha has inspired her to do something new, and she recalled her memories with her grandfather and this encouraged her to want to do something more for society.

Internationalising one’s work: On Ms. Widyantoro ’s travel to different countries, what are key messages that will bring us all together?
Ibu Ms. Widyantoro states: “It is sheer willingness on the part of people, wherever she meets people, the entry point of conversation revolves around herself, her body and this is a great way to open up and have meaningful conversations with people. “It is not enough that we keep talking to people in the movement who are already converted and are aware of the issues, it is important that we change the mindsets and world view of people who have the power to change things.”

RECOMMENDATIONS AND WAY FORWARD

On the investments required in the area of SRHR, Ms. Widyantoro recommends the following:

1. Changes in the mindsets of UNFPA. UNFPA needs to take a strong leadership role on issues of SRHR at the national and the regional level. UNFPA has to be proactive in steering and supporting the provision of rights based SRHR information and services at the national level.

2. WHF works in poor areas in East Java. Early marriage is a major issue here. Fathers want to get rid of their daughters as soon as they are 11-12 years old. Marriages occur mostly between young girls with older men, mostly Muslim leaders, and there needs to be action and review around this issue.

3. Peer education and trainings among young women and girls can go a long way in improving the lives of women and young girls.

4. Corporate social responsibility approach needs to be studied to bring resource support for the initiatives. This approach, however, has to be approached with caution.

On the issue of religious extremism, Ms. Widyantoro highlighted the influence of religious extremism in the rural areas. However, when Ms. Widyantoro talked about issues of SRHR which are so central to human development and existence, about respecting the bodies etc, Muslim Islam women leaders tell Ibu Ms. Widyantoro , “I WISH I MET YOU LONG BEFORE.” She further notes “sex” is not something that cannot be discussed, it is not dirty, and it is given by god.

5. Enable women to decide and exercise control over her fertility, the number of children she actually wants to have, addressing issues of reproductive health and morbidity, so that women can actively engage in productive work, participate in economic and political arena and move ahead to claim their agency.

6. Budget analysis from gender perspective needs to be implemented, in addition to, the actual implementation of laws and policies promoting women empowerment.

Ms. Sivananthi Thanenthiran

8: MALAYSIA

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“ARROW works across 12 countries on women’s SRHR; poverty as differentials in access to health has surfaced, but not an in-depth understanding of poverty. In Malaysia, poverty was eradicated since the development plans of the 70s; since then, there has been a redefinition of national poverty lines. The government is trying to take into consideration the concept of urban poverty which is set at US$700 per month per household. There is not enough focus on women’s poverty – perhaps there is even apathy towards women’s issues, as if to say more women than men in universities, and more women in the civil service make it no longer an issue. However, in the east coast and in East Malaysia, this is really an issue that needs to be looked at; also, for vulnerable populations such as migrants and the indigenous peoples.

The SRHR movement has a very narrow version of poverty i.e. many children make families poor and family planning is essential to reducing poverty, because they would have fewer children. This is happening despite much research that children in poorer families start earning their keep, and hence, are a source of income (not that I’m trying to condone child labour) rather than an expense which keeps families in poverty. There is also a lack of recognition that even if you have two children, one child or no child – you still can be poor. However, suffering from sexual and reproductive ill-health i.e. morbidities, maternal deaths, STIs & RTIs, impacts women’s abilities to lead productive lives and perpetuates conditions which keep women in poverty.”

Field Dilemmas: There are several dilemmas in our work to name a few – often, the choice of contraceptive methods is not made available, and only long term methods are on the table; birth facilities reveal ill-treatment of the poorer and the lesser educated; the laws of the country – i.e. abortion and of migrants giving birth are problems, and lastly, just to name a few, advocating for equal access for transgenders and same-sex relationships are major problems. We, therefore, sometimes only do what allows us to operate as legal entities.

ARROW's partnerships and regional diversity: ARROW's work in 12 countries and the issue of comparative locations is important to bear in mind. E.g. the direct contrast of Malaysia in comparison to the 12 countries, with countries such as Lao PDR which is land locked, with a socialist government; with Nepal which is also landlocked, an LDC country and has people living in mountainous terrains; and Pakistan which is comparatively less developed than India, with poor government accountability on issues of health.

The issues of inequality between the richest and poorest in the Indian context; with China being a large country with some provinces less developed such as the western province (higher rates of maternal mortality) in comparison to the rest of the country. "CSOs in China operate differently, as CSOs and NGO settings are different from other country contexts – NGOs are administered by government offices and have government support. The "Hukou system," which is basically the household registration system, restricts population mobility and access to state sponsored essential health and education services if people are away from their respective place of origin.

As a result, migrant health, especially migrant women health especially SRHR is a serious problem in China. We have partnered Yunnan Health and Development Research Association who advocate with the Chinese government. It is difficult to critic and speak out within the Chinese context which is heavily controlled by the State. The context of Fiji and most of the Pacific states is difficult to follow, too. These States are mostly funded by Australia and New Zealand and largely have a centralised health system. ARROW tries to work in these countries with women organisations, most women's organisations in these countries do not recognise the governments, and if we want to impact health programmes and policies it is important we work with governments, and hence, the situation is difficult here.

Some of the Pacific states have worse sexual and reproductive health indicators such as Papua New Guinea and Solomon Islands. With respect to Indonesia, the system is decentralised, and as a result of this, we see the clampdown on women rights due to cultural and religious conservatisms at the local level, resulting in numerous battle fronts due to decentralised units of administration which is very difficult."

Ms. Thanenthiran also underscored that creating universal access to services is what ARROW is working towards. She, however, cautioned that the mechanisms of decentralisation and devolution that they are currently seeing are all World Bank driven and it is important for the women's groups to be concrete and precise in what they ask for and clearly define this. With regard to the State providing health and education (State subject in India), Ms. Thanenthiran noted that "this would be unfair as the some state governments that have poor resources and generally with poor health indicators are not able to invest enough on the health of the people in comparison to well off states. It will be appropriate that health becomes a federal subject and the central governments pool the resources in a common basket and allocate accordingly."

On the issue of why one policy does not fit all and how ARROW would find it demanding to work in different country contexts, and Ms. Thanenthiran's referenced to poverty and how this is seen as an issue of demography and being poor is used against people, and what is it that makes it difficult to contest with religious leaders, churches, ethical structures that reproduce and recreate poverty, and how ARROW in public policy is relating to this: "Most ARROW partners are not directly working on issues of poverty and ARROW is of the belief that the poverty aspect is important, especially in our work relating to SRHR.

The privatisation of the health sector and the basic premise on which the society operates which is to monetise everything, to create, run and sustain economies is detrimental in addressing the health needs of people, especially vulnerable people. For instance, the buying of insurance for health and education and such structures where everything is monetised, are being created. At the same time, there is a large section of the society that is left out. There is a lack of government accountability to address issues of poverty. While in different countries the strategies may differ, it is important that ethical normatives should not be compromised or violated and setting forth standards."

The Bretton Woods project of the 1980s in the African countries, basically encashed on poverty in these countries – the economic reforms and the structural adjustments programmes – basically put large masses of people in diminished state to access social services – which is part of privatisation efforts and the introduction of user financing models all adhering to the economic model of MONETISING EVERYTHING, the trade in human organs and parts etc., the promotion of private corporate interests by the State, in contrast to a situation where the role of state is to ensure a higher order of governance. The high out-of-pocket expenditures especially among poor households, the corporatisation of basic services – in principle, the purchasing power of individuals should not determine the quality of services. Citizenship rights, the issue of transgender sex relationships etc., and where we can see the common standards are important.

Table 8. Malaysia : Key Poverty, Food Security and SRHR indicators

INDICATOR	DATA
General Indicators	
Total Population (in millions)	28.9
Life Expectancy at Birth (2011)	74.2
Human Development Index(Rank and Value) 2011	61 (0.761)
Inequality Adjusted Human Development Index	
Income Gini Coefficient (2000-2011)	46.2
Population below income poverty line PPP$1.25 a day (%)	
Gender Inequality Index	43 (0.286)
Women Empowerment and Sexual and Reproductive Health and Rights Indicators	
Maternal Mortality Ratio	29
Adolescent Fertility Rate (women aged 15-19)	14.2
Contraceptive Prevalence Rate, any Method (% of marriedwomen ages 15-49) 15–49)	54.5
Unmet need for Contraception	
Median age of marriage(25-49	
Violence against Women legislation	Domestic Violence Act 1994
Seats in National Parliament (% Female)	14.0
Labour Force Participation Rate (%) Female-Male (2009)	44.4 - 79.2
Population with at least Secondary education (% ages 25 and older) Female-male 2010	66.0 - 72.8
Health Expenditure Indicators	
GDP per Capita PPP$	14,012
Total Expenditure on Health as percentage of GDP	4.8
Food Security and Nutrition Indicators	
Aneamia Prevalence in pregnant women(Proportion of the population Population with anaemia with Hb<110 g/L)	38.3
Under- Five Mortality Rate %	0.6
Population under 5 suffering from stunting (%)- wasting (%)	

Source: World Contraceptive Use 2011; Respective Demographic and Health Survey using Statcompiler; Global Hunger Index Database; Human Development Report 2011; Trends in Maternal Mortality: 1990 to 2010. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. WHO 2012; UN Secretary General's Database on VAW; UN Data; Worldwide Prevalence of Anaemia (1993-2005)

Types of organisations – "There are some organisations that work on maternal health and solely focus on this, and would not work on issues of abortions rights, some organisations work on comprehensive sexuality education, which according to them needs to be culturally sensitive and taught by parents. However, not all organisations are like that. ARROW aims to push boundaries for a full realisation of sexual and reproductive health and rights in its fullest rights-based definition.

Sometimes, there is a divide - a clash in philosophy, fall outs with funders. If you want to be an advocate, the advocacy messages have to be crafted in such a way that it deals with issues practically, for instance, abortion procedure is a very safe procedure. However, given the legal restrictions in the Philippines on grounds for which abortion is permitted, many unsafe abortions take place (since it is not done by persons with the necessary skills, or in an environment lacking minimal medical standards or both) and hence, abortion becomes unsafe – this is the practical context in the Philippines – and advocacy has to be geared to take into account the practical context and the issue at hand."

On issues of the right of LGBTIQ in Malaysia and China, and whether it is acceptable to religious groups in Malaysia, Ms. Thanenthiran explained that "in the Malaysian context it is a Challenge. There has been a Sexuality Merdeka Campaign.[14] The government in Malaysia says that homosexuality is

unacceptable in Islam – 'these people have to be reformed.' It is a challenge for LGBTIQ communities in Malaysia. In China, I came across a university which is running a course on sexuality in Shanghai and I think that the society might be opening up to the issues of LGBTIQ. Traditional groups in Asia look at the LGBTIQ movement as being a western agenda and mostly, LGBTIQ are looked at from the HIV prevention and treatment point of view rather than a rights issue."

This is not a priority issue in any developing country, and in the complex intersections of SRHR with poverty, class, gender, and ethnicity, within the complexity of it all, where does the LGBTIQ agenda get integrated? Most poverty eradication work deals with structural work and here Ms. Thanenthiran noted that by "[l]ooking at the transgender community, they have little opportunities to go beyond the community. There is no social mobility, and many issues of identities arise. At the same time, when we talk of sexual rights, it is not just the LGBTIQ but also women and their sexual rights that are at stake."

Question: Please describe your experiences in working with women in poverty and vulnerability conditions and what were your entry points? (These could be country specific given the extreme variations often within countries). Do you think that the campaigns against poverty-free societies and the right to food need to build closer linkages to SRHR and if so, what do you think would be the way this can be done? Has the failure by State to address issues of poverty affected also investments for health care for the poor? Do you see visible trends in SRHR service availabilities for the poor? Please describe the linkages you consider to be crucial."
Ms. Sivananthi Thanenthiran states: "In Malaysia, the policy of universal health coverage has been in practice since the 70s. Within the universal health coverage iron folate and ante-natal vitamins are often prescribed. Food is highly subsidised in the country – essential items such as rice, flour, milk, salt etc. are controlled by the government to make it affordable for all Malaysians and hence, the problems of our nutrition are more on the changing patterns of food consumption from traditional food to fast food; and a sedentary lifestyle. Hence, it is health conditions like diabetes, hypertension, and cholesterol, which also have an impact on SRHR, that are coming into the picture. However, in recent years, there has been an introduction of a privatised health care system, which is insurance-based with prohibitive costs."

On the issue of universal coverage and food subsidies, and how a person, especially women can gain access, Ms. Thanenthiran noted that the food subsidy is for everybody, there are price controls and the subsidies are for all citizens. On the issue of some countries, where people are graded and targeted for distribution of essential commodities and food items based on certain classifications of poverty and income levels, a food pricing policy in Malaysia for the general population seems like a universal system and prevents the monetisation of essential food items and whether such a policy also works in East Malaysia, where poverty levels are more evident. Ms. Thanenthiran responded by saying the food prices are a little higher in East Malaysia due to transportation costs as the geographic terrain of the place is spread out and hence, a nominal 20 *sens* or so is added to the cost of commodities in East Malaysia.

On the public health system, Ms Thanenthiran noted that there is a good and efficient PHC system in Malaysia, run by the government which is universal. At the same time, a private health care system also co-exists. The government system is very efficient with a triage counters that assess the seriousness of the patient and the patient is given care accordingly within the specified time. The Government is now trying to introduce the mass based insurance system, a system in line with the Singapore health system. "Super Freakonomics" puts Singapore as a model where public health and insurance are brought together rather than either or. Shobha noted the key principle of Singapore's national health scheme where no medical service is provided free of charge, regardless of the level of subsidy, even within the public health care system, and insurance based health financing, and the preference of people would be for a reform of the health system for more efficiency rather than change in the economic structure of health care provision based on market principles and monetisation of public services.

Question: Way Forward – In conclusion, please share with us your perceptions on the challenges for the SRHR movements in engaging with poverty and sustainable development social movements. What would you recommend as critical for the movement in terms of growing food insecurity and poverty in the Asia Pacific region? In research, what should be the linking spaces that need elaboration and political re-mapping? In campaigns, can you suggest to us the crucial alliances that serve struggles at both the national levels as well as the regional and international levels? (Please focus from Malaysia's perspectives where priorities may be different. Then tell us what you think should be the main priorities for a more sustainable intervention and solidarity building.)
"The challenge for the SRHR community is that it is a community which has not really considered 'macro' solutions to be the way things are done; and questions of poverty and food security are issues that do call for a macro understanding and changing the ways in which things are done or the way the world operates. Important organisations for alliance building would be Third World Network, Pesticide Action Network, and for the right to food movement, SAAPE, would be key at the regional and global levels.

There needs to be a linking of our agendas together; there needs to be an understanding that we need to work on these holistic solutions together, rather than in dividing the agendas up and that, essentially, we need to discover new solutions and we need to keep an open mind, because the world has changed, and the operating systems in the world also have changed and we may not understand the 'unseen' hands as well as we did two or three decades ago."

RECOMMENDATIONS AND WAY FORWARD

On the issue of not having a theoretical base on how to integrate SRHR issues within poverty, engendering development and locating SRHR within the poverty debate in a divided world, based on the Malaysian experience, Ms. Thanenthiran noted the following recommendations:

1. The current development work is not going to bring any change, Malaysia was also a recipient of development assistance in the 70s, 80s, and after that something happened. The current MDGs are worse, a holistic development agenda needs to be pursued, getting groups out of poverty and instituting systems that work for the 99% not just the 1%.

2. The blurring of lines of citizen and corporations. The case of United States where corporate personhood is the legal concept that a corporation may sue and be sued in court in the same way as natural persons. This provides a legal recognition that corporations, as groups of people, may hold and exercise certain rights under the common law and this sort of developments will be detrimental to protect the rights and interests of citizens.

3. There is a need to provide universal access to services.

Dr. Renu Rajbhandari

9: NEPAL

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Dr. Renu Rajbhandari is the founder member of WOREC in Nepal, at the regional level is associated with Asia Pacific Forum on Women Law and Development (APWLD). Dr. Rajbhandari has effectively worked to integrate issues of women's SRHR, especially Uterine Prolapse, for the past 20 years in Nepal into the broader sustainable development framework.

Question: Please describe your work in civil society which has some bearing on the issues of poverty, food security, and sexual and reproductive health. Do you feel that for organisations working on poverty issues in Nepal, there is sufficient focus on how poverty affects women in particular? And, in that context, is the right to health linked with the right to adequate food? Has your involvement in the SRHR movements led you to also determine the agenda on combating poverty? Please explain the dilemmas faced by SRHR organisations when they work on issues of poverty eradication.
To this, Dr. Rajbhandari responded by stating that there is a narrow focus on women's health – governments and donors focus on the symptoms be it Uterine Prolapse or any other condition – without addressing the structural issues of food security and poverty. Dr. Rajbhandari shared: "Undeniably, women's health issues need attention and women cannot control her bodies without having food security."

Citing an example, she commented: "Advocacy on the issue of Uterine Prolapse has resulted only in surgical care. This is an unfortunate situation, which resulted in governments and donor programmes focusing narrowly on surgery and the removal of uterus. After the surgery, women are discharged from the health facilities without any food or follow up. This irresponsible butchering of women's uterus is under question. What right do governments have to butcher women bodies, unless they take responsibility for the overall well-being of women?" The narrow project's focus on issues of women's health hinders the holistic overall rights of women. WOREC'S work tries to integrate all aspects in their work with women in Nepal.

On the possibilities of inter-linkages, Dr. Rajbhandari noted that WOREC Nepal works on integrating women's health issues with livelihood issues such as agriculture, land rights movement, cooperative setting etc. She cited examples of WOREC starting training centres to build capacities on these issues. The issue of food security is a national problem, and in this environment, how can a woman control her body if she does not have access to basic need which is food. Dr. Rajbhandari talked about pilot models such as the "model village" where issues of food security and violence against women were addressed.

Dr. Rajbhandari mentioned that SRHR groups and women groups have to explore the possibilities, and show linkages of women's health to broader issues of poverty and food security. These need to be shared and advocated with policy makers. For example, in Nepal, work is ongoing simultaneously with the national planning commission, agricultural ministry, and the health ministry and concerned ministries to affect change for holistic, integrated action on Uterine Prolapse.

Question: In the context of the liberal agenda taking over, with privatisation and deregulation being the norms for the day, and in this context, how do we envision the positioning of women's SRHR at the international level?
To this Dr. Rajbhandari noted that her experience at the regional and international level is through APWLD, which focuses on bringing the evidence from the grassroots and linking it up at the regional and international discourses and debates. Work is ongoing to integrate poverty within Sustainable Development Goals (SDGs).

She observed: "At the Commission on the Status of Women (CSW) as well there was a discussion and debates on issues of food security and globalisation within the women's groups, however, these debates are not fully substantiated with evidence from the ground and do not get connected and linked up with realities on the ground. WOREC is the only organisation that critically looks at different linkages and works on women's rights issues."

Question: On the need to connect the local, district, national, regional, and international spaces and consistently connecting the linkages of right to food, right to employment, food security and drawing these linkages at the international level and forming serious alliances between poverty and SRHR groups to stop the liberal agenda being taken over.
To this, Dr. Rajbhandari responded: "There are examples of good working alliances, such as the National Coalition for food and water rights, unfortunately, women groups are not part of the alliance. WOREC Nepal is the secretariat. It is observed that SRHR groups mostly work on a project basis, these projects are often not developed holistically and do not integrate broader aspects of women's health. A lot of advocacy efforts and follow up is done with women's groups, including the political women's wing – who although is left wing, sometimes embrace the liberal agenda."

The unfortunate thing is there is zero political understanding of women's groups on frameworks such as CEDAW, and mostly it is the donor agenda that supersedes.

Question: Please describe your experiences in working with women in poverty and vulnerability conditions and what were your entry points? (These could be country specific given the extreme variations often within countries). Do you think that the campaigns against poverty-free societies, and the right to food need to build closer linkages to SRHR and if so, what do you think would be the way this can be done? Has the failure by State to address issues of poverty affected also investments for health care for the poor? Do you see visible trends in SRHR service availabilities for the poor? Please describe the linkages you consider to be crucial.
Dr. Rajbhandari described her personal journey into the movement. In a health camp in the countryside, Dr. Rajbhandari met with a woman of 56-57 years of age with complaints of backache and white discharge. She was afraid even to talk with the doctor as she turned up late at the camp. She was requested to lie down for check up. Smelly discharge, very dirty body parts and extremely dirty sari which she was wearing forced the doctor to ask why she was in such a situation. Her answer was disheartening. According to her, she was not allowed to take bath in public tap because of her smelly discharge even by the women in the village. She had to allow other women to fill their water tanks for drinking purpose before she takes bath. Shocked with her reply, Dr. Rajbhandari proceeded with the internal inspection which was even more shocking. Dr. Rajbhandari felt some resistance inside her vagina, however, she dared to pull that out and after that the scene was unimaginable.

Her whole uterus (prolapsed part) came out with a fountain of smelly dark yellowish watery discharge and the element which obstructed her passage was a piece of a rubber slipper. That lady had inserted it inside her vagina with the hope that it would ease her walking as that kept her uterus inside. She further shared her story of how she was discriminated against all members of society; she mentioned that she was married at the age of 12; had her first child at 15 and her uterus prolapsed after the birth of her third child at the age of 20.

She had neither attended any health personnel nor

Table 9. Nepal: Key Poverty, Food Security and SRHR indicators

INDICATOR	DATA
General Indicators	
Total Population (in millions)	
Life Expectancy at Birth (2011)	68.8
Human Development Index(Rank and Value) 2011	157(0.458)
Inequality Adjusted Human Development Index	0.301 change in rank= (0)
Income Gini Coefficient (2000-2011)	47.3
Population below income poverty line PPP$1.25 a day (%)	55.1
Gender Inequality Index	113 (0.558)
Women Empowerment and Sexual and Reproductive Health and Rights Indicators	
Maternal Mortality Ratio	170
Adolescent Fertility Rate (women aged 15-19)	103.4
Contraceptive Prevalence Rate, any Method (% of marriedwomen ages 15-49) 15–49)	48.0
Unmet need for Contraception	24.6
Median age of marriage(25-49	17 years
Violence against Women legislation	2009 Domestic Violence (offence and punishment) Act 2066
Seats in National Parliament (% Female)	33.2
Labour Force Participation Rate (%) Female-Male (2009)	63.3 - 80.3
Population with at least Secondary education (% ages 25 and older) Female-male 2010	17.9 - 39.9
Health Expenditure Indicators	
GDP per Capita PPP$	1,155
Total Expenditure on Health as percentage of GDP	5.8
Food Security and Nutrition Indicators	
Aneamia Prevalence in pregnant women(Proportion of the population Population with anaemia with Hb<110 g/L)	74.6
Under- Five Mortality Rate %	4.8
Population under 5 suffering from stunting (%)- wasting (%)	49.3- 38.8

Source: World Contraceptive Use 2011; Respective Demographic and Health Survey using Statcompiler; Global Hunger Index Database; Human Development Report 2011; Trends in Maternal Mortality: 1990 to 2010. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. WHO 2012; UN Secretary General's Database on VAW; UN Data; Worldwide Prevalence of Anaemia (1993-2005)

received any information about her health. Five years later, her husband abandoned her with five children and married another lady. After that, along with the worsening condition of her health, the difficulties of her life began. She went to see several local health institution for treatment but all denied saying they don't have medicines for WOMEN'S DISEASE. This case changed WOREC's working direction and since then WOREC has incorporated women's health programme from women's perspective guided by a book such as *Our Body Our Selves (OBOS)* and adopted the concept of barefoot gynaecologist in her programme and training.

Dr Rajbhandari was criticised by human rights groups, noting that the issue of uterine prolapse was not that severe. With strong advocacy, the national plan of action against uterine prolapse has been approved. The inputs provided by Dr. Rajbhandari into the national plan of action integrated all the aspects not limited to health services. These included addressing the issues of violence against women and improving the status of women.

While there are some positive changes happening such as awareness generation, we have not moved very far. Although the Government of Nepal adopted its national action plan (NAP), on United Nations Security Council Resolutions 1325 and 1820, the plan needs to be addressed. Dr. Rajbhandari cited disappointment with the women's rights groups. Dr. Rajbhandari makes some observations on the

donor agenda. For example, if a donor agency such as UNFPA works on Obstetric Fistula, it supports the operations, and the health ministry follows. While repair is just one aspect of this morbidity condition, there is a need to allocate funds for the root causes and address them.

As a result of the advocacy with the planning commission, and concerned ministries and consistent work at the district and village level, where decisions are being made now, 10 out of 75 plans have mentioned the issue of uterine prolapse.
On the question of funding nature which has lost its focus of social development, and further exploring the root causes for poor reproductive health conditions, Dr. Rajbhandari noted: “The root causes are discrimination against women, poverty, early marriage, not enough food, no access to health care, and prevailing poor health care services. There is an urgent need to improve health care delivery. Poor health conditions of women are an outcome of discrimination and lack of access to health and food.”

On the issues of growing violence against women, which contravenes the fundamental right of women to exist, and perpetuates the genocide against women, Dr. Rajbhandari commented: “The situation in Nepal with regards to violence against women is difficult to assess. The reporting has increased, women groups are strong, and there is more reported violence in the areas they work. VAW has become more visible in areas where these groups work and women are coming out in the open and breaking the silence. In addition, violence is taking different forms, previously, it was more of trafficking of women, now new forms of violence such as surrogacy.”

The increase in fundamentalism is another trend. All kinds of fundamentalisms – religious, ethic – Nepal is a secular country now, but there is growing fundamentalisms to retain this as a Hindu rastra and these have created other forms of violence for women.

On the reforms that need to be advocated for women in terms of accessibility, equity in SRHR, Dr. Rajbhandari recommended a pro woman reform agenda. Dr. Rajbhandari noted that for the first time in Nepal there is free health care provided. A list of 44 essential drugs are being provided. Medicines are free for all at the community level. This was not there previously.

This provision is presently on paper and the government needs to implement this and there is resistance to implement these reforms even from women and left parties. Among the 44 medicines, they have put ring pesery (for uterine prolapse) in the list for 44 medicines in some places. There is a big resistance to free health care and positive action, in the present context of globalisation, and most people say Nepal cannot implement this free health care concept.

Question: With respect to the issue of food security, current trends of supermarketisation, and declining contribution of agriculture to the country’s GDP, dramatic changes in food patterns, and its impact on rural and urban poor access to food, Dr. Rajbhandari notes that food security is a fundamental constitutional right of the people of Nepal.
She shares the difficult situation in Nepal, lack of labourers due to migration resulting in cultivable land becoming barren. There are pockets where actually there is no food deficit for local foods, however, rice, which is mostly consumed by the government officers, is not available and the use of World Food Programme (WFP) resources to airlift the food takes place.

The resources from WFP should, in fact, be promoted to improve the agricultural system rather than airlifting the food in places where other local foods are available. In urban areas, the availability of junk food, which is comparatively cheaper, is resulting in nutritional problems for the people. In fact, be promoted to improve the agricultural system rather than airlifting the food in places where other local foods are available. The migration pattern, where remittances are sent home which is used to buy food and eat, is having a negative impact on agriculture production.”

Dr. Rajbhandari mentioned a model project on sustainable livelihood, integrating both livelihood and agriculture for landless people. They build on a concept of community forestry to develop medicinal and food tuber plants and at the same time, generate livelihoods.

Integrating SRHR in poverty eradication programmes is occurring at the regional level with organisations such as APWLD and SAAPE.

RECOMMENDATIONS AND WAY FORWARD

1. We need to advocate for a basic minimum primary health care for all.
2. We need to bring health care services to the people, rather than people going for the services. E.g. community birthing services.
3. It is very important to start planning from BELOW. Women need to be actively involved in all the planning processes.
4. There is a need to focus on discrimination against women, which is the fundamental root cause.
5. Women have the right to sustainable development and livelihood.
6. Governments need to actively integrate gender sensitive planning processes.)

Dr. Rajbhandari goes back to the community, poor people’s movement, and organisations working at grassroots when she wants to draw inspiration.

CONCLUSION

What is the way forward? What are the perceptions of the challenges for the SRHR movements in engaging with poverty and sustainable development social movements? What is critical for the movement in terms of growing food insecurity and poverty in the Asia Pacific region? In research, what should be the linking spaces that need elaboration and political re-mapping? In campaigns, the crucial alliances that are fostered struggle at the national level as well as the regional and international levels, which are needed. Priorities differ from country to country and yet, there are universal values which cast the actors in solidarity. The main priorities for a more sustainable intervention and solidarity building include holding paramount the goals of dignity, gender equity, universalisation of health care, and inclusion of ICPD goals in all poverty eradication efforts.

We have attempted through these conversations to develop a praxeological mode of calling for a future which integrates in social action and in development planning SRHR in a more structural manner all social action for poverty eradication and sustainable development. The recommendations stemming from the issues and the critiques built around the major problems articulated in this paper have come from the civil society representatives, we had the opportunity to dialogue with. These have been presented in the concluding chapter in Part I. The recommendations to governments and civil society organisations in Part I of this report have drawn heavily from the interviews conducted by Sai Jyothirmai Racherla of ARROW and myself. These interviews have been provided here in Part II in detail with minimal editing. The entire report provides strong field-based recommendations that respond to the need for structural changes, refusing superficial short-term responses.

We recall the message that has been consistent in this report: sustainable development, poverty eradication, gender equity, and health equity are long term goals which cannot be postponed. SRHR is an integral aspect of this holistic framework. They are intimately connected to a collective social will for a genuine democratic framework of governance. Without a political will and ethical standards that form the bedrock of social change, it will not be possible to reach any of the goals that have been set in internationally agreed declarations. The set of public policy and normative standards provided by our speakers can serve as pointers to a compass of social action that guarantees the holistic future of material equality and social justice. Their voices, their actions, their public stands, and their work with the affected on the field in difficult circumstances all compel us to remain resolute in building lasting alliances and working for a future that has been articulated throughout these conversations.

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ANNEX 1

A study on exploring the linkages between poverty, food security and sexual and reproductive health and rights- Way forward for the sexual and reproductive health and rights movement (SRHR)

The broad format for the dialogue (30mins)

1. Please describe your work in civil society which has some bearing on the issues of poverty, food security and sexual and reproductive health. Do you feel that for organisations working on poverty issues in your country there is sufficient focus on how poverty affects women in particular? And, in that context is the right to health linked with the right to adequate food? Has your involvement in the SRHR movements led you to also determine the agenda on combating poverty? Please explain the dilemmas faced by SRHR organisations when they work on issues of poverty eradication.

2. Please describe your experiences in working with women in poverty and vulnerability conditions and what were your entry points? (These could be country specific given the extreme variations often within countries). Do you think that the campaigns against poverty free societies, and the right to food need to build closer linkages to SRHR and if so what do you think would be the way this can be done. Has the failure by State to address issues of poverty affected also investments for health care for the poor? Do you see visible trends in SRHR service availabilities for the poor? Please describe the linkages you consider to be crucial .

3. Way Forward- In conclusion, please share with us your perceptions on the challenges for the SRHR movements in engaging with poverty and sustainable development social movements. What would you recommend as critical for the movement in terms of growing food insecurity and poverty in the Asia Pacific region? In research what should be the linking spaces that need elaboration and political re- mapping? In campaigns can you suggest to us the crucial alliances that serve struggles at both the national levels as well as the regional and international levels? (Please focus from your country's perspectives where priorities may be different. Then tell us what you think should be the main priorities for a more sustainable intervention and solidarity building?)

4. Please place on the agenda some other critical points that need follow up. Please also feel free to send us in writing your responses even after the interview is over including written texts of the institution which refer to these issues.

ENDNOTES

1 See Part 1 for further information (p.16-17, Part I) .

2 Reuters. (2012, July 8). Afghan woman accused of adultery shot dead in public. *The Guardian.* Retrieved from http://www.guardian.co.uk/world/2012/jul/08/afghan-woman-accused-adultery-shot-dead

3 Reuters. (2012, July 8). Afghan woman accused of adultery shot dead in public. *The Guardian.* Retrieved from http://www.guardian.co.uk/world/2012/jul/08/afghan-woman-accused-adultery-shot-dead

4 For more information, see Bangladesh Nari Progati Sangha (BNPS). (n.d.). *News*. Retrieved from http://bnps.org/?p=312#

5 For more information, see Yunnan Health and Development Research Association. (n.d.). Retrieved from http://www.yhdra.org/

6 For more information, see Kunming Medical University. (n.d.). Retrieved from http://www.kmmc.cn/kmmc/exxzl.html

7 The New CMS proposed by the National Rural Health Conference and further shaped by the policy positions taken at the end of 2002, during the 16th Party Congress of the CCCPC. There, China's determination to build "Xiaokong" Society in an all-round way was clearly stated. To realize this over-arching goal, the government proposed a new concept of development – "Put people first and promote overall, harmonized and sustainable." "This concept is supported by "five balanced developments": 1) balance between economic and social concerns; 2) urban and rural areas; 3) between regions; 4) between human beings and nature; and 5) between domestic reform and opening to the outside world.

8 Ms. Sivananthi Thanenthiran mentioned in her interview on the need to have standards, ethical normative in place, while addressing issues concerning SRHR in different country context.

9 For more information, see Rural Women's Social Education Centre (RUWSEC). (n.d.). Retrieved from http://www.ruwsec.org/

10 The protein deficiency in the cereal heavy diets of most Indian is leading to protein-deficiency and this is leading to the rise of the thin-fat Indian phenomenon – one who appears thin in size but has more body fat than his counterparts from other ethnicities in the organs predisposing them to diabetes and cardio vascular diseases.

11 Admin (2007, March 2). History. *Sangama*. Retrieved from http://sangama.org/about/history

12 Chacko, S. (2011). *Chasing Numbers Betraying People: Relooking at HIV Related Services in Karnataka*. Bangalore, India: Aneka & Karnataka Sexual minorities Forum (KSMF). Retrieved from http://manoharban.wordpress.com/2012/03/12/web-link-to-chasing-numbers-betraying-people-relooking-at-hiv-services-in-karnataka-report/

13 For further information, see Pension Parishad. (n.d.). Retrieved from http://pensionparishad.org/pension/

14 Seksualiti Merdeka. (n.d.). Retrieved from http://www.seksualitimerdeka.org/