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for change

SRHR in the Era of the SDGs



Protest against Section 377 of the Indian Penal Code by Muskan, the male and transgender sex worker collective with SANGRAM. Photo courtesy of SANGRAM.

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UNIVERSAL ACCESS TO SRH AND UNIVERSALITY OF SRR: Achieving the Impossible?

Universal access to sexual and reproductive health (SRH) and universality of sexual and reproductive rights (SRR) are over-arching, ambitious calls to governments to fulfil the sexual and reproductive health and rights (SRHR) of people to the fullest possible extent. Both of these calls have been captured in different ways and means within the International Conference on Population and Development Programme of Action (ICPD PoA), the Beijing Platform of Action (BPfA), in various human rights conventions and resolutions, and at present, in the Sustainable Development Goals (SDGs).

To fully explore the potential and the possibilities that the SDGs hold for us to take forward our agenda, we need to closely look at the pitfalls in recent years.

Universal Access to SRH. If we consider universal access to SRH, the term covers three important criteria: what, for whom, and how. As far back as 1994, the ICPD PoA¹ defined the “what” as follows:

Reproductive health care should, inter alia, include family-planning counselling, information, education, communication, and services; education and services for pre-natal care, safe delivery, and post-natal care, especially breast-feeding and infant and women’s health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25,² including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections,

sexually transmitted diseases, and other reproductive health conditions; and information, education, and counselling, as appropriate, on human sexuality, reproductive health, and responsible parenthood. Referral for family planning services and further diagnosis and treatment for complications of pregnancy, delivery, and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS, should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health-care programmes. (Para 7.6)

Within the ambit of reproductive health services, abortion was considered contentious, and consistently caveated with “in accordance with the law” and “not a method of family-planning.” These caveats loom large till today. Within the range of services, sexual health services for common prevalent diseases—such as chlamydia, syphilis, gonorrhoea, and HPV—were subsumed under reproductive health conditions, and as such were invisibilised, with the exception of HIV and AIDS.

The ICPD PoA also recommended that the full range of sexual and reproductive health services should be an integral component at the primary health care level: the level of health care system which is accessible to most of the population. However, the establishment

of primary health care systems across countries, and within countries was uneven—more easily achieved in countries with smaller populations, especially if they were highly urbanised, and lesser so in countries with larger, disparate populations.

The second criterion “for whom” was also stated in the ICPD PoA: all women and men, including young people, both as individuals and as couples.

If we survey the landscape of health service provision, we know that universal access still remains a distant goal, especially for the poor and marginalised who need it the most. The call of universal access has been hampered at different levels by different forces.

The third criterion—“how”—has been a defining one, which modified greatly what services were to be offered, and to whom. Hence, it merits greater elaboration.

Firstly, the premise in the 80s was that governments would and should provide health services as a right of all its citizens. Alma Ata called upon governments to set aside at least 7% of their annual budget for providing health services. Some countries forged ahead on such a model, and to a large extent, are able to offer a variety (though not all) of these SRH services through their health care delivery models. China, for example, has been able to reduce maternal mortality and increase access to contraception through investment in a centrally controlled health system

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with wide reach. Malaysia, Singapore, and Thailand invested in their health systems in the early 80s, and reach was comparatively good because their populations are relatively smaller in size. In recent years, Vietnam too has been able to do the same.

... universal access was not consistent across and within countries. Even in countries enjoying good health outcomes as defined by the SDG indicators, there still are substantial gaps for indigenous people, migrants, the poor, and those living in hard-to-reach areas...

In larger countries like Indonesia, Pakistan, and the Philippines, in the late 90s, health was decentralised to provincial governments rather than centrally budgeted, planned, and implemented. Decentralisation of health then became subject to local budgets and local laws, and the range and quality of services offered became divergent. People who lived in poorer regions experienced lesser access, and when budget prioritisation needed to be made, health services were minimised, and SRH further so. Local religious laws and traditions saw that family planning programmes over time emphasised birth spacing, and almost never mentioned birth limiting, as it was considered a religious taboo to discuss ending births.

However, in the early 2000s, the model touted for governments shifted to one based on privatisation of health services, enabling different providers to enter the market and introduce services for fees (which would need be paid out-of-pocket or through a variety of insurance schemes). In recent years, under the guise of ‘austerity’ measures, there has been a gradual withdrawal of

governments from the health sector. Governments which were already investing in a spectrum of services could not cut down the services entirely as this would mean a political fallout with their citizenry, neither did they expand their services. However, poorer countries that had not been able to invest in services substantially and were donor-dependent for health funding would take a different trajectory.

In this landscape, universal access was not consistent across countries and within countries. Even in countries enjoying good health outcomes as defined by the SDG indicators, there still are substantial gaps for indigenous people, migrants, the poor, and those living in hard-to-reach areas, as demonstrated by all demographic health surveys and population datasets. In under-resourced settings, these groups were hardly considered, as the gaps for the poor, rurally located, and lesser educated were considerable.^{3, 4}

Secondly, universal access should mean access to a comprehensive range of services over the life-cycle. However, even in countries which had invested in building their health systems where most—though not all—of the services were available, conditions such as reproductive tract infections and sexually transmitted infections (with the exception of HIV) were largely sidelined. These services were sometimes available only through maternal health or HIV and AIDS channels, resulting in the larger population being left out for screening and treatment. Further, access to information, screening, and treatment for reproductive cancers were largely unavailable for the poor and marginalised, as was access to infertility treatment. Morbidities such as fistula and uterine prolapse were neither talked about nor addressed. Access to safe abortions became more

restricted in countries where abortion is legal on a number of grounds: there was stricter interpretations of admissibility, service providers were able to raise ‘conscientious objection’ clauses to provide neither services nor referrals, and abortions which were defined as ‘sex-selective abortions’ were clamped down on.

The life-cycle approach was also not the service norm. Women aged 15 to 49—categorised as within the reproductive age—received far more focus for contraceptive and maternal health services. Comprehensive sexuality education and SRH services for young people (especially those unmarried) was neglected, even if they formed a large demographic. Women beyond the age of 49 usually were not even targeted for HIV information and screening, as they were considered non-sexual being beyond their reproductive years.

Third, universal access should mean that all groups in the community could access any of these services. However, groups such as young people, unmarried women, LGBTIQ persons, sex workers, and migrants continue to face innumerable barriers, which stem from systemic bias, provider attitudes, discrimination, and stigma when trying to access services. Universal access should also mean that men and boys were also equally targeted for information and services, but male participation in contraception remains negligible over the last 30 years.

Fourth, a number of countries which had embarked on fertility reduction policies, and had reached below-replacement fertility, are now facing the ‘spectre’ of an ageing population. These are both upper income countries, such as Japan, Singapore, and South Korea, as well as middle-income and lower-middle income countries, such as China, Malaysia, and Thailand. The second set of countries

then tried to revise policies and enable increases in total fertility rates (for example, China relaxed its one-child policy). Population structure is not only determined by fertility, and migration policies can enable youthful migration. However, dominant national political discourse based on ethno-religious nationalism often tied women of the dominant ethnic and religious groups to reproduction for race, religion, and the nation, and obscured the role positive migration could play. This has been noted in countries such as India and Sri Lanka.

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Fifth, although the call was for universal access to sexual and reproductive health and universality of sexual and reproductive rights, there was far more emphasis by governments and donors on reproductive health service provision, including maternal health services, and HIV and AIDS, as compared to the establishment and affirmation of sexual and reproductive rights.

Both SRH and SRR are essential and mutually reinforce each other. While reduction in health inequities would have greater impact on women (because women are disproportionately represented amongst the poor), the past decades show us this alone is not enough. The perpetuation of 'contentious' issues—such as female genital mutilation (FGM), early marriage, access to safe abortion services, access to contraception, and safe sex services for unmarried people—are a result of not

having had equal investment in the rights aspects of the work by governments and donors. Greater investment in sexual and reproductive rights would have reinforced the respect for agency and decision-making of women within SRH services, because subjugation of women across societies has meant that they are often invisible as bearers of rights and the capacity to exercise rights differs between different groups of women according to social privilege.⁵ Utilising the 'health' lens as the primary lens for SRHR has also meant the emergence of ludicrous policy practices, such as the medicalisation of female circumcision in hospital settings to make it 'health'-compliant.⁶

Universality of SRR. This brings us to the other key paradigm of our agenda—universality of sexual and reproductive rights. This entails respect for, recognition, and fulfillment of sexual and reproductive rights, not only to ensure sexual and reproductive health services for all, but also to concretise bodily autonomy and bodily integrity, and enable agency and choice for individuals. It is telling that even with considerable investment in family planning and maternal health services, there is still deference to spousal and parental consent to obtain services.⁷ There is also a constant need to legitimise family planning services by ensuring communal acceptance through religious leaders. In this regard, indicators within the SDG on gender equality pertaining to FGM, early marriage, sexual violence, and reproductive rights are helpful and can help us move the agenda as governments will now have to monitor and report on these.

However, the future of achieving universality of sexual and reproductive rights seems opaque, as the past was built on shifting sands.

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Firstly, in all international documents and agreements, including human rights conventions, deference is given to national sovereignty, and achievement is subject to the respective religions and traditions of countries. This has been a stumbling block in ensuring gender equality within the family, and enabling women, young people, sexual, racial, and religious minorities to achieve their sexual and reproductive rights. Even the most basic unit of society, the family, is a place where gender inequality is rampantly manifest: violence, including sexual violence is common; biases in allocation of current and future resources (including food, education, play), as well as inheritance, are skewed in favour of men and boys; freedom to contract multiple marriages and divorce are still male-dominated (especially in countries with religious laws); and practices, such as early marriage and FGM are carried out within the family unit. Hence, to ensure individual autonomy and bodily integrity will entail changing deep-rooted practices within the family institution.

Secondly, it is this very same family institution which has come to be vigorously defended by ethno-religious nationalist political groups, which seem to dominate political discourse across countries. Changes to the family

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institution to ensure equality—such as ensuring equal inheritance of land and other resources, rights to divorce and alimony, changing care work roles within the family, ensuring women’s unilateral right to access contraception and abortion services, and enabling young unmarried people’s access to SRHR—are seen as threatening the family institution, and undermining their rights to practise their traditions and religions within their families. This means that families and communities remain male-dominated despite changes in educational attainments and labour force participation of girls and women.

Advocacy at national and regional levels needs to be strengthened, emphasising government accountability and South-South and regional cooperation as donor resources dwindle (post the Trump budget decimation) and de-prioritise the region. Concerted efforts need to be made to uphold the sexual and reproductive rights agenda, and ensure that provision of SRH services is consistently underpinned by women’s rights and human rights.

Thirdly, in these discourses, sexuality is limited to the framework of marriage and family, and sexual activity outside of it is still seen as ‘illegal.’ The purpose of sex is reproduction, and non-procreative sex is also considered illegal. Hence, premarital sex is censured and punished, as is homosexual sex. Parents themselves who have not had the comprehensive sexuality education often misunderstand and decry the curriculum, putting pressure on school authorities, and local and national government authorities to remove such

programmes. The ‘rehabilitation’ of homosexuals is a featured programme of religious authorities and groups, as seen in Indonesia and Malaysia. This does not bode well particularly for the sexual and reproductive rights of young people, sexual minorities, and non-conforming women.

Fourthly, there is a clear intention by ethno-religious groups to dismantle secular, legal frameworks and make these compliant to religious and traditional laws within countries in order to strengthen the national religious identity. Hence, constitutional guarantees, which hold up equality and equal decision-making of women, are watered down and then re-interpreted through other policies. In the last decade, we have seen dress-codes and curfews being applied to women and girls in India, as well as Aceh, Indonesia. Dress-codes and curfews are in actuality code-words for social and sexual control of women.

We have a long way to go in getting governments to fully recognise, respect, and fulfil the sexual and reproductive rights of people. If indeed we are to achieve this by 2030 as per the 2030 Agenda for Sustainable Development, we have to be strategic and intensify our efforts. Advocacy at national and regional levels needs to be strengthened, emphasising government accountability and South-South and regional cooperation as donor resources dwindle (post the Trump budget decimation) and de-prioritise the region. Concerted efforts need to be made to uphold the sexual and reproductive rights agenda, and ensure that provision of SRH services is consistently underpinned by women’s rights and human rights.

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CHAOTIC, ISOLATIONIST, AND ANTI-WOMAN: The Trump Administration and SRHR

The start of the Trump Administration has been destabilising, demoralising, and devastating for democracy and the trajectory of sexual and reproductive health and rights (SRHR) in the United States and globally. The Administration's proposed funding cuts for family planning, the defunding of the United Nations Population Fund (UNFPA), and the dramatically expanded global gag rule (GGR) fuels a global conservative agenda that attacks democratic institutions, halts progress in global reproductive health, and jeopardises women's health and civil liberties. In the midst of such political chaos, national and donor governments, funders, and civil society must stick to their own priorities. Abortion advocacy, human rights, and the needs of women will far outlast this doomed administration.

The Expanded Global Gag Rule. In 1984, Reagan announced the Mexico City Policy (MCP), also known as the global gag rule, a policy that prohibited U.S. international family planning funding from going to any non-U.S.-based organisation that provided, referred, counseled, or advocated for "abortion as a method of family planning." This phrase is defined in policy guidance as abortion for the purposes of spacing births, and excludes abortion in cases of rape, incest, and life endangerment. Generally, the rule is instated during Republican presidencies and rescinded during Democratic presidencies.

The GGR is a speech restriction, and extends beyond what can and cannot be done with U.S. money. It restricts

how an organisation provides services, as well as how they advocate amongst governments and civil society. Over the last three decades, there have been several legal challenges, all of which were unsuccessful.¹

As one of his first acts in office, Trump signed a presidential memorandum on 23 January 2017 to revive the GGR as seen in the Bush Administration. The memorandum then directs the Secretary of State to lead a process to expand the GGR to "all of global health assistance."² The presidential memorandum calls for agencies such as USAID to create guidance and standard contract provisions to implement the policy.

While this has always been a failed and harmful policy, Trump's GGR is unparalleled in several ways.³ The world has changed—over 40 countries have liberalised their abortion laws since 1984.^{4,5} This means that the GGR is the outlier, dragging countries backward from where their citizens and governments would like to go. Moreover, global health systems have changed. Much of the donor and civil society focus has been on women-centered programming, integration, and country-ownership.⁶

In March 2017, the first phase of Trump's GGR was rolled out via standard provisions from USAID's Office of Population and Reproductive Health. The second phase, which expanded the GGR to all other global health assistance, was approved and announced on 15 May 2017 by Secretary of State Rex Tillerson.

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The world has changed—over 40 countries have liberalised their abortion laws since 1984. This means that the GGR is the outlier, dragging countries backward from where their citizens and governments would like to go.

Renamed as "Protecting Life in Global Health Assistance," the GGR expansion includes funding for international health programmes, such as HIV, maternal and child health, malaria, family planning, and Zika. Trump's GGR applies to nearly nine billion U.S. dollars, compared to roughly USD600 million in family planning funds under previous Republican presidents.⁷

The GGR sets up the dichotomy of two types of organisations in the global health universe: those that take U.S. funds, and those who do not, and can thus provide or refer for abortions, counsel on a full range of pregnancy options, and advocate for changes in laws related to maternal mortality and abortion as a method of family planning.

It is hard to even begin to hypothesise the global impacts of Trump's GGR, though we should expect to see two general types of impacts: disruption in services and relationships. While we do not have comprehensive data on the health and civil society impact of the GGR, the GGR has been associated with reduced access to contraception,⁸ an increase in abortion (which in this context is mostly unsafe abortion),⁹ the

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stoppage of condom distribution,¹⁰ and the closure of clinics.

The most obvious places where we expect to see service disintegration are where Marie Stopes International (MSI) and International Planned Parenthood Federation (IPPF) have been providing services with U.S. funds, since their organisational ethics mandate that they do not certify Trump's GGR. MSI wrote that in the few months after the devastating Nepal earthquake in April 2015, they used U.S. assistance to give 2,843 general and gynecological examinations, provide 586 contraceptive implants, distribute 355 safe-delivery kits, and provide 886 pre- and post-natal visits for women and their infants.¹¹ If they are funded through U.S. global health assistance, such services by MSI will be eliminated under the GGR.¹²

This withdrawal from family planning would impact at least 40 nations directly, including a loss of USD27.0 million in Bangladesh, USD14 million for contraceptives in India, and USD18 million in the Philippines.

The less overt and more insidious disruption will be to relationships and advocacy. Advocates are working tirelessly in often challenging or dangerous conditions to address maternal mortality and safe abortion laws throughout the world. Several countries, such as Kenya and Swaziland, have recently liberalised through their constitutions, meaning their laws decriminalise abortion, or create more instances where it is legal. Others, like Cambodia and Mozambique, have laws that have evolved since Reagan's original policy. Indonesian law changed in 2009 to permit abortion to save the life of a woman and in cases of rape or severe foetal impairment.

Recent Changes in US Development

Aid. The Trump Administration's other international policies on SRHR should all be understood to rest on no evidence, but rather on a bedrock of manufactured scarcity that falls hardest on the already marginalised.

On 23 May 2017, President Trump released his fiscal year 2018 proposed budget, "A New Foundation for American Greatness." While civil society advocates will turn their attention to the United States Congress to make sure these cuts are never realised, the Trump Administration's actions signal a shift toward isolationism. In funding lines that impact SRHR globally, we see a 17% reduction to the Global Fund, an 11% cut to bilateral PEPFAR, a USD65-million bilateral cut for Maternal and Child Health, and a complete elimination of international family planning funding.¹³ This withdrawal from family planning would impact at least 40 nations directly, including a loss (based on FY2015 funding) of USD27.0 million in Bangladesh, USD14 million for contraceptives in India, and USD18 million in the Philippines.¹⁴

On 30 March 2017, the Trump Administration provided a determination that effectively defunded UNFPA.¹⁵ The withdrawal from UNFPA has been immediate, and requires no Congressional approval. Because the defunding is a politically motivated act based on no new information or findings, it will be essentially non-reversible until there is a new President willing to do a new determination. While allowed by a specific piece of legislation and fueled by specific anti-family planning ideologies, defunding UNFPA should be considered a harbinger of a new resistance to (and misunderstanding of) multilaterals. There have been draft executive actions leaked that propose massive cuts to UN contributions across agencies.

A terrifying attack by the Trump Administration to SRHR is the cooption of 'gender empowerment' language, stripped of all relationships to the policies on, and investments in, family planning, safe motherhood, abortion, and sexual rights that give it meaning. In the first months of the Administration, we have seen a high profile women's entrepreneurship event with the Canadians,¹⁶ and Ivanka Trump's official Administration representation to the W20 Summit—where she relayed not her father's policies or beliefs, but rather how he treats her.¹⁷ These actions happened concurrently with including the Center for Family and Human Rights (C-Fam), a designated hate group with extreme anti-abortion and anti-LGBTIQ positions, as civil society on the official U.S. delegation to the UN Commission on the Status of Women (CSW).¹⁸

We see similar cooption of language from the Trump Administration in both LGBTIQ rights and gender-based violence (GBV). U.S. Ambassador to the UN Nikki Haley spoke about the horrific human rights abuses of gay men in Chechnya, while simultaneously undermining both the international bodies and frame of sexual rights that support them as individuals.¹⁹ Her willingness to do so should give us all pause. The dangerous misuse of anti-GBV rhetoric, coupled with isolationism and Islamophobia, can be seen in the text of both of the Administration's Muslim bans (actions that themselves undermine core commitments to the global community and are currently held up by U.S. courts). The operational text of both Executive Orders includes data gathering requirements for GBV perpetrated by foreign nationals in the United States. This use of GBV to promote Islamophobia feeds a false narrative that GBV is specific to Muslim, or non-Western countries only.

The World's Response. In the face of such a dramatic turn in SRHR globally, what can be done?

With a U.S. Administration so catastrophically divergent from the status quo, and the structure of universality provided by the 2030 Agenda, it could be viewed as an opportunity for feminist activists to disrupt the development paradigm. The prerogatives of donor governments, and the neocolonial structures of power they maintain, have had disproportionate and harmful impacts on the creation of robust and resilient civil society, and of governments setting and maintaining their own priorities.²⁰

While long-term solutions may be accelerated by a chaotic Trump Administration, the vacuum of financial and political leadership is likely to disproportionately impact already marginalised populations, such as sex workers and adolescent girls and young women, who are usually low-priorities of their governments. Additionally, we saw the Bush Administration send an influx of funds to socially conservative, religious NGOs, which both undermined service provision (both to populations like men who have sex with men, sex workers, and unmarried women, and of certain commodities like condoms, modern contraceptives, and emergency contraception), and created a hostile environment that still has outsized impact in countries like Kenya and Uganda. Donors cannot just fill the commodity gap, and leave civil society to slide backward into more hostility.

Donor governments, including through new mechanisms of support like She Decides, will look to fill the gaps in service provision left by the U.S. abandoning investments. While four years is short in political terms, it is unbearably long in the contraceptive,

post-rape, and antiretroviral needs of real women and girls around the world.

Other donors and donor governments must also pour money and support into in-country advocacy organisations. Coalitions to address maternal mortality, unsafe abortion, and the rights of marginalised populations are already reeling as they try to assess what 'advocacy' means in the GGR, who can continue to engage, and what this means for advocacy momentum and partnerships. In already underfunded advocacy environments, large accountability projects supported by the U.S. will become poison, and other governments must boldly step into the fray. We must ensure advocacy coalitions are not being splintered apart and make sure that they are able to maintain their advocacy in the face of U.S. requirements.

With a U.S. Administration so catastrophically divergent from the status quo, and the structure of universality provided by the 2030 Agenda, it could be viewed as an opportunity for feminist activists to disrupt the development paradigm. The prerogatives of donor governments, and the neocolonial structures of power they maintain, have had disproportionate and harmful impacts on the creation of robust and resilient civil society, and of governments setting and maintaining their own priorities.

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While four years is short in political terms, it is unbearably long in the contraceptive, post-rape, and antiretroviral needs of real women and girls around the world.

For advocates and providers, this is a vital time for expanding legal access. Other funders and governments should promote narrowness in GGR implementation, and make sure there is legal support to NGOs large and small, who want to navigate, but not over-implement, the restriction. Other SRHR champions can reduce the harm to the relationships that make up the fabric of civil society by providing safe spaces for learning, sharing, and relationship maintenance/building.

As individuals and organisations, we must support our colleagues and partners—whether they receive U.S. funds or not. We must build new relationships and share the work—there is too much to go around and we cannot behave in all our old ways and expect new results. In the midst of such chaotic and cruel SRHR policy, we will find new ways to think, and new ways to respond.

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TRADE AGREEMENTS, SDGS, AND UNIVERSAL ACCESS TO SRHR

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In 2015, all United Nations members committed to achieve the Sustainable Development Goals (SDGs) by 2030.¹ Goal 3 commits to "ensure healthy lives and promote well being for all at all ages." Goal 3b makes the critical link between the achievement of this goal and the implementation of trade agreements, in particular where intellectual property obligations impact public health. It requires that countries:

Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the

Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

The SDGs were agreed two decades after the World Trade Organisation's (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) came into effect. TRIPS requires all WTO member countries to grant 20-year patents in all areas of technology, including pharmaceutical products like medicines.² By 2005, all developing country WTO members implemented this requirement, while Least Developed Countries (LDCs) have till 2033 to do so.

The exclusivity granted by a patent usually results in a monopoly and in high prices of medicines, a concern clearly expressed through Goal 3b. In the

context of sexual and reproductive health and rights (SRHR), it has been argued that the "pharmaceutical industry plays a major role in the lack of access to essential medicines for sexual and reproductive health care, by a) investing in products for profit-making reasons despite their negative health impact (e.g., hormone replacement therapy), b) marketing new essential medicines at prices beyond the reach of countries that most need them (e.g., HPV vaccines), and c) failing to invest in the development of new products (e.g., microbicides and medical abortion pills)."³ Trade agreements and patents are certainly implicated in these barriers to both access and innovation.

While the examples of HIV treatment and breast cancer treatment are discussed in detail below, the impact of patent protection on other SRHR-related

critical diseases and conditions has also been felt, for example, in the quest for affordable HPV vaccines⁴ and affordable treatment for cervical and prostate cancers.⁵

Over the past decade, the crisis in drug research and development (R&D) has become evident; the World Health Organisation (WHO)'s Commission on Intellectual Property Rights, Innovation, and Public Health (CIPIH) found little evidence that the implementation of TRIPS in developing countries would significantly boost R&D in diseases that predominantly affect developing countries.⁶ The lack of R&D in reproductive and maternal health is an example.⁷ The lack of new treatments to treat increasingly drug-resistant gonorrhoea is another. According to the WHO, "development of new antibiotics is not very attractive for commercial pharmaceutical companies. Treatments are taken only for short periods of time (unlike medicines for chronic diseases) and they become less effective as resistance develops, meaning that the supply of new drugs constantly needs to be replenished."⁸ WHO and the Drugs

for Neglected Diseases initiative (DNDi) have now launched the Global Antibiotic Research and Development Partnership (GARDP) to undertake R&D for treatment of neonatal sepsis, drug-resistant STIs, and paediatric antibiotics with access proposals aimed at delinking the cost of R&D from the product price.⁹

Patents, TRIPS Flexibilities, and

HIV Treatment. Within five years of the WTO coming into being, the HIV epidemic exploded across Africa, Asia, and Latin America. The best discount price for anti-retrovirals (ARVs) offered by patent holders, usually multinational pharmaceutical companies (MNCs) for patients in the developing world was approximately USD10,000 per year. In 2001, an Indian generic company announced that it could offer first-line ARVs for less than a dollar a day. Subsequent competition by and between generic companies saw further price reductions that was crucial to the provision of low-cost ARVs and scale-up of government treatment programmes globally. (See Graph 1.)

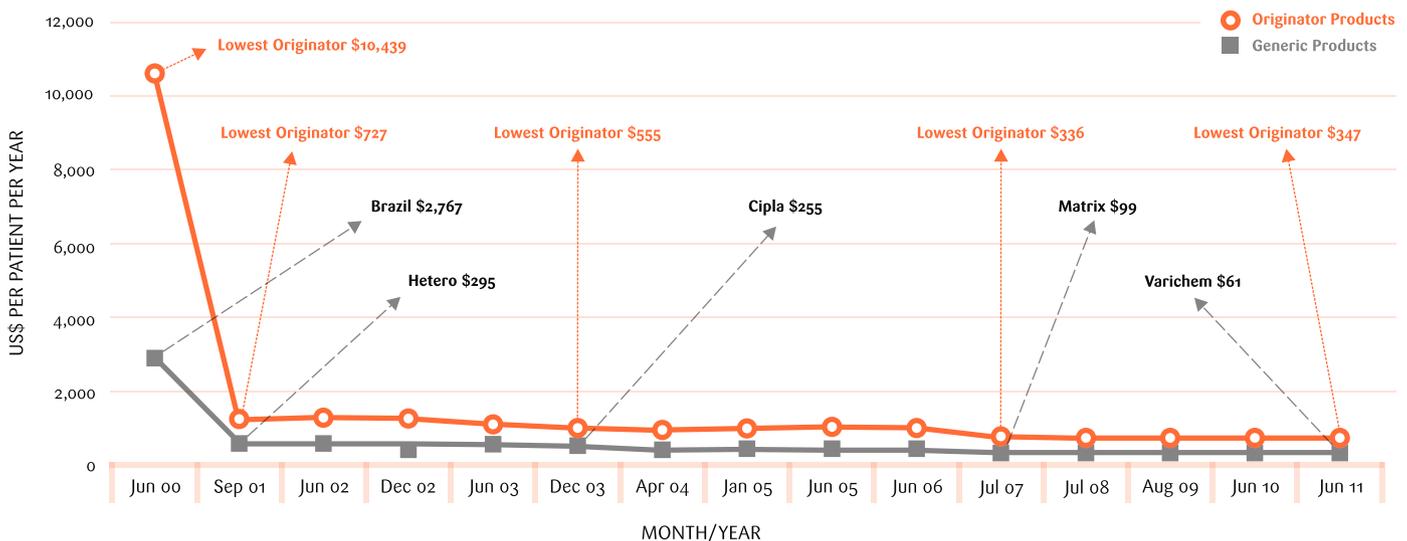
Later that year, in November 2001, all WTO members signed the Doha Declaration on TRIPS and Public Health, which stated that "the (TRIPS) Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all."¹⁰ What the Doha Declaration reiterated was the right of countries to use safeguards in the TRIPS Agreement, also known as TRIPS flexibilities, to ensure access to medicines, despite the requirement of granting 20-year patents on medicines.

It is these flexibilities that are referred to in the Goal 3.b.

The signing of the Doha Declaration was necessitated by the increasing difficulties faced by many developing countries in accessing generic ARVs because of TRIPS requirements and because of threats of legal actions by MNCs and of trade sanctions and disputes by developed countries.¹¹ In 1999, amendments to the Medicines Act of South Africa to allow parallel imports of generic medicines resulted in a lawsuit filed by 39

GRAPH 1: GENERIC COMPETITION AS A CATALYST FOR PRICE REDUCTIONS

The Fall in the Price of First-line Combination of Stavudine (d4T), Lamivudine (3TC), and Nevirapine (NVP), Since 2000



Source: MSF Access Campaign, "Untangling the Web of Antiretroviral Price Reductions," 14th ed., 2011, <https://www.msfaccess.org/content/untangling-web-antiretroviral-price-reductions>.

spotlight

pharmaceutical companies. Global outrage over the case saw it being dropped in 2001 and the signing of the Doha Declaration that year.

Several developing countries are increasingly using TRIPS flexibilities to ensure access to ARVs. Thailand issued compulsory licences in 2007 and 2008 to access generic ARVs like efavirenz and lopinavir/ritonavir, as well as cancer and heart disease medicines.¹² India's patent law uses another TRIPS flexibility—strict patent criteria, which restricts “evergreening”¹³ and does not grant patents to new forms of old medicines, unless they show a significant increase in efficacy. For example, a patent application for nevirapine syrup, a key first-line HIV medicine, which already existed in tablet form but whose syrup form is important for the treatment of children with HIV, was rejected. Most first and second line ARVs are off-patent in India due to the use of this critical TRIPS flexibility allowing generic manufacture and export to continue.

Today, 80% of the nearly 17 million people living with HIV on treatment¹⁴ are on generic medicines.¹⁵ Generic companies also simplified HIV treatment by combining ARVs into fixed-dose combinations (FDCs). Even the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) could not sustain reliance on patented medicines. In 2008, PEPFAR had an estimating savings of USD215 million by procuring 90% of its ARVs from generic manufacturers.¹⁶

Patents and Breast Cancer. The adverse impact of patents has also been witnessed in the diagnosis and treatment of breast cancer. Mutations of the BRCA1 and BRCA2 genes are associated with significantly increased risks of breast and ovarian cancer.¹⁷ In several countries, one company—Myriad—was the only one offering diagnostics and screening

for these mutations as they patented the genes themselves. This also created barriers to further research in diagnostics or other gene variants.¹⁸ In 2013, the US Supreme Court held that “genes and the information they encode are not patent eligible...simply because they have been isolated from the surrounding genetic material.”¹⁹ Screening for these mutations is now offered by other companies for USD249 as compared to Myriad's price of USD4,000.²⁰

For some women with HER2²¹ positive breast cancer, trastuzumab, a medicine patented in 1994 by Roche and usually sold as Herceptin can be effective. Though it should have been off-patent by now, Roche filed multiple secondary patents that are expected to expire in 2033. In South Africa, the annual private sector price is USD38,365 and USD15,735 in some public facilities. In Brazil, it is USD17,562; in Malaysia, USD17,929; and in India, USD10,938.²² In India, the application of strict patentability criteria resulted in Roche's secondary patent applications being rejected or lapsing, allowing the entry of biosimilar manufacturers whose prices are relatively affordably, though they are still high.

The Tobeka Daki Campaign for Access to Affordable Trastuzumab²³ leads global protests in 2017 against the inhuman pricing and litigation tactics of the medicine by Roche. In another use of TRIPS flexibilities, the South African Competition Commission is now probing Roche's pricing²⁴ as activists are also demanding that countries issue compulsory licenses to access affordable alternatives.

Free Trade Agreements and Emerging Threats to Affordable Treatment: The Case of RCEP. Even as developing countries struggle to work within the WTO framework to provide access to

We demand justice for Tobeka Daki, a fearless activist from South Africa who was living with HER2+ breast cancer since 2013. Despite being a good candidate for trastuzumab, Tobeka was never able to access the treatment due to its high cost. On 14 November 2016 she died in her home. We do not know whether trastuzumab would have saved Tobeka's life—trastuzumab does not always work. We do know, however, that Tobeka was never given a chance. Even though she was dying and the medicine existed, she was never given an opportunity to try it.



Poster featuring Tobeka Daki used in global protests against Roche's pricing of the breast cancer drug held in February 2017. Image courtesy of the Tobeka Daki Campaign for Access to Affordable Trastuzumab.

medicines, developed countries are working to get their trade 'partners' to sign Free Trade Agreements (FTAs). FTAs are negotiated country by country or by regional blocks and often feature, along

IMPACT OF HIGH-PRICED PATENTED MEDICINES ON HEALTH SYSTEMS

“...as a young woman who is a breast cancer survivor, I was once faced with the reality of the issue and the problems that are caused by the patents. I needed to have Herceptin because I had HER positive 2 cancer. I couldn’t access it because my medical aid—I am talking about a private hospital, a private health sector—my medical aid said it was too expensive and therefore they cannot allow me to be treated with that Herceptin drug. I had to struggle and be faced with costs—the costs of actually dealing legally with my medical aid first and the cost of trying to save my life by checking the public hospitals. This means that I was thrown from the private sector to a public health situation. When I got to the public health, I discovered that they don’t offer Herceptin to breast cancer patients and on my research, I discovered that in South Africa it’s only the [Kimberly] hospital that gives Herceptin to its patients... in its budget, it only allows for its patients... on my research I discovered that the patent around Herceptin will only end in 2033...2033 means death to me.” – Testimony of Babalwa Malgas, Lawyer, Activist and Breast Cancer Survivor, Johannesburg Hearing of UN High Level Panel on Access to Medicines, March 2017²⁵

with other demands for greater trade liberalisation, TRIPS-plus provisions that go far beyond the obligations under the TRIPS Agreement and limit or overturn TRIPS flexibilities.

One such FTA is the Regional Comprehensive Economic Partnership (RCEP) being negotiated between 16 countries from the Asia-Pacific region since 2012; this includes developed countries (Australia, Japan, New Zealand, Singapore, and South Korea), developing countries (Brunei Darussalam, China, India, Indonesia, Malaysia, the Philippines, Thailand, and Vietnam), and least developed countries (Cambodia, Laos, and Myanmar).

As with other FTAs, RCEP is being negotiated in secret. In 2016, leaked IP and investment chapters confirmed the fears of activists that TRIPS-plus IP provisions had been proposed by Japan and South Korea, which may prevent the production, registration, transportation, and exportation of generic medicines. Today, there is evidence of the impact of TRIPS-plus provisions on access to medicines. A study on data exclusivity in Jordan (which was introduced by the US-Jordan FTA), found that of 103 medicines registered and launched since 2001 that currently have no patent protection, at

least 79% have no competition from a generic equivalent.²⁶

Three critical producers and suppliers of generic medicines are in the RCEP negotiations: China, India, and Thailand. To some extent, developing countries, particularly India²⁷ and the ASEAN²⁸ bloc are attempting to push back against the TRIPS-plus demands. However, as pressure to conclude the agreement mounts, it remains to be seen to what extent developing countries in RCEP will resist the demands of the developed countries.

Universal Access to SRHR in the Time of WTO and FTAs. Even as trade agreements strengthen intellectual property protection, there is a noticeable attempt to weaken international commitments on health. SDG Goal 3b itself is an example of an important but limited goal. It is ironic that trade ministers and representatives signing the Doha Declaration in 2001 made a far broader commitment to ensure access to medicines for all, while the SDGs, thanks to developed country positions, limit this commitment to “essential” medicines.

Governments must consider SDG 3 as a stepping stone in progressing towards the right to health. It may be recalled

after all that the MDGs only focused on child mortality, maternal health, HIV, TB and malaria. SDG3 therefore represents the next, important expansion of international health goals. It is, however, the right to the highest attainable standard of health that defines the international and national obligations of governments on health.

In addition, despite the growing number of FTAs and investment agreement negotiations, the SDGs make little reference to them or their impact. Instead, trade-related goals in Goal 17 are considered a means of implementing SDGs. Just a few months before the adoption of the SDGs, a joint statement by 10 UN experts and special rapporteurs reveals the flaws in this approach, stating that there was “a legitimate concern that both bilateral and multilateral investment treaties might aggravate the problem of extreme poverty, jeopardise fair and efficient foreign debt renegotiation, and affect the rights of indigenous peoples, minorities, persons with disabilities, older persons, and other persons leaving in vulnerable situations.”²⁹ Within two months of the adoption of the SDGs, the UN Secretary General established a High-Level Panel on Access to Medicines recognising the interdependence of health and development. The

Panel's September 2016 Report also raised serious concerns on FTAs and recommended: "[G]overnments engaged in bilateral and regional trade and investment treaties should ensure that these agreements do not include provisions that interfere with their obligations to fulfil the right to health."³⁰

The tension between the right to health and trade agreements goes back to the establishment of the WTO and even as FTAs represent a greater threat to access to health technologies and the achievement of SDG3, it is worth reiterating that developing countries are still grappling with the adverse impact of TRIPS on access to medicines. So-called middle income countries are excluded from voluntary licensing mechanisms adopted by MNCs to head off criticism and prevent the government use of TRIPS flexibilities. Trapped by FTAs and continuing trade pressures from developed countries, these governments are stuck in price negotiations with patent holders that usually lead to unaffordable prices, limited availability and consequently the rationing of treatment by governments. Instead of such price negotiations, as the High Level Panel on Access to Medicines found, governments are duty bound to "protect the rights of their citizens by using TRIPS flexibilities."³¹ In terms of ongoing FTA negotiations like RCEP, public consultation is critical and governments must release the negotiating texts. Further, as the High Level Panel concluded, the "failure to conduct robust impact assessments before concluding such agreements is tantamount to a neglect of state duties to safeguard the right to health."³² TRIPS-plus provisions should be rejected in such trade agreements.

In this scenario, it is the activism, advocacy, and legal interventions of community-led groups and public health

SNAPSHOT OF TRIPS-PLUS PROVISIONS IN THE RCEP NEGOTIATIONS²⁷

According to the leaked IP and investment chapters, several TRIPS-plus provisions appear to be on the table that adversely impact public health and access to medicines. These include the following:

- **Data Exclusivity** prevents governments from relying on clinical trial data to register generic versions of medicines even if they are off-patent, their patents have expired, or are revoked, and complicates the issuance of compulsory licences;
- **Patent Term Extentions** extend patent life beyond 20 years and delay generic entry;
- **Weakened Patentability Criteria** could put restrictions in terms of the time period and content of material that the patent office can take into consideration in determining whether a medicine is actually new or inventive;
- **Accelerated Patent Examination** may create undue pressure on already burdened patent offices in developing countries with limited human and financial resources to take hurried decisions on pharmaceutical patent applications that require close, detailed scrutiny;
- **Technical Assistance** measures that may result in the indirect introduction of the lower patentability standards of developed countries into developing country patent offices through patent examiner trainings and increasing reliance on patent examination reports and conclusions of developed countries;
- **Weakened Patent Exceptions** may impose restrictions on how developing countries in the Asia-Pacific region employ and define research and experimental exceptions to patent rights;
- **Border Measures** may deny medicines to patients in other developing countries with custom officials seizing generic medicines that are being imported or exported;
- **Injunctions and Damages** undermine the independence of the judiciary in issuing orders relating to the enforcement of patents in a manner that prioritises the right to health of patients;
- **Other IP Enforcement Measures** put third parties like treatment providers at risk of court cases and draw the whole manufacturing, distribution, and supply chain for generic medicines into litigation;
- **WTO-Plus Dispute Settlement on TRIPS** by including TRIPS compliance in the RCEP negotiations; RCEP countries could sue each other for alleged TRIPS violations outside of the WTO; and
- **Investor Protection Rules** allow foreign companies to sue governments in private international arbitration over domestic health policies like compulsory licences, patent revocations or refusals, health safeguards in patent laws, price reduction, negotiation and reimbursement measures, and may prevent governments from promoting local production.

Source: Shiba Phurailatpam and Kajal Bhardwaj, "RCEP and Health: This Kind of 'Progress' Is Not What India and the World Need," *The Wire*, 27 February 27, 2017, <https://thewire.in/112260/rcepthis-kind-of-progress-is-not-what-india-and-the-world-need/>.

organisations that has been critical in safeguarding public health and access to medicines. A global movement has emerged around FTA negotiations that has seen some critical successes. In India, campaigning by local groups has seen the government take public positions against TRIPS-plus demands in the EU-India FTA³³ and RCEP. The European Parliament rejected the Anti-Counterfeiting Trade Agreement (ACTA) over its impact on public interest,³⁴ and the stalling of the Trans-Pacific Partnership Agreement (TPPA) emerged as a significant victory for progressive groups across the globe.³⁵ Activists and organisations working on public health are now using meagre resources to attend each successive round of RCEP negotiations to raise these concerns directly with trade negotiators and ensure that TRIPS-plus provisions are rebuffed.³⁶

Networks of people living with HIV, who have traditionally been at the forefront of challenging patents and FTAs, are now being joined by a broader health coalition. Groups working on sexual and reproductive health and rights must urgently join this struggle to ensure that the right to health and universal access to SRHR are not undermined by trade agreements.

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WOMEN'S ECONOMIC EMPOWERMENT AND SRHR: The Missing Link

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Introduction. Despite the long-standing international consensus on women's economic empowerment being a key driver for gender equality (as seen in the Beijing Platform for Action¹ in 1995 and 20 years later in the Sustainable Development Goals), progress on this front has been uneven. Recent data from the International Labour Organisation (ILO)² highlights significant gender inequality³ in the global labour market, such as decreased female labour force participation,⁴ unemployment affecting more young women, lack of social protection,⁵ and women spending more time on unpaid care work.⁶

Missing the Link? In order to address these concerns in 2015, the UN Secretary General set up a High Level Panel on Women's Economic Empowerment,⁷ which identified seven drivers of change.⁸ Other global reports by major influencers, such as the International Monetary Fund (IMF)⁹ and global consultancy firm McKinsey,¹⁰ looked at the inter-play between women's economic empowerment and global economic growth. However, aside from instrumentalising women's economic empowerment, the growing global attention has not focused adequately on sexual and reproductive health and rights (SRHR) and how its absence impacts on women's economic security and vice versa.

Women's ability to have control over their own bodies, decide on who to have sex with and how often, and whether to have children and how many to have, have huge implications on women's

ability to participate in economic activities. Studies have shown that globally, female labour force participation decreases with each additional child by about 10 to 15 percentage points among women aged 25 to 39.¹¹ In addition, pregnancy and the consequences of childbirth remain the leading causes of death and disability among women of reproductive age in developing countries today.¹² For the world's poor and marginalised women, many of whom work in the informal economy, lack of SRHR can entrench them further into a vicious cycle of poverty. For us to effectively achieve the SDGs by the 2030, we must acknowledge the multi-faceted and complex relationships amongst Goals 1 (No poverty), 3 (Good health and wellbeing), 5 (Gender equality), 8 (Decent work and economic growth), and 10 (Reduce inequalities).

While we establish the inter-linkages further, we must bear in mind that the struggle to locate decent work and to have access to sexual and reproductive health have different implications for women of different age groups. Young women face particular challenges due to both their age and gender as they begin to enter the work-force, begin to access SRH services, and manoeuvre their way onto adulthood.

Making the Case for Linking Economic Justice and Sexual and Reproductive Health Justice. The "Young Urban Women: Life Choices and Livelihoods" (YUWP) programme was initiated by ActionAid in July 2013 to address young women's bodily autonomy and economic

security, using a human rights' based approach. Implemented in Ghana, India, and South Africa, the programme recognises the unique vulnerabilities of young urban young women (aged 15 to 25 years), and supports them to seek decent work opportunities, balance unpaid care responsibilities, access SRH services, and stake claim to make decisions over their futures. Between 2012 and 2017, a number of qualitative studies¹³ aimed to understand how these different aspects of their lives were threaded together. We found strong evidence to support our hypothesis that economic empowerment and SRHR are strongly intertwined. This paper consolidates our findings in arguing for a more comprehensive understanding of the links.

Young Women, SRHR, and the Informal Economy. Across the cities¹⁴ where the programme is being implemented, young urban women are at the bottom of the pyramid, restricted to unpaid family work, home-based workers, or, at the most, informal wage work and casual labour. This trend seems to be increasing. The outsourcing of production, including through the creation of global value chains¹⁵ has resulted in the rapid emergence of home-based work that is dominated by young women and often invisible. The specific characteristics of informal sector work (such as insecure work environment, lack of appropriate regulations, or of enforcement of existing labour regulations) create additional layers of vulnerability for young women, which has an impact on both their economic security and their SRHR.

To start with, insecure work environments leave a direct impact on young women's reproductive health. Young women are either being forced to drop out of paid work completely after giving birth due to care responsibilities, or being dismissed from employment because of having taken time out to recuperate. At the same time, young women are forced to return to work shortly after difficult pregnancies due to economic compulsions, at a great cost to their health and that of their new-borns. Maternity entitlement in the informal sector commensurate with lost wages is almost completely absent in the three countries covered by the project. Even the Indian government's recent implementation of a long-enacted law on maternity benefits is inadequate to address wage losses.¹⁶

... when the capacity of young women to earn independent incomes increases, it improves their ability to afford contraceptives. Earning an income also enables them to access health care in general. Having an improved financial status has further empowered them to engage in independent or consultative decision-making regarding their sexual and reproductive health, and to contest violence.

Economic insecurities and precarious work conditions manifest in terms of various physical ailments, including body aches, headaches, stomach pains, worsening eye sight, and troubles with reproductive organs. This was especially prevalent in the case of home-based young women workers in Hyderabad, particularly bangle makers whose

work exposed them to lead and other hazardous chemicals. In Hyderabad, young women also work out of small¹⁷ *karkhanas* (informal factories), where they lack clean functioning toilets and drinking water, leading to reproductive and urinary tract infections. However, these issues are absent from any policymaking agenda on women's economic empowerment.

The place where young women work and the lack of implementation of relevant protection mechanisms they have at their places of work also has a bearing on their SRHR. Young women's bodies are often seen as commodities that are available to provide pleasure to male co-workers and bosses. For example, our studies found considerable sexual harassment at the work-place with no effective redress mechanism in place. Relevant laws in India have failed to cover women in the informal sector. Young home-based women workers in Hyderabad faced sexual harassment by middlemen, while in the *karkhanas*, young women are molested when using dark corners for defecation. Young women in South Africa faced termination of employment after refusing sexual advances from their bosses. ActionAid's research has also found that countries where more women are self-employed or in vulnerable forms of work are, on average, associated with higher rates of Intimate Partner Violence (IPV).

On the other hand, when the capacity of young women to earn independent incomes increases, it improves their ability to afford contraceptives and to access health care in general. Having an improved financial status has further empowered them to engage in independent or consultative decision-making regarding their sexual and reproductive health, and to contest violence. Among married young women, economic security shifted the

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power balance in favour of the women. However, while young women are able to perceive of these inter-connections between financial freedom and sexual autonomy, they are not always in a position to challenge their partners' control over their bodies.¹⁸

We found a direct correlation between care responsibilities and SRHR. If young women do not have the required knowledge and information regarding SRHR, and have little or no access to SRH services, this leads to unplanned and multiple pregnancies. This makes them drop out of formal education systems, impacting their economic security and increasing care responsibilities.

Linking Economic Empowerment, Unpaid Care, and SRHR. Gendered division of labour is one of the key reasons why we find young women at the bottom of the employment chain. The combined burden of income generation and unpaid household responsibilities can be extreme in their lives. We found a direct correlation between care responsibilities and SRHR. If young women do not have the required knowledge and information regarding SRHR, and have little or no access to SRH services,¹⁹ this leads to unplanned and multiple pregnancies. This makes them drop out of formal education systems, impacting their economic security and increasing care responsibilities. In South Africa, a large number of young women become mothers at a very young age and have to drop out of school.²⁰ Correspondingly, South Africa has a high rate of youth unemployment, particularly amongst young women.²¹ It also does not provide any robust fully government-

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supported, accessible, and affordable universal child care programmes.

Despite this, the links between high rates of early pregnancy, care responsibilities, and youth employment have seldom been explored at a policy level, nor has the provisioning of gender-responsive public services been a policy priority. Even in India, the long-running Integrated Child Development Scheme²² cannot really be seen as an effective child care programme because of several lacunae in its implementation.²³ Prevailing macro-economic policy framework has shifted priorities away from public provisioning of services to privatisation of public resources. This has impacted both publicly funded SRH and child care services, leaving women, particularly young women, to bear the burden of withdrawal of state services.²⁴

When states draw up employment policies for women, what we find missing is an understanding that while moving women into formal jobs may help increase their economic independence, it will not, by itself, increase their ability to secure their bodily integrity, nor will it decrease their burden of unpaid care work.

A Call for Acknowledging the Inter-linkages. We all have the data. We know how women's lived realities reflect the gendered discriminations not only at the place of work but also inside their homes and communities. We are also at the right time in history to take advantage of the renewed focus on women's economic empowerment. The Sustainable Development Goals have an underlying message of inclusiveness: "leaving no one behind." However, for

us to be truly inclusive and ensure that poor young women across the world control their economic future, and fulfil Goals 1, 3, 5, 8, and 10, among others, we must focus our energies and resources on approaches that are truly transformative.

Women's economic empowerment is complex and deeply attached to the many facets of their lives. When states draw up employment policies for women, what we find missing is an understanding that while moving women into formal jobs may help increase their economic independence, it will not, by itself, increase their ability to secure their bodily integrity, nor will it decrease their burden of unpaid care work. Therefore, the conversation on women's economic empowerment needs to move beyond the familiar solutions of credit and entrepreneurship (which are important), towards providing an economic alternative that is cognizant of the multiplicity of the rights violations in the lives of women.

It is about time that we recognise how the common thread of macro-economic policy framework of the state is also linking these issues together and that such a policy framework must always take into account its impact on the lives of the poorest women. Activists from both labour rights and public health movements must come together to challenge the discourse of privatisation of basic services, making a common cause for demanding basic public services that cater to women's SRHR, and the reduction and redistribution of unpaid care responsibilities.

The state must respond to the non-implementation of crucial laws, such as those that address sexual harassment in the workplace. It needs to put back the spotlight on creation of "decent work" and not just employment for women;

address social norms within its economic strategy; mobilise public resources to respond to provisioning of SRH and care services; and ensure that there is a robust legal and budgetary framework in place.

Notes & References

- 1 The Beijing Platform for Action acknowledges the existing gender inequality in "economic structures and policies, in all forms of productive activities and in access to resources." United Nations, "Beijing Declaration and Platform for Action," 1995, <http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf>.
- 2 International Labour Organisation, *Women at Work: Trends 2016* (Geneva: ILO, 2016), http://www.ilo.org/gender/Informationresources/Publications/WCMS_457317/lang-en/index.htm.
- 3 In 2016, ILO noted in the executive summary of its *Women at Work Trends 2016* report that "only marginal improvements have been achieved since the Fourth World Conference on Women in Beijing in 1995" on women's economic empowerment.
- 4 The female labour force participation fell from 52.4% to 49.6%, while the corresponding figures for more for men was at 79.9% and 76.1%. The gap has grown wider particularly in South Asia.
- 5 More women workers in sub-Saharan Africa (63.2%) and Southern Asia (74.2%) have no access to social protection, informal employment being the dominant form of employment for women in these regions.
- 6 While women spend 2.5 times more time performing unpaid care and domestic work than men, globally, women on average are paid 24% less than men.
- 7 "Economic Empowerment," <https://www.empowerwomen.org/en/who-we-are/initiatives/sg-high-level-panel-on-womens-economic-empowerment>.
- 8 The seven drivers are: enabling environment (including macro-economic policies), gender-based norms and discriminations, legal reforms, investments in care, changing business culture and practice, improving public sector practices in employment, and procurement.
- 9 Kalpana Kochhar, Sonali Jain-Chandra, and Monique Newiak (eds), *Women, Work and Economic Growth, Levelling the Playing Field* (Excerpt) (Washington, D.C.: International Monetary Fund, 2016), http://www.elibrary.imf.org/staticfiles/misc/excerpts/women_work_growth_excerpt.pdf.
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- 12 Ibid.
- 13 The researches are:
 - a. Prabha Kosla, *Young Urban Women: Life Choices and Livelihoods in Poor Urban Areas* (Johannesburg: Action Aid, 2012), http://www.actionaid.org/sites/files/actionaid/young_women_urban.pdf.

- b. *Young Urban Women: Exploring Inter-linkages-Bodily Integrity, Economic Security and Equitable Distribution of Unpaid Care Work* (Johannesburg: ActionAid, 2015), <http://www.actionaid.org/publications/young-urban-women-exploring-interlinkages-bodily-integrity-economic-security-and-equity>.
- c. Rachel Noble, *Double Jeopardy: Violence against Women and Economic Inequality* (London: ActionAid, 2017), <http://www.actionaid.org/publications/double-jeopardy-violence-against-women-and-economic-inequality>.
- d. A research on gender responsive public services and its linkages with young women's economic empowerment has been carried out by ActionAid and the Institute of Development Studies, Sussex. This report is still at a draft stage and is currently being finalised.
- 14 The programme is being implemented across seven cities in three countries—Accra and Tamale in Ghana; Cape Town and Johannesburg in South Africa; and Mumbai, Chennai, and Hyderabad in India.
- 15 The UNCTAD World Investment Report 2013 notes that "today's global economy is characterised by global value chains (GVCs), in which intermediate goods and services (such as garments) are traded in fragmented and internationally dispersed production processes. Transnational corporations coordinated GVCs account for some 80% of global trade. This dispersed means of production spread across several countries has given rise to the phenomenon of sub-contracted home-based work outside of the purview of regulations." See: UNCTAD, *World Investment Report 2013—Global Value Chains: Investment and Trade for Development* (Geneva: UNCTAD, 2013), http://unctad.org/en/PublicationsLibrary/wir2013_en.pdf.
- 16 Pregnant women and lactating mothers will receive INR 6,000 (approximately USD93), INR 5,000 (approximately USD77) of which will be given in three instalments, provided that certain conditions related to completion of registration of pregnancy and birth, antenatal care and immunisation are met. The scheme is also restricted to the first live birth. See: Dipa Sinha, "Modi Government's Maternity Benefits Scheme Will Likely Exclude Women Who Need It the Most," *The Wire*, May, 19, 2017, <https://thewire.in/137366/maternity-benefit-programme/>.
- 17 These are small in size, accommodating about 25 women in average in a place of 100 square feet.
- 18 For example, in India, marital rape is not yet recognised as a criminal offence.
- 19 The Ghana Demographic and Health Survey (2014) data shows that the prevalence of contraceptive use is lowest among currently married women between the age group of 15-19 years. Overall, 14% of women age 15-19 have begun childbearing. The proportion of teenagers who have begun childbearing rises rapidly with age, from 1% at age 15 to 31% at age 19. See: Ghana Statistical Service, Ghana Health Service, and ICF International, *Ghana Demographic and Health Survey 2014: Key Indicators*, http://www.statsghana.gov.gh/docfiles/DHS_Report/Ghana_DHS_2014-KIR-21_May_2015.pdf.
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- Indicators Report mentions that 16% of SA women have begun child-bearing between the ages of 15-19 years. See: *South Africa Demographic and Health Survey*, May 15, 2017, <http://www.statssa.gov.za/?s=teenage+pregnancy>.
- 21 Lynsey Chutel, "Record Unemployment Affects These South Africans the Most," *Quartz Media*, November 23, 2016, <https://qz.com/844825/south-africas-unemployment-rate-is-at-a-13-year-high-most-affecting-women-and-the-youth/>.
- 22 *Anganwadi* is a kind of rural mother and child care centre in India, which was started by the Indian government in 1975 as part of the Integrated Child Development Services programme to combat child hunger and malnutrition. *Anganwadi* means "courtyard shelter" in Indian languages. See: <https://en.wikipedia.org/wiki/Anganwadi>.
- 23 Indian activists note that "the Restructured Integrated Child Development Services committed 70,000 *anganwadi*-cum-crèches in the 12th Five Year Plan period. Not more than 500 such centres have been operationalised in last three years." See: "Public Hearing on Maternity Entitlements and Child-Care Provisions: 3rd May 2016," *India Resists*, April 27, 2016, <http://www.indiaresists.com/maternity-entitlements-right-to-food/>.
- 24 Michael Thomson, Alexander Kentikelenis, and Thomas Stubbs, "Structural Adjustment Programmes Adversely Affect Vulnerable Populations: A Systematic-Narrative Review of Their Effect on Child and Maternal Health," *Public Health Reviews*, July 10, 2017, <https://pubmed.ncbi.nlm.nih.gov/31866409/>.

WHY PRIORITISE SRHR IN CLIMATE CHANGE PROGRAMMING AND POLICYMAKING

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To achieve universal access to sexual and reproductive health and rights (SRHR) as indicated in Goal 3 of the 2030 Agenda for Sustainable Development,¹ the impact of climate change on women's health, including SRHR, cannot be ignored.² Conversely, realising their SRHR is crucial for women to take the lead in climate action related to mitigation and adaptation, and demonstrate the resiliency needed to address climate change effects. It is thus imperative that SRHR be prioritised in climate change policies, strategies, financing, and programmes.

Studies by ARROW's partners in eight Asian countries³ have found that climate

change exacerbates gender and SRHR issues. In developing countries, women are already facing gender inequality and poverty, and climate change puts them at further disadvantage.⁴ Due to climate change extreme events,⁵ the difficulty in accessing food⁶ would affect women's food consumption (particularly as in many countries in the region, women already eat last and least),⁷ which leads to higher susceptibility to undernutrition and other health problems.⁸ Undernourished women are at higher risk of pregnancy and delivery related complications, amenorrhea, and infertility, while girls experience delays in menarche.⁹

Other examples on how climate change impact women's SRHR are: (i) changes in temperature and rainfall pattern create more mosquito breeding sites, thus leading to more vector-borne diseases such as malaria, which in turn increases the risk of spontaneous abortion, premature delivery, stillbirth, and low-birth-weight babies among pregnant women; (ii) rising sea levels and floods at coastal areas result in saline contamination of drinking water, which is linked to pre-eclampsia, eclampsia, and hypertension amongst women; (iii) and conflict over resources (such as water and arable land) resulting in displacement, thus limiting access to SRH services and supplies for women.¹⁰ In difficult times, women often neglect

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their health, including SRHR, which would increase their risk of morbidity and mortality.¹¹

Women's work burden increases during climate change as gender roles often designate them as the carers for the sick, young, and old; they are also in charge of cooking, and fetching water and fuel for the family.¹² Women are also vulnerable to sexual harassment, rape, and other gender-based violence during climate change extreme events; for example, when walking to fetch water or fuel or while living in temporary camps.¹³ In addition, our partners in Bangladesh, Nepal, and the Philippines¹⁴ reported that early and child marriages amongst girls are happening. The findings indicate that poor families are using early marriage as a coping strategy to escape poverty brought about by climate change. Additionally, gender inequality restricts women's mobility and prevents them from learning survival skills (for example, swimming, and tree climbing), putting them at higher risk of being injured or dying compared to men.¹⁵

The impact of climate change on SRHR as described above affects women physically and mentally, both short- and long-term. Providing women with human rights-based SRHR services and information within climate change context would prove advantageous for both the women and the environment. Generally, women would prefer to have lesser children (as seen in the unmet need for family planning) and a healthier and empowered life, by which they could bring up healthier children, be gainfully employed, improve their family's socio-economic status, and conserve the natural resources and environment within their community. These would be women's contributions, made possible through universal access of SRHR, in building climate-resilient communities. There are reasons why women's SRHR

is not prioritised in climate change policies, strategies, financing, and programmes.¹⁶ Firstly, there is a lack of understanding regarding the impact of climate change on SRHR and vice versa among governments, and even amongst women's groups and CSOs. The report by the Fifth Intergovernmental Panel on Climate Change (IPCC) recognised reproductive health services as a "co-benefit," that is a human activity which mitigate climate change and also benefits human health.¹⁷ However, the report is silent on reproductive rights and sexual health and rights. SRHR entails the rights of women, for example, to choose whom they want to marry, to decide on how many children they want and when they want to have them, and to live free of gender-based violence. SRHR is part of women's human rights, which is non-negotiable. States cannot pick and choose which human rights they would grant to women.

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Secondly, even though women's roles as agents of change, as well as their resourcefulness and capacities, are acknowledged in the United Nations Framework Convention on Climate Change (UNFCCC) documents, ironically, at the implementation level, their contributions are "often overlooked"¹⁸ due to gender inequality. They are often

perceived as 'victims' to climate-related disasters, and their voices and needs, including SRHR, are not heeded. They are generally not included in the decision-making processes and implementation of climate-related actions, which often disregard their needs, including SRHR.

Thirdly, due to the patriarchal system and structure, decisions are still usually made by male leaders or policy-makers, even when pertaining to women's bodies, including their SRHR. This trend is not limited to developing countries. One recent example is the signing of the Global Gag Rule/Mexico City Policy by the American President.¹⁹

The fourth factor is the lack of transparency on processes and decisions during negotiations on climate change matters happening at the local, national, and international levels. For instance, in the Conference of the Parties (COP), civil society observers, including women's groups, have limited or no access to high-level negotiations. Moreover, civil society observers have limited or no access to the documents, and the dates and agenda of mandated events are announced late.²⁰ Similar scenarios occur in the Green Climate Fund board meetings.

The question then boils down to what can be done so that SRHR is prioritised in the climate change setting?

1. There is an urgent need to create awareness amongst women's groups and CSOs, including the environment-related CSOs, on the negative impact of climate change on women's SRHR. Support could be garnered through building inter-movement dialogues and alliance with the wider women's groups and CSOs. These bodies could then create awareness and advocate among their national and local authorities/policy-makers on the inclusion of SRHR in the climate change policies, budget, and

programme. They should also monitor and hold their governments accountable.

2. Much emphasis is on the coherence between the Paris Agreement and the Sustainable Development Goals (SDGs) at the international level. Aside from SDG 13,²¹ which focuses on climate change action, many are unaware of the inter-linkages between the two agreements and how the coherence could be operationalised at the country level. A working paper by the World Resources Institute indicates that theoretically, all the 17 Goals, including nearly all of targets, are aligned with climate actions in the Intended Nationally Determined Contributions (INDCs)²² under the Paris Agreement.²³ The paper underscored that by promoting coherence between the Paris Agreement and the SDGs nationally, it could result in mutual benefits.²⁴

This evidence provides CSOs the basis to advocate to governments to work towards aligned implementation of the SDGs and INDC policies, financing and programming. This approach would be pragmatic since most developing countries have limited resources and capacities. Also, through this approach, cross-cutting issues such as poverty; health, including SRHR; education; gender, including empowering women and building their resiliency to climate change impacts; and development would be taken into account in the integrated planning, budgeting, and implementation.

3. Since the Intergovernmental Panel on Climate Change (IPCC) Fifth Assessment Report acknowledged access to reproductive health services as a “co-benefit,” this is an entry point for SRHR advocates to pressure governments to incorporate SRHR²⁵ into their climate change policies, financing, and programme, including mitigation and adaptation²⁶ projects. The provision of SRHR services must be primarily for

addressing the unmet need through the rights-based approach, and should not be utilised for population control agenda.

4. SRHR advocates must persistently direct the climate change discourses and negotiations at all levels towards gendered solutions²⁷ and rights-based approaches, as well as introduce inclusion of SRHR in climate change policies, financing, and programmes. They must demand for women’s²⁸ access to and participation at climate change-related events at all levels.

The provision of SRHR services must be primarily for addressing the unmet need through the rights-based approach, and should not be utilised for population control agenda.

5. UN agencies and donors must collaborate with national women’s groups and CSOs, in which the latter could be mobilised for advocacy and awareness campaigns on the impact of climate change on women’s health, including SRHR; ways of mitigating them; and adaptation strategies to address them. The target groups for these campaigns would be the policy-makers, central and local government agencies, and grassroots communities, especially women.

6. In order to work towards aligned implementation of the SDGs and the INDC policies, financing, and programming, governments need to ensure that all ministries work together, instead of working in silos. Ministries should integrate gender-responsive solutions, including the inclusion of SRHR, into their plans and budgets, and at the same time take into account that these are in line with their national climate change actions.

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Notes & References

- 1 Goal 3 states, “By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programme.” United Nations, “Goal 3: Ensure Healthy Lives and Promote Well-being for All at All Ages,” <http://www.un.org/sustainabledevelopment/health/#7e9fb9boec8c8e6e6>.
- 2 WHO, “Keynote Address at the Human Rights Council Panel Discussion on Climate Change and the Right to Health,” Geneva, March 3, 2016, <http://www.who.int/dg/speeches/2016/human-rights-council/en/>.
- 3 This project was supported by the Norwegian Agency for Development Cooperation (Norad) and titled “Building New Constituencies for Women’s SRHR: Working with Rights-based Climate Change/Environment Groups and Faith-based Groups to Build Momentum for SRHR in the Lead-up to the New Development Framework.” Eight partners were involved in this project, namely, Khan Foundation (Bangladesh), *Yayasan Jurnal Perempuan* (Indonesia), University Health Sciences (Lao PDR), Penita Initiative (Malaysia), Huvadhoo Aid (Maldives), Women’s Rehabilitation Centre (Nepal), Sindh Foundation (Pakistan), and PATH Foundation (Philippines).
- 4 World Health Organisation, *Gender, Climate Change and Health* (Geneva: World Health Organisation, 2014), http://www.who.int/globalchange/publications/reports/gender_climate_change/en/.
- 5 Examples of climate extreme events are droughts, floods, cyclones, rising sea level, warmer weather, and air pollution.
- 6 This is due to crop failure and increase in food prices.
- 7 “Gender and Nutrition,” FAO, <http://www.fao.org/docrep/012/a184e/a184e00.pdf>.
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- 20 The Women and Gender Constituency (WGC) has expressed the issues identified to the UNFCCC. See: "Rights-holders and Duty-bearers," WGC, March 6, 2017, <http://womengenderclimate.org/rights-holders-duty-bearers/>.
- 21 Goal 13 is "Take urgent action to combat climate change and its impact."
- 22 Parties to the Conference of the Parties (COP) are required to submit their INDCs to the UNFCCC. Each country's INDC

would specify its post-2020 climate actions for reducing greenhouse gas emissions, and sometimes would also include "how they will adapt to climate change impacts, and what support they need from, or will provide to, other countries to adopt low-carbon pathways and to build climate resilience." See: "What is an INDC?," World Resources Institute, <http://www.wri.org/indc-definition>.

23 For more information, see: Eliza Notrhop, Hana Biru, Sylvia Lima, Mathilde Bouye, and Ranping Song, "Examining the Alignment Between the Intended Nationally Determined Contributions and Sustainable Development Goals," Working Paper (Washington DC: World Resources Institute, 2016), <http://www.wri.org/publication/examining-alignment-between-intended-nationally-determined-contributions-and-sustainable>.

24 The working paper mentioned that at the country level, well-designed sustainable development policies and actions would contribute to "reduction in greenhouse gas emissions and enhance resilience to climate impacts." On the other hand, national climate policies, strategies, and programming for mitigation and adaptation could contribute to achieving the SDGs.

25 The provision of reproductive health services is insufficient; it should encompass SRHR services and information for family planning services; pregnancy-related services, including skilled attendance at delivery, emergency obstetric care and post-abortion care; STI and HIV prevention and diagnosis and treatment of STIs; prevention and early diagnosis of breast and cervical cancers; prevention of gender-based violence and care

of survivors; integration of HIV prevention, management and care in SRH services; and gender-sensitive life-skills based SRH education. See: UNFPA, *Making Reproductive Rights and Sexual and Reproductive Health a Reality for All; Reproductive Rights and Sexual and Reproductive Health Framework* (New York: UNFPA, 2008), https://www.unfpa.org/sites/default/files/pub-pdf/SRH_Framework.pdf.

26 By linking reproductive health services to mitigation, it should be cautioned that the rights-based approach must be adhered to and comprehensive information about the services be provided to women to enable them to make informed choices on spacing and limiting. Reproductive health services must not be utilised as a means to control population growth, which often leads to abuses, coercion, and violation of women's human rights, for the purpose of reducing greenhouse gas emissions. Though the IPCC report only linked reproductive health services to mitigation, it is most crucial to link SRHR to adaptation. Adaptation projects generally include development components. The inclusion of SRHR would contribute to non-carbon benefits/social and gender benefits.

27 Women's groups and CSOs could use the tool developed by the Women's Environment and Development Organisation (WEDO) to track gender inclusion in climate change policies and documents at the international and national levels. See: "WEDO Launches Gender Climate Tracker Mobile App," November 15, 2016, <http://wedo.org/gender-climate-tracker-app/>.

28 This includes women from the indigenous, vulnerable, and marginalised populations.

SHIFTING THE GROUND ON SEXUAL RIGHTS AT THE UN

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Few topics elicit the ire and passion of States and advocates at the United Nations (UN) like sexual rights. The term is a geopolitical flashpoint and is often misconstrued by a broad range of actors.

Despite substantial normative and jurisprudential advancements on sexual rights within the international human rights system, some continue to resolutely deny their very existence, while others limit the term to mean sexual orientation and gender identity. Others try to separate sexual and reproductive health, sexual rights, reproductive rights, and rights related to gender neatly into different boxes as distinct issues. This lack of a common understanding of sexual rights as universal, affirmative, intersectional, and grounded in autonomy, has encouraged

fragmented approaches to sexual and reproductive health and rights (SRHR)¹ within the UN system. With the adoption of the 2030 Agenda for Sustainable Development, it is useful to reflect on the trajectory of sexual rights within the UN system, and to consider a variety of approaches that have the potential to shift the ground so that we can move forward on a cohesive vision for sexual rights in global policies.

Unprecedented mobilisation, politicisation, and advocacy by feminists around the world in the lead up to and during the 1993 Vienna World Conference on Human Rights, the 1994 Cairo International Conference on Population and Development (ICPD), and the 1995 Beijing Fourth World Conference on Women (Beijing)

irrevocably changed the discourse and direction of population policies, development, and women's rights. Among the many triumphs, reproductive rights were explicitly recognised and defined, women's rights were unequivocally affirmed as human rights, and a woman's right to have control over her sexuality was enshrined into non-binding international consensus agreements.

These hard-won achievements were rightly celebrated but came at a price. During ICPD negotiations, weaker language and national sovereignty qualifiers regarding abortion were accepted as compromises, sexual rights were sacrificed to safeguard other gains, and adolescent sexual and reproductive health provisions were limited to disease

and pregnancy prevention. In Beijing the next year, much of the ICPD language on abortion was replicated and even the much-lauded paragraph on women's rights to control their sexuality was qualified by a heteronormative framing.²

While follow-up reviews to ICPD and Beijing over the next 20 years made some advances, for the most part, States battled over previously agreed language and made little progress. Lack of meaningful accountability mechanisms, backlash against gains made in Cairo and Beijing, changes to funding priorities, financial crises, reinstatements of the US Global Gag Rule, and the sidelining of sexual and reproductive rights in the Millennium Development Goals (MDGs) (including seven years without a target on reproductive health) were among factors that contributed to a stalemate on sexual rights at the UN.

Despite political setbacks, advocates spotted opportunities for advancement within the UN human rights system. Starting in earnest in 2002, advocates working at the UN Commission on Human Rights (the predecessor to the UN Human Rights Council) began using this framework to forge an alternative path to make progress on sexual rights at the UN. This approach was premised on identifying rights holders and their entitlements on the one hand and duty-bearers and their obligations on the other. Utilising the system of independent experts³ mandated by the UN to analyse and report on a range of human rights issues and country situations, the complexity of people's lives was put front and centre with a spotlight on State accountability. This shift in the framing of sexual rights from individual conduct to State responsibility, as set out in international human rights treaties, was critical to advance an understanding of the different ways in which sexuality, gender, and

reproduction are interrelated, how they intersect with race, class, ethnicity, disability, geography, migration status, religion, and so on, and the positive obligations on States to remedy violations and create an enabling environment for the realisation of sexual rights.

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The strong foundation developed over the years led to significant progress on a range of sexual rights issues at the UN Human Rights Council.⁴ However, a disconnect with global development processes remained. As the MDGs were coming to an unceremonious end, and ICPD and Beijing were running out of time with major unfinished business, advocates around the world threw themselves into the post-2015 negotiations to push for meaningful integration of human rights standards related to sexuality, gender, and reproduction into the outcome document. Ultimately, the final language of the Sustainable Development Goals (SDGs) was a significant improvement from the MDGs. However, sexual rights were once again severed from

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reproductive rights, and the negotiations narrowed in scope to consider primarily the relevance of sexual rights to sexual orientation in the context of violence and non-discrimination. Arguments for the inclusion of sexual rights based on autonomy, intersectionality, and self-determination did not get sufficient traction at an early enough stage to carry through the negotiations.

While sexual rights were not explicitly included in the blueprint for the SDGs, there were considerable gains that provide opportunities to advance sexual rights at the national, regional, and global levels. First, the political declaration reaffirms the centrality of human rights to development and makes substantive references to international human rights treaties, sexual and reproductive health, reproductive rights, inequality, discrimination, access to justice, and commitments to reaching the most vulnerable. Second, some of the SDG indicators are in alignment with sexual and reproductive rights standards, particularly as they relate to non-discrimination (5.1.1, 10.3.1), autonomous decision making in sexual relations, contraception and reproductive health care (5.6.1), State obligations to guarantee access to sexual and reproductive health (5.6.2), disaggregation of data for new HIV infections including key populations (3.3.1), and acceptability of health services (16.6.2). Third, the emphasis on reaching those furthest behind first, empowers States to consider and remedy the structural and systemic discrimination and marginalisation that make sexual rights violations invisible.

Some States are now reorganising their development policies to align with the SDGs, and UN institutional mechanisms are being operationalised. This presents a unique opportunity to ensure linkages are made between

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binding international human rights instruments and voluntary commitments, to advocate for further alignment of SDG indicators with human rights indicators,⁵ and to demand that human rights principles of participation, accountability, transparency, international co-operation, empowerment, sustainability, and non-discrimination are systematically applied at all levels of implementation and follow-up processes.

The annual High Level Political Forum (HLPF) on the SDGs at the UN headquarters in New York is an obvious space to advocate for a more comprehensive vision of sexual rights that is premised on human rights norms and standards. However, this strategy is not without risks. There is the potential for the human rights framework to become co-opted by the development agenda, which does not have a similar foundation on sexual rights, and could ultimately lead to a weakening of the human rights framework. Another risk stems from the siphoning of particular sexual rights issues at politically expedient times, while undermining the overarching principle of autonomy. This is most clearly demonstrated by State efforts to promote access to family planning, but not support access to safe abortion,⁶ and rhetoric that instrumentalises women's rights as a means of achieving economic development.⁷ Moreover, although a considerable improvement upon the MDGs, the accountability system currently in place for the SDGs has been widely criticised⁸ as it is based on voluntary reviews prepared by States, data collection infrastructure to measure progress on goals is insufficient in many countries, and formal civil society participation is still ill-defined.

Sexual rights advocates must remain vigilant in their efforts to engage with the SDG processes, and consider alternative

entry points for strengthening sexual rights. The Human Rights Council and the treaty bodies offer one path. Under the Universal Periodic Review (UPR), all 193 UN States are reviewed every four and a half years on their entire human rights record. This peer review process, with significant civil society input and national level activity, has proven useful for raising neglected sexual rights issues. The Special Procedures, as independent experts (and therefore unconstrained by inter-governmental politics), continue to expand the analysis of sexual rights through their thematic reports, country visits, and the communications system. The treaty bodies, with their legitimacy derived from international law, drill down on the minutiae of laws, policies, and practices that hinder the realisation of sexual rights at the country level and deliver jurisprudence through the individual complaint system.

Another avenue is the regional Sustainable Development Forums set up to inform the annual HLPF. These forums could provide space for more contextual and productive debates on the issues facing particular regions because they are led by regional leaders, informed by local civil society organisations, and can draw upon regional human rights bodies already in place.

These alternative entry points are also not without their challenges. At the Human Rights Council, relentless attacks on sexual and reproductive rights are carefully organised by alliances of States from different regions, which can include Russia, Egypt, Pakistan, El Salvador, India, Saudi Arabia, Nigeria, Uganda, China, and now the USA, among others, depending on the issue. The entrenchment of the "Protection of the Family" resolution, supported by many of these same States, has created dangerous precedents, which are moving closer to according special protections

to heteronormative and patriarchal families and jeopardising rights to be free from violence within family settings.⁹ With regards to the regional Sustainable Development Forums, some regions are dominated by States that are extremely hostile to sexual rights and also lack robust regional human rights bodies, which limits opportunities for meaningful dialogue and progress.

Furthermore, engagement with UN mechanisms are dependent upon the ability of civil society and activists to freely organise, express dissent, travel to meetings, and constructively engage with government and UN officials without fear of reprisal. With the rise of authoritarian regimes and the corresponding rise in influence of regressive actors intent on safeguarding patriarchal norms, space for sexual rights advocacy is shrinking at all levels.¹⁰ Finally, the matter of who—or more importantly who does not—participate in UN processes raises serious questions as to who is representing 'civil society' in these fora, for whom do they purport to speak, and ultimately, what is the relevance of the UN to national contexts if developments are not effectively communicated and disseminated at the local level.

Notwithstanding these challenges, the emphasis built into the human rights framework on State accountability and the universality of rights creates critical entry points that have the potential to disrupt the circular logic of State sovereignty and cultural relativism that too often plagues global discourse on sexual rights. Enhanced coordination between all these UN mechanisms, including the SDGs, as well as addressing the urgent concerns noted above, is critical to improving accountability for State obligations to respect, protect, and fulfill a broad range of interdependent sexual rights. The cumulative effect of these accountability processes puts

Recognition of sexual rights at the UN and within the SDG processes are meaningless if they have no relevance to people's lives. As sexual rights advocates at the global level, we must never lose sight of this fact and consistently use the tools available to us to make the connections between national, regional, and international standards stronger, more cohesive, and premised upon every person's inalienable human rights to have control over and decide freely on all matters related to sexuality, gender, and reproduction.

pressure on each State to make the necessary law, policy, administrative, and budgetary changes that will contribute to the realisation of sexual rights for all persons within their jurisdiction. As domestic positions slowly shift in response to the pressure from civil society, where such advocacy is possible, the international political positions also shift, creating momentum for global support of sexual rights within the SDGs and beyond.¹¹

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As signatories to international human rights instruments, States must be held accountable for their actions or inactions in this regard wherever and whenever possible. Advocacy at the UN is only one piece of the vast sexual rights puzzle, and is not without its considerable flaws, but it has made and continues to make an indelible contribution to the policies that strengthen the systems necessary to protect every person's right to live in dignity.

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- 3 Independent experts of the UN human rights system include members of the treaty body committees mandated to monitor State implementation of human rights treaties and special procedures appointed by the UN Human Rights Council, but independent of any government who report and advise on human rights from a thematic or country specific perspectives. For more information, see: "Special Procedures of the Human Rights Council," UN Human Rights Office of the High Commissioner, <http://www.ohchr.org/EN/HRBodies/SP/Pages/Welcompage.aspx>.
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7 See, for example, the statement delivered by the Right Honourable Dr. Pakalitha B. Mosisili Prime Minister and Head of Government of the Kingdom of Lesotho during the Post-2015 Development Agenda Summit Interactive Dialogue: "Tackling Inequalities, Empowering Women and Girls and Leaving No One Behind" on September 25, 2015. He said, "Co-chairs, empowering women and girls is empowering humanity. As the saying goes, 'EMPOWERING WOMEN IS EMPOWERING A NATION.' It behoves us therefore, as leaders, to work together in unity of purpose as we pave the way for women and girls to play their rightful role in building a sustainable global economy for the benefit of humanity at large." <https://sustainabledevelopment.un.org/content/documents/19216lesotho.pdf>.

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10 Naureen Shameem, *Rights at Risk: Observatory on the Universality of Rights Trends Report 2017* (Toronto: Association of Women's Rights in Development, 2017), <https://www.oursplatform.org/wp-content/uploads/Rights-At-Risk-OURs-Trends-Report-2017.pdf>.

11 This was most recently observed in the case of Botswana. Previously, the government opposed the inclusion of comprehensive sexuality education (CSE) in UN resolutions. Following many years of national level advocacy, recommendations from CEDAW (CEDAW/C/BOT/CO/3 para 36), the Special Rapporteur on the Right to Education [E/CN.4/2006/45/Add.1 para 76 (k)], participation in the *Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa* coordinated by UNESCO, Botswana's policy changed and the government now votes in favour of CSE at the Human Rights Council, one of the few African States to do so. While Botswana has embraced CSE at the Human Rights Council, at the same time, it also vehemently opposes any debate related to sexual orientation and gender identity, further demonstrating the need to continue to make the links between the full range of sexual rights.

WHY ARE WOMEN STILL DYING FROM UNSAFE ABORTIONS?

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Introduction. For women to fulfil their potential as human beings in society, they need to be able to control their fertility. Since the pregnancy is borne by a woman within her body, risking health and sometimes life, she should be able to take a decision whether to be pregnant or not, and whether to continue a pregnancy or not.

The past few decades have seen a steady lowering of the age of menarche to 10 years of age now, while the age of menopause continues to be around 50.¹ So a girl who is 10 today can expect to deal with about 480 menstrual cycles in her lifetime, while desiring maybe one or two children. She will thus need a contraception that will protect her from having an unwanted pregnancy 398 times, without fail.

Contraception. In developing countries, about half of the sexually active women of reproductive age (or 818 million women) want to avoid pregnancy, but about 17% of those women (or 140 million) are not using any method of family planning, while 9% (or 75 million) are using less effective traditional methods² or are considered to have an unmet need for modern contraception.³ Issues like lack of knowledge, myths, and misconceptions, as well as limitations in women's autonomy and agency, means that⁴ access to such methods is often limited for some women who are unable to negotiate for it.

Furthermore, using contraception does not eliminate the need for safe abortion services. The World Health Organisation (WHO) estimates that 33 million users globally will experience accidental

pregnancy every year while using contraception.⁵ Even if all users were to follow instructions perfectly, there would still be nearly six million accidental pregnancies per year, according to earlier WHO estimates.⁶

Unwanted Pregnancies. In addition to problems of access and contraceptive failure, women experience many other life circumstances in which they want to interrupt a pregnancy, such as when resulting from rape, where it poses health and life risks to the woman, foetal abnormalities, economic and other personal reasons, such as being involved in an abusive relationship, having another small child, or any other reason impairing their ability to take the pregnancy to term and raise another child. With the increasing number of humanitarian crises, more women are likely to face unwanted pregnancies needing access to safe abortions.

Methods of Abortion. An unwanted pregnancy can be terminated by using surgical methods or using medical pills. The latter could be a combination of Mifepristone and Misoprostol or Misoprostol alone when Mifepristone is not registered in the country.⁷ Both methods have their advantages and disadvantages.⁸

Barriers to Access in Asia. Control over abortion access has been part of a long historical struggle, with the patriarchal culture, glorification of motherhood, religion, politics, and economics playing as big a role in every phase. When women want to terminate an unwanted pregnancy, whether it was planned or not, they will often face a multitude of

barriers. These range from restrictive laws,⁹ negative provider attitudes¹⁰ and disinclination to interpret the law to the fullest,¹¹ lack of service delivery facilities,¹² and non-availability of medical abortion pills, among many other reasons.

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The number of unsafe abortions in Asia seems to have gone up from 9.8 million in 2003 to 10.8 million in 2008.^{13, 14} Even in countries with liberal laws, such as India and Nepal, there are difficulties in access and women continue to die from unsafe abortions.¹⁵ Women seeking abortions in the second trimester face even greater barriers.¹⁶

The last two decades have seen a new hurdle to access emerging in some countries in Asia as a result of sex determination and the policy and programme responses to it.¹⁷ These protectionist approaches reflect a lack of understanding that inherent gender discrimination in the society is the root cause of sex determination, and a lack of recognition that safe abortion is a woman's right or a bodily autonomy issue.¹⁸

Laws and Their Impact on Access in Asia. The laws in most Asian countries continue to be based on the Penal Codes of their colonisers,¹⁹ despite

the colonising European countries having moved ahead from their own understanding.

In Nepal, where abortion was made legal on broad grounds in 2002, it appears that abortion-related complications are on the decline. A recent study in eight districts found that abortion-related complications accounted for 54% of all facility-treated maternal illnesses in 1998, but for only 28% in 2008–2009.²⁰ On the other hand, in countries like Indonesia and the Philippines where the laws on abortion are restrictive and access to safe services is difficult, the maternal deaths due to unsafe abortions are very high.^{21, 22}

While more countries have liberalised their abortion laws in the last decade,²³ much more is still needed. Speaking to the UN General Assembly in October 2011, then UN Special Rapporteur for Health, Anand Grover, made an urgent call to all governments to completely decriminalise abortion.²⁴

In fact, until the early 19th century, there were few legal prohibitions against abortion, and midwives in a variety of cultures and locations provided abortions. Abortion gradually became criminalised in Europe, often ostensibly under the guise of ‘protecting’ women. As many historians argue, this was actually part of an anti-woman backlash to the growing struggles for women’s rights that were emerging. Controlling access to abortion made it easier to restrict women to their traditional child-bearing role.

Preventing women healers from providing these abortions was another step,²⁵ with doctors attempting to establish exclusive rights to practice medicine. Thus, the newly formed American Medical Association (AMA) argued that abortion was both immoral and dangerous. By 1910, all but one state

in the United States had criminalised abortion, except where necessary, in a doctor’s judgment, to save the woman’s life. Legal abortion was successfully transformed into a ‘physicians-only’ practice.

In recent years, the Federation of Obstetricians and Gynaecologists in India (FOGSI) and the Indian Medical Association (IMA) played a similar role. Both opposed the proposal by the government to amend the abortion law to allow provision by non-allopathic doctors and nurses, despite studies showing that all these providers can be trained to safely do so.^{26, 27}

The role that Big Donors and Big Pharma play in deciding priorities, creating boundaries, and re-defining reproductive health is a serious issue that civil society has not spoken out against strongly enough yet.

The Politics and the Economics. Since 1984 when the first Mexico Policy (or Global Gag Rule) was implemented, abortion rights have become a global political issue with the US at its centre. The 1994 International Conference on Population and Development (ICPD) has been a key chapter in this global politics because it defined abortion as a major global health problem and legitimised the concept of reproductive rights. However, even the ICPD Programme of Action had to include conciliatory language asking for abortion to be “safe where legal.” Since then, we have had to deny that abortion is a family planning method when clearly it is for some women; we have had to agree that ‘repeat abortions’ should receive more counselling on contraception; we have accepted that abortion should be not only safe and legal, but also ‘rare’; and we have only

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mildly protested at assertions that increasing contraception is the solution to reduce the rate of abortions.²⁸

The Global Gag Rule, which the American President signed on the third day of assuming power, is going to leave a trail of devastation and dead women in its wake. In countries like Cambodia, Myanmar, and even Nepal, where USAID funding supports many international and local NGOs providing contraceptives, as well as safe abortion referrals or services, this is likely to result in close to 2,00,000 unintended pregnancies with a possibility of 50,000 unsafe abortions every year.²⁹

The role that Big Donors and Big Pharma play in deciding priorities, creating boundaries, and re-defining reproductive health is a serious issue that civil society has not spoken out against strongly enough yet. Are doctors working for ‘gagged’ service delivery systems expected to hide the knowledge of safe abortion options from women, knowing that this might lead to death for some of them? Is it acceptable for heavily funded ‘family planning’ programmes to create a programmatic dead end at the insertion of a long-term contraceptive method? Should the possibility of contraceptive failure not be recognised, which may lead to women needing safe abortion to terminate the same unwanted pregnancy they came there to prevent? In all the talk about ensuring post-abortion contraception, when will we talk about ensuring post-contraception abortion?

As neoliberal economic policies tighten their grip on us, we have the Sustainable Development Goals (SDGs) putting an emphasis on Public-Private Partnerships (PPP). There is even a separate fund to facilitate this ‘convergence,’ despite many critiques of this process.^{30, 31, 32, 33}

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Moreover, the recommendation for handing over healthcare services to the private sector does not contain guidelines on which services are to be considered vital and thus should remain the public sector's obligation and accountability. It is also not clear if the handover to PPPs is a time-bound process with a simultaneous capacity building of the public sector to take this back after a certain phase. Or will these services be effectively handed over in perpetuity, to eventually merge with the for-profit sector, thus leaving those dependent on the public part of the PPP without any facilities?³⁴

What happens if the government outsources safe abortion services to a PPP and puts a large proportion of its budget into that—rather than investing on strengthening its own services—and in ten years' time, that private group closes down or moves away to another high-need area? Who will provide those services to the women? Who will be accountable?³⁵

Women are change agents who are already shifting the boundaries of abortion service provision.

Innovations in Service Delivery. It is estimated that currently there are 2,882 million smartphone users in Asia and the Pacific. The use of social media and other smartphone-based technology or mHealth³⁶ can be a tool of empowerment and of subversion, since it can bypass traditional hegemonies of healthcare providers and doctors and go straight to the beneficiaries.³⁷

Women are change agents who are already shifting the boundaries of abortion service provision. The healthcare 'provider' for medical abortion pills has changed from needing to be a

gynaecologist to being any doctor to the nurse to the chemist and eventually to the woman herself. It can be empowering if embedded within an appropriate strategy, but not if women are just left to fend for themselves because the public sector is not fulfilling its role. The laws which criminalise the provider could be applied to women who self-use. Self-use of medical abortion pills is the latest phenomenon attracting negative publicity,^{38, 39} while the reality is that for most such women, it is a much safer method than traditional informal sector provision.⁴⁰ Safe self-use (as a means of subverting the mainstream which does not allow them access) should not be used as an excuse; the public sector must be held accountable for the lack of medical abortion services within the range of other sexual and reproductive health services.⁴¹

Safe self-use (as a means of subverting the mainstream which does not allow them access) should not be used as an excuse; the public sector must be held accountable for the lack of medical abortion services within the range of other sexual and reproductive health services.

What Do We Want in the Future?

We want universal access to safe abortion, with a choice between surgical and medical methods, non-coercive post-abortion contraception, post-contraception abortion access, and sensitive and timely post-abortion care.

We need to place safe abortion within the spectrum of sexual and reproductive health and rights, and advocate for decriminalisation, legalisation, and accurate information on availability of abortion. We need to address stigma on sexuality

and abortion, and bring in discussions on patriarchy, which leads to gender inequality and subordination of women to the extent that they do not have control over their sexuality and body.

We need to shift the conversation from pro-choice to pro-rights,⁴² since no choice exists in a vacuum. We need to question whether the laws preventing sex determination and punishing those involved push the decision burden on individuals, while not contributing to eliminating gender discrimination in any way.

We need to place safe abortion within the spectrum of sexual and reproductive health and rights, and advocate for decriminalisation, legalisation, and accurate information on availability of abortion. We need to address stigma on sexuality and abortion, and bring in discussions on patriarchy, which leads to gender inequality and subordination of women to the extent that they do not have control over their sexuality and body.

We need governments to invest adequate budgets for providing services in the public sector, and to ensure regularisation of services (quality and costs) in the private sector.

We need better tools for data collection, monitoring and evaluation, not just of technical quality, but also of women's perceptions.

We need to invest in gender and rights training of health care providers, in the pre-service years and beyond. We need

We need to create a world where it is unacceptable for a woman to die because she was forced to seek an unsafe abortion.

all service providers, whether in public or private, to be aware of and invest in data security measures, especially digital security, in order to ensure confidentiality and safety for the women and themselves.

We need to integrate safe abortion advocacy efforts with the entire intersectional movement around issues like safe motherhood, obstetric violence, sexual health and rights, reproductive health and rights, LGBTIQ rights, child marriage prevention, sexuality education, and violence against women.

We need to create a world where it is unacceptable for a woman to die because she was forced to seek an unsafe abortion.

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SDGs: Sex Workers Fall through the Cracks

Sex workers—whether female, male, or transgender—are likely to fall through the cracks of the Sustainable Development Goals (SDGs), despite the fact that people in sex work¹ are entitled to rights in the economic, political, social, civil, and cultural spheres. State and non-State actors continue to violate sex workers' rights with impunity. Discrimination and violence against sex workers is linked to the perception of them as less than equal citizens, leading to systemic and large-scale violation of human and fundamental rights, such as the right to life, dignity, equality, and equal protection of the law. Specific violations take place due to their marginalised status as sex workers, thus rendering the SDGs an unattainable goal for sex workers, unless these issues are addressed in a time-bound and strategic manner.

Unhealthy Trends. Goal 3 of the SDGs aims to “Ensure healthy lives and promote well-being for all at all ages.” Sex workers are more vulnerable to specific health conditions like reproductive tract infections (RTIs), sexually transmitted infections (STIs), cervical cancer, and opportunistic infections due to immune-suppression. On account of stigma and their economic and social vulnerability, they are unable to access commodities (e.g., condoms), diagnostic tests (e.g., speculum examination and Pap smear), pregnancy and abortion-related services, and extended treatment for infections and illnesses like cancer.²

In the discourse around the HIV pandemic, sex workers were identified as vectors of transmission, and therefore a site for control and regulation. Since the 1980s, a steadily increasing body of evidence linked the violence that

sex workers experience to HIV risk, since unprotected sex is the norm in incidents of sexual violence where sex workers' ability to negotiate condom use is compromised, in addition to injuries common during violent sexual acts.³ A bulk of the literature emanating from the public health perspective viewed violence against sex workers mainly at a higher risk for HIV and other sexually transmitted infections, and was premised on the notion of sex workers as vectors of disease. This assumption has since been proved inaccurate, with the growing recognition that sex workers are only links in the much broader network of sexual transmission of HIV, thus complicating the debate.^{4, 5, 6}

Sex workers—whether female, male, or transgender—are likely to fall through the cracks of the SDGs, despite the fact that people in sex work are entitled to rights in the economic, political, social, civil, and cultural spheres.

Sex workers must be able to access stigma-free health services, including periodic screening and periodic presumptive treatment for asymptomatic sexually transmitted infections, free antiretroviral therapy for HIV, and needle and syringe exchange programmes for sex workers injecting drugs. Male and female condoms and lubricants supplies must be destigmatised and made accessible for sex workers through local health care systems.

Gender Matters. Gender equality and empowering women and girls, as stated in SDG 5, remains limited when applied

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to sex workers. Gender-based violence is framed, in both popular discourse and the academia, as violence against women. Mainstream representations of the ‘sex worker’ are largely of women, yet, discussions around violence against women rarely include female sex workers. Moreover, a discussion on violence against female, male, and trans sex workers is missing from the global discourse on gender-based violence.^{7, 8} There are two possible explanations for this significant gap. The first factor is the widespread view that prostitution is violence per se, and that ‘sex work’ is a misnomer. The violence that sex workers experience is thus regarded as part and parcel of the ‘institution’ of sex work.

The second factor is the conflation of sex work and trafficking, which undermines the human rights of sex workers and restricts the rights of migrant women workers. It fails to secure the rights of trafficked persons by misdirecting resources into policing sex work, rather than identifying people who are coerced and providing them appropriate support. It exacerbates the lack of legal remedies to redress violence and erodes the efforts of sex workers fighting for legal and social recognition of their rights to dignity and livelihood.⁹ Protectionist measures steeped in patriarchal control over women's mobility result in curbing female migration within and outside the borders of the country.¹⁰ This limits women's access and opportunity to travel away from the family or wider kinship group, in search of a better life.

Even though the lines between deceitful transport of a person and her will to travel may be blurred (with women facing either situation at different points in their lives), curbing women's mobility is not the answer. The current global push to criminalise demand as a strategy to combat trafficking is pushing sex workers into hazardous working conditions and exposing them to higher levels of violence.

States must recognise the right of sex workers to migrate for better livelihood opportunities, the right to equal protection of laws in the countries of origin and destination, and safe mobility options. Anti-trafficking strategies must not be targeted against consenting adult sex workers and their clients. Laws that criminalise consenting adults buying or selling sex, or activities such as living off earnings of sex work, brothel-keeping, and soliciting must be repealed. States must take measures to ensure safe working conditions for sex workers through a decriminalised set up for sex work.

Sex Work as Decent Work. SDG 8 aims to promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all. The International Labour Organisation (ILO) and UNDP have emphasised the need to provide sex workers with legally enforceable rights to occupational health and safety and the right to participate in the process of developing workplace health and safety standards.^{11, 12}

The understanding of decent work as put forth by the ILO encompasses four components: employment, social protection, workers' rights, and social dialogue. Sex workers have over the years been working towards achieving these objectives within their communities. The right to decent work is irrespective of

the moral or legal positions of the state or society vis-à-vis a particular occupation. Worker rights must be respected, protected, and fulfilled irrespective of whether or not national governments recognise sex work as work.¹³

Moving beyond tokenism, policy and law-making bodies and agencies must be transparent, accountable, answerable to, and genuinely inclusive of sex workers at every stage of formulation and implementation process. . . . Sex worker groups globally, UN agencies, researchers, and activists have affirmed that universality, human rights, and leaving nobody behind. . . should translate into policies, laws, and practices that protect, respect, and fulfil the rights of sex workers.

An important aspect of economic growth is women's ownership of land and assets. Sex workers are often the primary earners with the ability to create assets and property within the household. They are unable to enjoy this income because of the challenges in obtaining identity proof to access or own property, open bank accounts, or access safe and secure housing as single women from the unorganised sector.

The Right to Decent Work must be applicable equally and without discrimination: sex workers must be given equal rights before the law, including the right to mobilise; form representative bodies and seek legal reform; pursue safe and healthy working conditions in a non-discriminatory manner; access social and health services; and obtain legal and other forms of protection from exploitation, abuse, and violence.

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Redefining Inclusiveness. The rights to education, political participation (including representation at the national and international levels), citizenship, livelihood, health, and equality before the law can be fully achieved only if discrimination is eliminated from all spheres. A comprehensive approach to realise the human rights of sex workers and interventions affecting sex workers must be undertaken through consultation, participation, and leadership of sex workers. Decriminalisation of sex work is a pre-requisite to ensure the physical and emotional inviolability of sex workers, as well as their right to life, right to freedom of labour, health, and sexual and reproductive rights.^{14, 15}

Moving beyond tokenism, policy and law-making bodies and agencies must be transparent, accountable, answerable to, and genuinely inclusive of sex workers at every stage of the formulation and implementation process. Sex worker groups globally, UN agencies, researchers, and activists have affirmed that universality, human rights, and leaving nobody behind should translate into policies, laws, and practices that protect, respect, and fulfil the rights of sex workers. Such policies and laws must protect and affirm sex workers' right to Decent Work (ILO standard), rights against violence and exploitation in work, prevent illegal police practices, and provide them with equality before law and due process.

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WHEN SOME ARE LEFT BEHIND, ALL ARE LEFT BEHIND: A Youth Trans Feminist Activist Perspective from the Pacific

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Human rights are for all. This fundamental truth must be realised and respected at international negotiations. There is no time to exclude any community, including young people of diverse sexual orientation, gender identities, and sexual characteristics (SOGIESC). Our islands are sinking. We are literally drowning. Species of all kinds, including us humans in all our diversities, are affected by climate change and gender injustice. This is particularly catastrophic for us from the Pacific Small Islands Developing States, who are also vulnerable to unfair trade liberalisation agreements.

The 2030 Agenda for Sustainable Development—as well as its corresponding implementation framework in the Asia-Pacific, the Regional Roadmap for Implementing the 2030 Agenda—is still far from being as ambitious as initially hoped. Issues of young people and the lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ) community were side-lined or traded off as bargaining chips during the intergovernmental negotiations, resulting in the exclusion of sexual rights, LGBTIQ rights, and comprehensive sexuality education in the final agreement.

Yet, our rights cannot be axed! We are not bargaining chips. The revolution grows here in the Pacific Islands, led mainly by feminist activists and human rights defenders of all diversities. We resist the opposition that refuses to recognise us and realise our human rights. We say this to the Central Powers of New York, the Banks of London, and the various regional political arms that speak of inclusivity, yet fail time and again to meaningfully engage or prioritise marginalised groups like us. We condone the dangerous actions of the US Administration in pulling out of the Paris Climate Agreement and the expansion

of the Global Gag Rule—actions that are already negatively affecting our lives. We also say no to abhorrent trade agreements, such as the Pacific Agreement on Closer Economic Relations Plus (PACER Plus) that threaten our fundamental human rights, including our sexual and reproductive health and rights (SRHR).¹

We bring attention to the many faces of inequality and poverty. We remind governments to remember their agreements even as they have committed to the 2030 Agenda, such as to the 1994 International Conference on Population and Development (ICPD). ICPD was a major vortex in the population and development debate, shifting the focus of policymakers, researchers, and advocates to respect for human rights and the promotion of equality and health, particularly, SRHR. These commitments were further strengthened a year later by the 1995 Beijing Platform for Action (BPfA) that enshrined women's rights and gender equality in global development. The Yogyakarta Principles must also apply in the Pacific context.

Financing is an important element in health reform. Since 1994, governments that are recipients of population-related aid have come closer to meeting the financial commitments made in Cairo than the donor countries have.² Even so, the country studies show that in most countries, reproductive health programmes still depend heavily on international assistance.

All Member States have committed to “leave no one behind” in September 2015 at the UN General Assembly, but majority have yet to include the LGBTIQ community in national policies and programmes. Bodily integrity and autonomy cannot just be empty rhetoric. These must be principles that are valued, and at the centre of SRHR and gender

equality. It is core to independent action, and therefore a precondition for the realisation of all other human rights.

The Pacific Governments have made progress over the past few years towards the realisation of our human rights.³ These include the decriminalisation of homosexuality by Palau in 2014, the recognition of discrimination on the basis of SOGIE in the 2013 National Constitutional provision under Section 26 of the Bill of Rights in Fiji, the decriminalisation of *fa'afafine*⁴ in Samoa in 2013 with the repeal of the female impersonation legislation, the passing of Marriage Equality for Guam and the 2015 high-level launch of the Pacific Free and Equal Campaign. These are important advancements in terms of repealing all laws and policies that criminalise same-sex relationships in the Pacific Small Island Development States, and in the recognition of all people with non-heteronormative SOGIESC as full and equal rights-holders. The Pacific Leaders also have a strong commitment to ensuring SRHR for all our peoples, without discrimination, in the Moana Declaration of 2013.⁵

Yet, the rise in the multiple intersecting forms of homophobia, transphobia, and other forms of stigmatisation, discrimination, and violence against persons of diverse SOGIESC people impedes sustainable development and threatens global, regional, and national progress on the SDGs. These issues are especially complex because the LGBTIQ community is truly diverse. The discrimination and exclusion that LGBTIQ people face are largely invisible because there seems to be no wide support by duty bearers on gathering national, regional, and global data consistently and comprehensively. The national bureaus of statistics must take a lead on this. In the national and regional processes, measuring inclusion of LGBTIQ people

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must also allow for political and civic participation (which is already recognised in the International Covenant on Civil and Political Rights). Laws must be reformed to ensure legal gender recognition as part of one's bodily rights. Furthermore, the decriminalisation of LGBTIQ people is vital, to ensure we are able to exercise freedom of association, assembly, and expression.

SDG 3 on Good Health and Wellbeing must also address and recognise inequities in health access and health outcomes experienced by LGBTIQ communities, including the continued pathologisation of transgender people. This must also include utmost respect for the bodily integrity and autonomy of all, including trans and intersex individuals.

SDG 5 on Gender Equality could be made more inclusive to ensure equality of all genders, and empowerment of lesbian, bisexual, and trans women as well. LGBTIQ can also be a key priority in SDG 5.

There is indeed a need for access to education for LGBTIQ peoples, including for comprehensive sexuality education (CSE), and the education systems must be rights-based and meet our needs as well. Moreover, CSE or SRHR education must also include material on SOGIESC. SDG 4 on Quality Education must address this even as the development of indicators unfold in the region.

SDG 3 on Good Health and Wellbeing must also address and recognise inequities in health access and health outcomes experienced by LGBTIQ communities, including the continued

pathologisation of transgender people. This must also include utmost respect for the bodily integrity and autonomy of all, including trans and intersex individuals. Hormonal treatment is very costly, but it is a key need of the trans^{*6} community. Lack of access to condoms, HIV testing, adequate counselling, as well access to medication for HIV positive people, and stigmatisation are also issues for men who have sex with men and transgender communities.⁷ Meanwhile, the invisibility of identities of women who have sex with women has resulted in lack of safe sex information, data, and prophylactics.⁸ Government ministries must ensure we are taken care of, and they and the private sector must be held accountable when our rights are abused.

Beyond the Security Council Resolutions on 1325, 1820, 1888, and 1960 and the new Youth Peace and Human Security 2250, the regional human security architecture must consider the personal security of and violence faced by the LGBTIQ constituency. All security sectors, including the judiciary and legal fraternity must ensure that the Principle and Value of the Rule of Law is recognised in considering gender sensitivity trainings for their personnel, and ensure gender mainstreaming into their programmes. SDG 16 on Peace, Justice, and Strong Institutions must address this.

The economic well-being, such as income disparities and high poverty levels of LGBTIQ communities, must also be addressed. Labour laws and policies on non-discrimination must be at the core of SDG 8 on Decent Work and Economic Growth.

National and Regional SDG Task Forces have been set up here in the Pacific. They must be able to demonstrate an understanding that inclusivity is not just a word on paper, but a principle

practised by all actors at the table. There is a need to fully recognise people of diverse SOGIESC without delay, as we are a population that are left out of many political processes. Moreover, governments must ensure an enabling environment and provide funding for movement building, as our movement and trans organising is under-resourced.

Rising to the challenges faced in our Pacific Islands and ocean home will require an intersectional approach that critically analyses the political, physical, ecological, economic, cultural, and social dimensions of these overlapping and cross-cutting concerns through one holistic frame. The bringing together of different sectors, alliances, and governments ministries will be necessary to ensure a truly transformative agenda for gender, social, ecological, and economic justice in the Pacific and globally. Any policy or programme involving our communities must be initiated and implemented by our communities and our chosen allies, working from a human rights and gender equality framework, which recognises the principles of feminism.

Despite the restriction of civil society spaces and diminishing funding, we young feminists will continue to fight to ensure that our issues and priorities are heard and leaders are held accountable. Our diversity from the Pacific is truly our strength.

We from the Haus of Kameleon (HK), a Suva-based youth trans-led feminist movement in the Pacific that is part of other wider economic Southern Coalitions,⁹ are committed to ensuring that the SDG processes at various levels in Asia and the wider Pacific clearly mention the LGBTIQ community and our issues, the intersections of our issues with those of other movements, and that SRHR is integral to fulfilling the 2030

Agenda. We are here to stay and ensure that our rights are recognised, respected, protected, and fulfilled, in accordance with the principles of “Do No Harm” and “Equality for All” and not just for some.

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5 UNFPA, AFPPD, IPPF, “Moana Declaration: Outcome Statement of Pacific Parliamentarians for Population and Development” (2013), <http://countryoffice.unfpa.org/pacific/?reports=7673>.

6 Trans* is an umbrella term that refers to all of the identities within the gender identity spectrum. There’s a ton of diversity in the different identities there, but we often group them all together (e.g., when we say “trans* issues”). In this way, trans (without the asterisk) can be intentionally used to describe trans men and trans women, while the asterisk makes special note in an effort to include all transgender, non-binary, and gender nonconforming identities, including (but not limited to) transgender, transsexual, transvestite, genderqueer, genderfluid, non-binary, genderfuck, genderless, agender, non-gendered, third gender, two-spirit, bigender, trans man, and trans woman.

7 PSDN, DIVA, and ARC International, “Our Voices, Our Communities, Our Rights.”

8 Ibid.

9 These include the Pacific Regional SRHR Feminist Collective, Youth Voices Count, Youth Coalition, and Pacific Urgent Action Hub on Climate Justice. To find out more about Haus of Kameleon, visit <http://www.hausofkameleon.org/>.

SRHR AND THE 2030 AGENDA: What's at Stake for Young People Living with and Affected by HIV?

Young people aged 15 to 24 account for 37% of new HIV infections in the Asia and the Pacific region.¹ Of this figure, 95% of new infections occur among those who are considered 'most-at-risk to HIV.'² Young 'most-at-risk' or 'key populations'³ pertain to young gay men and other men who have sex with men, young people who sell sex,⁴ young transgender people,⁵ and young people who inject drugs, who are, in almost all countries, heavily impacted by the HIV epidemic. Three in every four young persons from key populations do not know their HIV status, while HIV prevention coverage among these populations are 5% to 18% lower than those who are aged 25 and above.^{6,7} Once diagnosed positive, many young people living with HIV in the region are unable to access essential treatment, adding to the lack of necessary financial and psychological support in order to achieve a better quality of life.⁸

An Issue about Young People's Access to Sexual and Reproductive Health Services.

Young people need access to comprehensive HIV information and services to protect themselves from sexually transmitted infections (STIs), including HIV. However, young key populations are often barred from accessing these services. In most countries in Asia and the Pacific, age of consent laws⁹ restrict minors from accessing sexual and reproductive health (SRH) information, services, and commodities, including contraceptives and condoms.

The concept of the evolving capacities of the child, first introduced in the 1989

Convention on the Rights of the Child (CRC), acknowledges the capacity of the child in "forming his or her own views and the right to express those views freely in all matters affecting the child."¹⁰ However, consent laws provide premium over the moral responsibility of the parents or guardians, leaving the decision to access information, commodities, or services to them on behalf of the child. Moreover, in countries such as Indonesia and Malaysia, where sexual and reproductive health conversations are oriented towards married couples, young people whose civil status is 'single' are denied from accessing SRHR or HIV-related services or commodities unless they show proof of consent from their spouse.¹¹

Continuum of care for young key populations—from age-responsive comprehensive sexuality education to STI and HIV diagnosis to treatment and referral to a range of other health-related services—is much needed, and yet a comprehensive approach to these services among these groups is limited.¹²

As a young gay man growing up in the Philippines, I found it very difficult to look for services that would provide holistic sexual and reproductive health care. Information about STI and HIV are only limited to the technical know-how of healthcare service providers in social hygiene clinics who may sometimes be untrained to address specific needs of young gay men. At the same time, while HIV education in school curricula remain under the framework of biological sciences, it is also difficult to look for

in our own words

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Sexual and reproductive rights in most countries in Asia and the Pacific, age of consent laws restrict minors from accessing sexual and reproductive health (SRH) information, services, and commodities, including contraceptives and condoms.

psychologists or counselors who I can talk to about emotional issues, and spaces where I will not feel shameful in sharing them. For someone living with HIV, I find it difficult to find spaces where I can talk about my intimate relationships and SRHR needs, which includes discussions about disclosure, consent, and safer sex, to name a few. These intersections of lived experiences have yet to be reflected into national SRHR programmes.

The SDGs and the AIDS Target. AIDS is now the second most common cause of death among adolescents aged 10-19 globally.¹³ The 2017 All-In to End Adolescent AIDS Launch Report by UNICEF shows that adolescent girls are disproportionately affected because of gender-based inequality, age-disparate sex, and intimate partner violence.¹⁴ Moreover, while the Sustainable Development Goals (SDGs) can serve as a development compass for countries to address HIV issues,¹⁵ its non-binding policy makes it difficult for countries to address legal impediments to achieving its targets. Further, populations who are historically criminalised, such as young key populations and young people living with HIV, are left behind in the response.

in our own words

To address this, civil societies and key population communities worked with the United Nations to pressure its members and convene for a High-Level Meeting on HIV/AIDS in June 2016, which adopted the Political Declaration to fast track the fight against HIV and to end the AIDS epidemic by 2030 and adopted 10 Fast Track Commitments.¹⁶ This sets regional commissions and Member States to plan roadmaps to end the epidemic. Most importantly, this Political Declaration highlighted the need to address HIV from an intersectoral approach by linking several SDG together, in particular SDGs 3 (Good Health and Well-Being), 5 (Gender Equality), 10 (Reducing Inequalities), 16 (Peace, Justice, and Strong Institutions), and 17 (Partnership for the Goals). This sets a platform to bridge HIV and SRHR together that neither oversteps nor overshadows one another, but both addresses issues of young people from key populations in a person-centered approach.

Sexual and reproductive rights are not accessory rights, but are integrated in our collective notion of human rights that impacts achievement of sustainable development and quality of life for all. These rights are contingent to achieving the optimum development of all young people, and that includes young people from key populations. Beyond HIV, young people from key populations have SRHR issues which must be recognised, promoted, and protected.

While some countries have ensured participation of young people in policy decision-making and implementation of SRHR programmes at many levels of engagement, young key populations still find it difficult to participate

due to marginalisation, stigma and discrimination, and perceived notions of lack of capacity to engage due to age. In particular, young women who use drugs, young women who sell sex, and young trans women migrants are excluded in these conversations and their SRHR issues are not given sufficient attention due to the multiple forms of stigma and discrimination they face. For instance, a young trans woman migrant who sells sex is ostracised because of her gender identity, is criminalised and extorted by law enforcers due to her occupation, and is barred by health service facilities due to her citizenship status. Instead of putting these populations in isolation, we need to recognise the need for community organisations and civil society organisations to come together and call for inclusion of young key populations into the greater frame of SRHR agenda.¹⁷

If we are to end AIDS by 2030 among young key populations, we have to ensure that issues relating to SRHR, gender equality, and age of consent, are addressed through a person-centered, rights-based approach which acknowledges the intersectionality of lived experiences of young key populations. Sexual and reproductive rights are not accessory rights, but are integrated in our collective notion of human rights that impacts achievement of sustainable development and quality of life for all. These rights are contingent to achieving the optimum development of all young people, and that includes young people from key populations. Beyond HIV, young people from key populations have SRHR issues too, and these must be recognised, promoted, and protected.

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STAYING INSPIRED FOR WOMEN LIVING WITH HIV AND WOMEN WHO USE DRUGS

In Conversation with Baby Rivona

*In this interview, ARROW spoke with **Baby Rivona**, a woman living with HIV and a long-time Indonesian HIV advocate. Baby is the co-founder and coordinator of the Indonesian Positive Women Network (IPPI), the only national network in Indonesia for women living with and affected by HIV, and which currently has a membership of about 600 women from across 25 provinces. Established in 2006, IPPI aims to build a strong movement of women living with and key affected by HIV, develop their knowledge related to sexual and reproductive health and rights (SRHR), improve their access to services, and increase their meaningful participation in policy and advocacy spaces.¹ Baby shared the challenges of women living with HIV and women who use drugs, as well as the difficulty of getting funding for SRHR and for organisational strengthening.*

Please tell us briefly about your activist journey. How did you start working on issues of HIV, SRHR, and rights of women who use drugs and live with and affected by HIV?

I used drugs before, and went to work in Malaysia as a domestic worker. On my second year working there, I found out I was HIV-positive and got deported. I had no job, no money, no information; I was just waiting to die. Then I read books. I joined a support group for HIV. I went to the field and learnt from the doctors, the clients, from families; and then I became a buddy for clients. Then in 2006, after the tsunami in Aceh, I started my own

organisation. Since then, I have been an activist wearing many hats: a woman living with HIV, a person who used drugs, and a former migrant worker (I was involved with the National AIDS Commission in developing the Strategic Plan for Migrants). I am also a mother. In 2009, I was shocked to learn I was pregnant at the age of 42. However, I was lucky because I was able to access the Prevention of Mother-to-Child Transmission (PMCT) services I helped develop.

Can you tell us why IPPI decided to focus on sexual and reproductive health and rights, and what have you done to address this gap?

In 2011, we started asking our members what they really need and want to focus on for capacity building and advocacy. The first priority identified in the survey was the need for information about SRHR and its implications for women living with HIV.

Considering that none of us really knew about this topic, we asked for help from several experts to develop with us a training module.² In the process, we shared our experiences as women living with HIV on abortion, sexually transmitted infections, violence against women, access to treatment, and gender issues, amongst others. Despite limited funding, we trained several facilitators who then went on to train women living with HIV.

voices from the global south

*Interview conducted by **Maria Melinda (Malyn) Ando**, ARROW for Change Managing Editor, and Senior Programme Officer, Publications, Communications & Advocacy, ARROW*

The evaluation we did in 2013 revealed that the training has resulted in women living with HIV knowing how to protect themselves from unwanted pregnancy and STIs, gaining increased awareness to access SRH services, such as pap smears, and understanding that forced contraception and forced sterilisation are direct violations of their rights.

However, there were also gaps, such as the module not including information focusing specifically on women who use drugs and their specific SRHR needs. For example, we do not have information on the impact of drugs, including methadone, on women's pregnancy. Issues related to sexual orientation and gender identity and expression (SOGIE) were also not included.

“In my perspective, all women need to know about SRHR, including prevention of unwanted pregnancy, STI, and HIV, regardless of age, and whether or not she is a ‘key affected’ or ‘high-risk’ woman.”

Many networks of other key population groups have since adapted the module for their own members, including the International Community of Women Living with HIV Asia Pacific (ICWAP) in 2014 and the Indonesian national sex workers' network in 2015. More recently, a group working for harm reduction wanted to adapt this module as well. In

vocies from the global south

terms of next steps, I want to conduct a comprehensive evaluation on the module's impact, and to update it. We also want more women trained since right now only 15% of IPPI members have been given the training. However, finding funding is not easy.

Can you tell us what the SRHR concerns are of women living with HIV, and of women who use drugs, particularly from the region?

A lot of people are still afraid of HIV, so there is still stigma and discrimination. When it comes to reproductive health though, everyone finds it easy to accept that this is important for married women, even those living with HIV. However, this remains an issue for unmarried adolescents and young people in general, since sex is still considered a taboo for them. In my perspective, all women need to know about SRHR, including prevention of unwanted pregnancy, STI, and HIV, regardless of age, and whether or not she is a 'key affected' or 'high-risk' woman.

Violence against women and forced sterilisation are key issues for women living with HIV. We did a study on this in Indonesia in 2012,³ and found that 30.2% of respondents experienced economic violence, 29.7% experienced psychological violence, 28.9% experienced sexual violence, 24.8% experienced physical violence, and 13.5% had undergone forced sterilisation. In fact, in 2012, I raised the issue of forced sterilisation amongst women living with HIV at the CEDAW Committee. We did not hear of more incidences of forced sterilisation after that, but earlier this May, we heard about a 23-year-old woman living with HIV who had sterilisation. We are still collecting evidence on why she had the procedure, and if we do find out that it was indeed coerced, we will raise this as an issue again.

For women who use drugs, an issue is that the menstrual cycle of women who use methadone become irregular, making it more difficult for them to know if they are pregnant. They usually find out once they are in rehabilitation facilities. When they do, what is the best option for them: to have an abortion, or to continue the pregnancy while maintaining methadone usage? The Indonesian Drug Users' Network (PKNI) has done a study on this issue.

“While the government has services for women living with HIV, there needs more involvement from the community in terms of assessing the quality of these services on the ground, not just serving as beneficiaries.”

As I mentioned earlier, the lack of funding for the SRHR of women living with HIV is a key concern for us. The lack of inclusion in policies could be a factor in why there is no government funding for this.⁴ While we have already added SRHR and integration of violence and HIV services in the National Strategy and Action Plan for the HIV and AIDS Response 2015-2019, it has not been signed yet by the Ministry of Health. The integration of violence and HIV services is already funded by the Global Fund, but there is no funding for SRHR. Last year, UNFPA supported us and the national sex workers' network with some funds to jointly provide trainings for facilitators; however, this is not equivalent to sustainable programming. Unfortunately, it seems we do not have sufficient convincing evidence that SRHR is a really an important issue to address for women living with HIV.

What roles should communities, of women living with and affected by HIV, and women who use drugs, play in the implementation and monitoring of the Sustainable Development Goals? How can these be fostered?

There is currently a lack of understanding amongst HIV activists and communities on the importance of the SDGs, considering that this new global framework has both SRHR and HIV targets.

In terms of the government's involvement of civil society in the development of the strategic plan for implementing the SDGs, I think they need to be more transparent on who they invite and why, and to ensure more diversity. When I asked them, they said some organisations are already engaged with the National Planning Bureau. I said fine, but next time remember to invite me since I am interested, and want to raise issues of women living with HIV.

While the government has services for women living with HIV, there needs more involvement from the community in terms of assessing the quality of these services on the ground, not just serving as beneficiaries. In fact, this is one of the areas we included in this recent round of proposals to the Global Fund in collaboration with the Ministry of Health.

What are some of your recommendations to governments, the UN, and donors towards ensuring that the SRHR of women living with and affected by HIV, and women who use drugs are not forgotten?

There is a need for more investments for the SRHR of women living with HIV in Indonesia, both by the government and by donors. Knowledge about SRHR is very important for women living with HIV for them to live their lives well, and

to protect themselves from unwanted pregnancy, and STIs.

Another key issue is the need for donors to fund organisational strengthening. While donors may be interested in funding some of our programmes, they do not give us salaries. How can we survive to do this otherwise? We already put in our time and energy; don't count us as volunteers. Please look at us as experts because we've lived through these; our expertise come from our experience.

I am asking the same from the government. They also need to give support for women's organisations so they can start awareness raising, especially on SRHR, and to strengthen organisations. They need to fund us and see this as their responsibility, rather than us looking for donors overseas. The government needs to set up a funding mechanism for civil society organisations from the national budget.

In terms of laws and policies, the law on anti-discrimination of people living with HIV needs to be implemented properly. For example, just recently, a child was not accepted by the school because of HIV. For drug use, we still have the death penalty for drug dealers and for people who use drugs, some go to rehabilitation and some still go to jail. I am worried about the target set by the government that by 2020, Indonesia will be free from drugs, and the resulting war on drugs. If the National Narcotic Bureau does not reach the yearly target of people who use drugs going for rehabilitation, can you imagine what will happen? Laws and policies needs to be rights-based.

In terms for access to medicine and treatment, we are advocating that the government provide medication for Hepatitis C. Right now, it is still not available in hospitals in Indonesia and

only available commercially at double the cost of the price in India, so the networks have to access this from India via Thailand.⁵ Laboratory tests are also very expensive for communities and need to be free or more affordable.

“Another key issue is the need for donors to fund organisational strengthening. While donors may be interested in funding some of our programmes, they do not give us salaries. How can we survive to do this otherwise? We already put in our time and energy; don't count us as volunteers. Please look at us as experts because we've lived through these; our expertise come from our experience.”

Lastly, the national health insurance, which is given by the government for all citizens, currently states that if you get sick because of drugs, then you are not covered. Those clauses need to be removed. If you want to give it, it should be for all.

Is there anything you'd like to add?

Right now, I feel tired of being a person living with HIV, because the number of HIV positive people is always increasing, and there is still stigma. We have so many conferences, but why is it that yesterday, there was a forced sterilisation again? Why was my son (who isn't HIV positive) kicked out of school since the parents were afraid? There are lots of thoughts in my mind of things that we have not achieved despite all our efforts.

voices from the global south

Given that, what keeps you inspired? What drives you to go on?

Because a lot of women do not realise they have equal rights, especially women living with HIV. This inspires me to keep moving forward.

Baby Rivona can be contacted at babyrivona@gmail.com.

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THE YOGYAKARTA PRINCIPLES:

Looking Back, Looking Forward

A key aspect of the Sustainable Development Goals (SDGs) is the commitment to “leave no one behind” and to proceed on the basis that “the dignity of the human person is fundamental.” Both aspects need to be invoked in the context of sexual orientation and gender identity-based struggles, as until today, laws criminalise expressions and identities related to sexuality and gender in many parts of the world.

One of the important normative markers in this struggle against discrimination and violence on grounds of sexual orientation and gender identity (SOGI) has been the adoption in 2006 of the Yogyakarta Principles (YPs) on SOGI by a group of 28 UN experts, human rights lawyers, and academics.¹ On the tenth anniversary of this legal document, we must not only remember the unthinkable violence inflicted on LGBTIQ persons around the world, but also work towards a future where such violence must end.

The struggle to establish that LGBTI person are human beings, entitled to full moral consideration, is a continuing battle.

How then do we evaluate what the YPs have achieved?

Emphasising the Universality of Rights.

The philosophy underlying the YPs is to be found in Principle 1, which makes these points: “All human beings are born free and equal in dignity and rights,” and

“Human beings of all sexual orientations and gender identities are entitled to the full enjoyment of all human rights.”² Today, this principle of universality still continues to be denied in countries around the world. The struggle to establish that LGBTI person are human beings, entitled to full moral³ consideration, is a continuing battle.

... when we say that anti-sodomy laws violate the right to privacy, we are not asserting the patriarchal understanding that a “man’s home is his castle” (i.e., the untrammelled right to do what we want in the zone of the home), but asserting that forming intimate ties with others comes within the rubric of protecting your right to form relations with the person of your choice and your right to choose who to form such ties with.

The Definitions of SOGI. The broad definitions of SOGI in the YP carefully avoid the trap of protecting only established identities like gay, lesbian, bisexual, or transgender, and expressly broaden the protection to a wide range of people, all of whom could be targeted for either their sexual behaviour, sexual acts, sexual identities, gender expression, or gender identity. In Argentina, the historic Gender Identity Law borrowed its definition of gender identity from the Yogyakarta Principles.⁴ In India, the Delhi High Court judgment in Naz Foundation

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v. NCR Delhi, reading down Section 377 of the Indian Penal Code, as well as the Supreme Court judgment recognising transgender rights in National Legal Services Authority v. Union of India (NALSA), cited the Yogyakarta Principles.⁵

Developing the Right to Recognition

before the Law. Principle 3 provides for recognition before the law,⁶ innovating by applying this right to gender identity and sexual orientation. This is a central axis of struggle for transgender people globally. Legal systems around the world routinely deny them legal recognition in the gender of their choice, rendering them “rightless” by denying their right to identify with the gender of their choice. Principle 3 has since then found its way into the domestic legislations of Argentina,⁷ Ireland,⁸ and Malta,⁹ all of which recognise the right to choose one’s gender.

Moving Beyond Zonal Privacy. Principle 6 enshrines the right to privacy, which is normally seen as the right not to be interrupted in the peaceful enjoyment of one’s home. The YPs go beyond this understanding to include “decisions and choices regarding both one’s own body and consensual sexual and other relations with others.” Principle 6 takes privacy beyond the notion of “zonal privacy” to also include what has been called, “decisional privacy” and “relational privacy.” Thus, when we say that anti-sodomy laws violate the right to privacy, we are not asserting the patriarchal

understanding that a “man’s home is his castle” (i.e., the untrammelled right to do what we want in the zone of the home), but asserting that forming intimate ties with others comes within the rubric of protecting your right to form relations with the person of your choice and your right to choose who to form such ties with. By expanding the notion of privacy beyond the “zonal,” the YPs make a link to the conceptual framework provided by “dignity” and “autonomy.” This link between dignity, privacy, and liberty is made powerfully in jurisprudence in India,¹⁰ South Africa,¹¹ and the USA,¹² where the principle that to protect privacy is really to protect the realm of intimate decision making emerges.

Addressing the Need for Protection from Medical Abuse.

Principle 18 underscores that control and regulation of SOGI happens not just through the State and laws but through multiple social institutions, and addresses another possible violator of rights—the medical profession. Medical abuse as defined in this principle elaborates three contexts in which a person may be forced to undergo based on SOGI:

- Medical or psychological treatment, procedure, or testing;
- Confinement to a medical facility; and
- Classifications of SOGI are not in and of themselves, medical conditions to be treated, cured, or suppressed.

This jurisprudential development is a vital expansion of protections from medical abuse to persons who may be affected on grounds of their SOGI. This applies with greatest force to the context of intersex infants, whose bodies are subjected to irreversible medical surgery, often under the guise of protecting the best interest of the child. This principle is a beginning point in developing a legal framework around outlawing such surgeries.

Principle 18 underscores that control and regulation of SOGI happens not just through the State and laws but through multiple social institutions, and addresses another possible violator of rights—the medical profession.

Looking Ahead. In the ten years since the YPs were formulated, there has been an exponential growth of SOGI jurisprudence, but there is still a long way to go. One example would be the use of the term “sex characteristics” to conceptualise the basis on which intersex infants are subjected to medically unnecessary intervention. The rights of trans sex workers and of LGBT refugees, as well as gender expression, may require specific elaboration within the framework of the YPs.

There is a need to both reanimate the principles, and to fill in its gaps so that the Yogyakarta Principles continue to be the beating heart of SOGI jurisprudence in the years to come. If the SDGs are indeed to “leave no one behind” and to “protect the dignity of the human person,” its imperative that the YPs be part of the framework for implementation.

Notes & References

- 1 “The Yogyakarta Principles: The Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity,” <http://www.yogyakartaprinciples.org/>.
- 2 This principle derives from Article 1 of the Universal Declaration of Human Rights (UDHR), which states that ‘All human beings are born free and equal in dignity and rights.’ Article 1 of the UDHR is a poignant reminder of a history of Nazi persecution, torture, and murder of Jews, Romas, Slavs, people with disability, and homosexuals.
- 3 The authors contend that while “moral” and “morality” have certain connotations that can be captured by religious discourses, they need to be reclaimed. The examples of this reclamation in law is the idea of “full moral citizenship” articulated by Justice Sachs in South Africa, and constitutional morality by Ambedkar in India. See: National Coalition for Gay and Lesbian Equality and Another v. Minister of Justice and Others (CCT11/98) [1998] ZACC 15; 1999 (1) SA 6; 1998 (12) BCLR 1517 (9 October 1998). Also see Ambedkar’s speech in the Constituent Assembly cited by C.J. Shah in Naz Foundation v. NCT Delhi, <https://indiankanoon.org/doc/100472805/>.
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WOMEN'S SRHR AND CLIMATE CHANGE:

The Case of Mindoro, the Philippines

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The earth is warming. Climate change is happening everywhere.¹ Its adverse impacts are affecting humanity and the resources they depend upon. Unless everyone takes responsibility, makes the right choices, and takes action, the phenomenon will continue and will be distressing to all people and the planet.

Events, such as rising sea levels and extreme weather patterns, are now more pronounced and varied compared to previous decades. According to the Germanwatch Global Climate Risk Index, the Philippines was one of the world's most vulnerable country to climate change and severely suffered from extreme weather events along with Haiti in 2012.² Data trends also reveal increasing temperature at an average of 0.01 Celsius per year in the past five decades,³ endangering the health of the people and the state of the resources. The findings mimic results of the assessment done in the Verde Island Passage (VIP) marine key biodiversity area in the Philippines.⁴ Described as the "centre of the centre" of marine shore fish biodiversity⁵ in the world, facts point to an ecology that is vulnerable to climate variability. The increasing sea surface temperature is resulting to rising sea levels and increasing storm frequency and intensity inundating coastal areas.⁶ With over seven million people in the vicinity, these changes pose risks to the ecosystems' functions and services, i.e., water, air, food, income, and livelihoods that people derive from their resources.

Oriental Mindoro Province is one of the islands in the VIP with a total population

of 844,059 in 2015.⁷ Poverty (47.1% in 2006)⁸ and adolescent birth rate (57% in 2013) are high.⁹ Maternal mortality ratio has not reduced fast enough (209/100,000 live births in 1990 vs. 221 in 2011) and contraceptive prevalence rate remains low at 55.1% in 2013.¹⁰ These are barriers to improving the sexual and reproductive health and rights (SRHR) status of women. Moreover, human activities such as illegal or destructive fishing, pollution, and unsustainable land use practices contribute to biodiversity loss, threatening the VIP's productive fishing grounds. All of these make women, youth, and fishers increasingly susceptible to climate change.

Women are capable and central to solutions, but they also need support to build resiliency to the effects of climate change. Governments thus must implement women-centred policy and programmes ...

One proof is Jovita, who is married to a fisher at 17 and lives along the coast of VIP. At 37, she has nine children. While she knows SRHR as including family planning, reproductive health, and responsible parenthood, she never had any prenatal check up and had no savings for a facility-based delivery. Low fish catch and unpredictable weather made earning a living difficult and unfortunately, her husband will not be able to fish anymore after meeting an accident. To support the family, she weaves nipa mats, while she takes care of

her young children. Their eldest daughter stopped schooling to work as a housemaid.

For Jovita and the many women in VIP, there is no local term for climate change but an ongoing experience.¹¹ Their vulnerability is intimately related to barriers in accessing health and SRHR information and services; traditions and preferences; women's dual roles as carers and providers; and limited economic opportunities placing the "burden on the woman" at the core of the people, earth, and climate change nexus.

Women are capable and central to solutions, but they also need support to build resiliency to the effects of climate change. Governments thus must implement women-centred policy and programmes to build risk resiliency. These must include the following elements: 1) actions that promote health- and SRHR-seeking behaviours, and access to safe, effective, affordable, and accessible SRHR services; 2) equal opportunity to economically productive and sustainable livelihoods, enabling a steady income for the family; 3) sustained community based awareness and actions on the linkages amongst SRHR, health, conservation, and climate change; and 4) ensuring women's rights and women's empowerment, and building capacity to meaningfully engage in decision-making processes, policy making, and implementation. With these, women would be able to plan their families, care for their health, manage their resources, build capacities to be engaged meaningfully, be economically productive, and make a difference.

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VOICING CONCERNS TO ENSURE YOUNG PEOPLE'S SRHR

The Youth-led Submission on the Universal Periodic Review of Pakistan

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Since the 18th Amendment to the Constitution of Pakistan in 2010, "Youth Affairs" has become a jurisdiction of the provincial government. In seven years, only two out of four provinces² have had their youth policies approved, while the other two drafts have been developed but bureaucracy and political instability are causing delays in their adoption. While Pakistan's National Health Policy was developed in 2001, no provincial policy has been formulated since 2010. Some provisions on young people's sexual and reproductive health and rights (SRHR) in Pakistan are present in the policies,³ but remain largely unimplemented. Pakistan is also a signatory to several relevant international agreements.⁴

The limited policy framework in Pakistan is further compounded by social determinants, such as cultural norms and service provider bias which further limits young people's, especially young girls,' access to SRH services and information.

This dismal situation is reflected in SRHR outcomes for young people. Early age marriage is highly prevalent in the country, with the median age of marriage for girls in Pakistan being 19.5 years of age.⁵ There were 508 reported cases of child sexual abuse in 2014—a 17% increase from the previous year.⁶ Young people (below 30 years) remain ill-equipped to handle the complex health challenges they face due to inadequate information, lack of access to resources, and lack of decision-making power.⁷ Due to the criminalisation of homosexuality,⁸ sexual and gender minorities, youth included, are reluctant to reveal their sexual orientation and gender identity to health service providers and often face abuse and discrimination.⁹

In order to raise these issues, the "Right Here, Right Now" (RHRN) Pakistan alliance¹⁰ collaborated in the first Youth Submission to the Universal Periodic Review (UPR)¹¹ of Pakistan. The submission was drafted by young people,

with the primary research also conducted by youth representatives¹² of RHRN's 11 civil society organisation members.

... there is an urgent need for the Government of Pakistan to address SRHR issues of youth, including provision of and enabling access to youth-friendly and gender-sensitive SRH information and services for all, with particular attention to marginalised groups; life skill basic education (LSBE), including the essential components of comprehensive sexuality education for in and out-of-school youth; and comprehensive legislation to address sexual and gender-based violence (SGBV), and harmful cultural practices...

Youth platform members of the RHRN Pakistan participated in a workshop¹³ organised by ARROW and dance4life, which aimed to enhance knowledge on UPR's effectiveness as an advocacy and accountability tool to monitor and improve the situation of human rights, the recommendations Pakistan has received previously, and the SRHR status in Pakistan. After the workshop, the participants held consultations with their constituencies through surveys and focus group discussion on young people's access to SRHR information and services.¹⁴ A drafting committee was selected to compile the findings, analyse the results, and draft the UPR submission.¹⁵ The process took three and a half months and featured responses from 197 young people.

The UPR can also contribute to strengthening the implementation of SDGs at the national level, since the 2030 Agenda is underpinned and guided by human rights principles and instruments.

The recommendations from this process have been submitted as part of the shadow report for the upcoming UPR of Pakistan to highlight the gaps in access to SRHR information and services, especially for young people, and to demand urgent action from the state. Based on these youth consultations, several recommendations stand out very clearly: there is an urgent need for the Government of Pakistan to address SRHR issues of youth, including provision of and enabling access to youth-friendly and gender-sensitive SRH information and services for all, with particular attention to marginalised groups; life skill basic education (LSBE), including the essential components of comprehensive sexuality education for in and out-of-school

youth; and comprehensive legislation to address sexual and gender-based violence (SGBV), and harmful cultural practices, such as child marriages, and discrimination.

Even as the 2030 Agenda for Sustainable Development is getting a lot of attention, human rights accountability mechanisms, such as the UPR, serve as important platforms for monitoring young people's SRHR. The UPR can also contribute to strengthening the implementation of SDGs at the national level, since the 2030 Agenda is underpinned and guided by human rights principles and instruments. It therefore presents the perfect opportunity for youth-led organisations to jointly voice their concerns and act as a pressure group for the government. Pakistan will be under review for UPR for the third time in 2017. As consulting young people for the UPR reporting is, unfortunately, still very rare in Pakistan, producing this shadow report is a milestone in terms of monitoring progress on young people's SRHR.

Drawing from this report, an advocacy brief is being developed for lobbying with member states participating in Pakistan's UPR prior to the session. RHRN Pakistan and its youth platform members will also hold a briefing session with Ministry of Human Rights and media to consult on follow-up actions after the UPR.

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- 4 These include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), the International Covenant on Civil and Political Rights (ICCPR), the International Conference on Population and Development (ICPD), and the 2030 Agenda for Sustainable Development.

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10 Right Here, Right Now (RHRN) Pakistan is part of the Right Here, Right Now global consortium. RHRN envisions a world where young people, in all their diversity, acquire full and uninterrupted access to comprehensive sexuality education, and youth-friendly sexual and reproductive health services, including safe abortion. The RHRN Pakistan member organisations are as follows: Rahnuma Family Planning Association of Pakistan, Bargad, Forum for Dignity Initiatives (FDI), Chanan Development Association (CDA), Youth Advocacy Network (YAN), Rutgers Pakistan, Indus Resource Center (IRC), Aahung, Aware Girls, Blue Veins, and Idara Taleem-o-Agahi (ITA).

11 The Universal Periodic Review (UPR) is a mechanism of the United Nations (UN) Human Rights Council (HRC) that emerged from the 2005 UN reform process. Commonly referred to as the UN-UPR, it was established by General Assembly resolution 60/251 of 3 April 2006, the UN-UPR periodically examines the human rights performance of all 193 UN Member States.

12 RHRN Pakistan defines young people as youth and adolescents aged between 15 to 30 yrs.

13 The workshop was organised on 5-9 December 2016 in Islamabad, Pakistan. Eight youth platform members, nominated by member organisations of RHRN Pakistan, participated in the workshop.

14 Consultations were carried out in each of the four provinces of the country with youth from diverse backgrounds, including sexual and gender minorities, rural youth, and youth from different networks.

15 This was done under the guidance of the Rahnuma Family Planning Association of Pakistan (FPAP), ARROW, Sexual Rights Initiative (SRI), and dance4life.

PUSHING BOUNDARIES: Advocating for the Right to Safe Abortion in the Philippines

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No woman should die from complications of unsafe abortion and of lack of access to post-abortion care. However, everyday in the Philippines, approximately 1,671 women undergo medically unsafe abortion procedures, 274 women are hospitalised, and three women die as a result of unsafe abortion complications.¹

Women have to go through unsafe, clandestine procedures because of the criminal ban on abortion without any clear exceptions.² Under the Revised Penal Code (RPC) of the Philippines, a colonial legacy from the Spanish Código Penal of 1870, a woman who consents to and undergoes an abortion may be imprisoned for up to six years and anyone assisting her up to 20 years.³ This punitive law was reinforced when members of the 1986 Constitutional Commission carrying the views of the Catholic Church hierarchy⁴ successfully inserted a provision in the 1987 Philippine Constitution that declares that the government shall “equally protect the life of the mother and the life of the unborn from conception.”⁵

The legal restrictions on abortion violates women’s fundamental human rights, including the rights to life, health, non-discrimination, privacy, and freedom from cruel, inhuman, and degrading treatment. Human rights bodies have recommended the Philippines to review and amend its prohibitive law on abortion, and to decriminalise abortion on certain grounds.⁶

While prosecutions are rare, these criminal provisions and the stigma associated with abortion force women

to resort to unsafe abortion that gravely endanger their health and lives.

The dismal state of Filipino women’s reproductive health, and the restrictive abortion law, leads to high maternal mortality and morbidity due to unsafe abortion complications. In a country where there is high unmet need for modern contraceptives due to lack of access to information and services, there is also high incidence of unintended pregnancy.⁷ One in three births in the country is either unwanted or mistimed,⁸ and there is a high rate of women with unintended pregnancies who undergo unsafe abortion procedures.⁹

The legal restrictions on abortion violates women’s fundamental human rights, including the rights to life, health, non-discrimination, privacy, and freedom from cruel, inhuman, and degrading treatment. Human rights bodies have recommended the Philippines to review and amend its prohibitive law on abortion, and to decriminalise abortion on certain grounds.

The full implementation of the Responsible Parenthood and Reproductive Health (RPRH) Law, which was adopted in 2013 after women’s rights organisations successfully fought for its enactment, is derailed by budgets cuts and the temporary restraining order (TRO) on the procurement and distribution of contraceptives.¹⁰ The TRO stemmed from the oppositions of

conservative and religious group claiming that the contraceptives have abortifacient characters. This framing against contraceptives further enflames the stigma around abortion. Despite the law stating that women has the right to “humane, compassionate, nonjudgmental, post-abortion care,” they remain fearful of seeking medical treatment following complications from unsafe abortion because of the fear of criminalisation and stigma.¹¹

PINSAN: Creating Safe Spaces for Dialogue and Collaboration. The social, cultural, and legal conditions in the country make it very difficult for women and local advocates to find platforms to openly discuss the impact of unsafe abortion and the urgent need for appropriate post-abortion care. While the processes related to the passage of the RPRH Law provided some room for the discussion on abortion, and even some supporters emerging out of it, some women’s rights activists feel that the discourse on abortion as an integral part of sexual and reproductive health rights (SRHR) is lacking. Thus, in 2015, women’s rights organisations, lawyers, academics, and advocates established a network to openly work on the issue of abortion.

The Philippine Safe Abortion Advocacy Network (PINSAN) has created a safe space where advocates can openly discuss and collaborate on actions to address abortion issues, a first of its kind in the country. Through its online¹² and offline communications work, PINSAN addresses the stigma, challenges

misconceptions, and disseminates accurate and scientific information on abortion. PINSAN is currently conducting a study to capture the lived realities of women and their communities on abortion. It has trained NGO workers, community-based leaders, and religious leaders on abortion stigma elimination, and those who have been trained have already conducted community outreach discussions, expanding the reach of the network.

The PINSAN experience presents evidence that it is possible to promote access to abortion services and reduce stigma in restrictive settings, as well as demonstrates the imperative of ensuring that local advocates' capacities are built and they are supported to take advantage of advocacy opportunities as they arise.

PINSAN has also been advocating for quality post-abortion care. The policy engagement has resulted in the Department of Health's National Policy on Prevention and Management of Abortion Complications (PMAC).¹³ The policy aims to provide quality, humane, respectful, non-judgmental, and compassionate care and services to women who suffer from complications arising from unsafe and spontaneous abortion. It will also greatly reduce maternal mortality and morbidity by making post-abortion care available at every level of care in both high- and low-resource settings.

It is often argued that it is difficult to advance the right to access to safe abortion in highly restrictive contexts, due to conservative cultural norms, pervasive abortion-related stigma,

discrimination, and the criminalisation of women and abortion service providers, among other factors. The PINSAN experience presents evidence that it is possible to promote access to abortion services and reduce stigma in restrictive settings, as well as demonstrates the imperative of ensuring that local advocates' capacities are built and they are supported to take advantage of advocacy opportunities as they arise.

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- 9 Finer and Hussain, "Unintended Pregnancy and Induced Abortion in the Philippines."
- 10 Particularly Implanon and Implanon NXT.
- 11 Fritzie Rodriguez, "Death by Stigma: Problems with Post-abortion Care," *Rappler*, May 20, 2015, <http://www.rappler.com/move-ph/issues/gender-issues/92621-post-abortion-care-stigma>.
- 12 Follow PINSAN on social media at @pinsanorg and <https://www.facebook.com/pinsanorg/>.
- 13 Department of Health Administrative Order on the Prevention and Management of Abortion Complications (PMAC AO No 2016-0041, Nov. 25, 2016), <https://www.scribd.com/document/344526773/DOH-AO-2016-0041-Prevention-and-Management-of-Abortion-Complications>.

RESOURCES FROM THE ARROW SRHR KNOWLEDGE SHARING CENTRE

ARROW's SRHR Knowledge Sharing Centre (ASK-us) hosts a special collection of resources on gender, women's rights, and sexual and reproductive health and rights (SRHR). It aims to make critical information on these topics accessible to all. The ARROW ASK-us will be going online in the last quarter of 2017. To contact ASK-us, write to km@arrow.org.my.

KEY RESOURCES ON UNIVERSAL ACCESS TO SRHR

Action for Global Health and Countdown 2030 Europe. *Universal Health Coverage: Sexual and Reproductive Health and Rights on the Agenda.* Discussion paper, March 2017. <http://www.countdown2030europe.org/storage/app/media/universal-health-coverage-srhr-on-the-agenda-afgh-countdown2030.pdf>.

This updated paper seeks to show how the World Health Organisation (WHO) definition of universal health coverage (UHC) and its vision of the social determinants of health underpinning UHC relate to SRHR and the enabling factors which affect SRHR. It argues that UHC cannot be truly achieved without addressing SRHR as a matter of priority, and that an approach to UHC which is grounded in human rights is critical for making progress on SRHR. It acknowledges that some aspects of SRHR continue to be deprioritised and will continue to require ongoing and additional focus and activism. It concludes with some key messages and recommendations on what it means to achieve universal access to SRHR.

Beattie, Allison, Robert Yates, and Douglas Noble. *Accelerating Progress Towards Universal Health Coverage for Women and Children in South Asia, East Asia and The Pacific.* Thematic paper. UNICEF South Asia Regional Office, 2016. <http://billion-brains.org/wp-content/uploads/2016/10/UHC-Paper.pdf>.

This thematic paper looks at the basics of universal health coverage (UHC), including its benefits and essential ingredients, synthesising the current situation in Asia and the Pacific regions. It examines the global and regional policy context for health (and UHC) including the SDGs, the new global health agenda, and rising concerns about global health security. The main lessons learned from countries' experience with UHC are summarised, including the examples and short case studies from the region, as well as the determinants of success and barriers to the progress. Policy recommendations and next steps are outlined in the final section of the paper.

Boldosser-Boesch, Amy, Dan Byrnes, Cindy Carr, Shiza Farid, Kimberly Lovell, Helena Minchew, Joanne Omang, Robyn Russell, and Ann Warner. *Briefing Cards: Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda.* UN Foundation's Universal Access Project, 2015. <http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/universal-access-project/briefing-cards-srhr.pdf>.

This set of briefing cards highlights the links between SRHR and the achievement of other development priorities, such as education; economic benefits; broader health agenda; gender equity; and environment.

resources

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Center for Health and Gender Equity (CHANGE). *All Women, All Rights, Sex Workers Included: US Foreign Assistance and the Sexual and Reproductive Health and Rights of Female Sex Workers.* CHANGE, 2016. http://www.genderhealth.org/files/uploads/All_Women_All_Rights_Sex_Workers_Included_Report.pdf.

The report is based on a review of peer-reviewed articles, collaborative guidance and recommendations, and grey literature which examined the SRHR needs of female sex workers (FSWs). CHANGE also conducted semi-structured, not-for-attribution interviews with key informants, including U.S. officials, country-based implementers, researchers, sex workers, sex worker advocates, service providers, and representatives from multilateral organisations. Based on the review and interviews, priority areas were identified where US foreign assistance should be better harmonised with best practices and fundamental human rights principles in order to more effectively promote the health and rights of FSWs.

Hawkins, Kate, Stephen Wood, Tanya Charles, Xiaopei He, Zhen Li, Anne Lim, Ilana Moutian and Jaya Sharma. "Sexuality and Poverty Synthesis Report." Evidence Report No. 53, Sexuality, Poverty and Law. Institute of Development Studies (IDS), 2014. <https://opendocs.ids.ac.uk/opendocs/bitstream/handle/123456789/3525/ER53.pdf?sequence=1>.

resources

This report synthesises learning from a set of sexuality and poverty audits in 2012-2013 and is part of a larger project that focuses on understanding the links between sexuality, gender plurality, and poverty with the aim of improving socioeconomic policy and programming to support people marginalised because of their sexuality. The research indicated that sexuality is directly related to physical, social, and economic wellbeing, political participation, and socioeconomic inclusion and the realisation of human rights, particularly for the poor and most marginalised.

Ipas. *Women's Access to Safe Abortion in the 2030 Agenda for Sustainable Development: Advancing Maternal Health, Gender Equality, and Reproductive Rights.* Ipas, 2015. <http://www.ipas.org/en/Resources/Ipas%20Publications/Womens-access-to-safe-abortion-in-2030-agenda-for-sustainable-development.aspx>.

Advancing women's access to safe and legal abortion is a priority for women's reproductive health and rights, in accordance with the new SDGs focused on health and gender equality. This briefing paper presents the SDG goals and targets whose achievement depends on safe and legal abortion and recommends minimum indicators for measuring global progress on abortion access.

Livingstone, Amanda. *Briefing Kit: Sexual and Reproductive Health and Rights in South Asia.* White Ribbon Alliance, 2016. <http://whiteribbonalliance.org/wp-content/uploads/2016/03/Briefing-Kit-SRHR-in-South-Asia.pdf>.

This briefing kit is intended for citizens who want to advocate for their involvement in accountability and monitoring mechanisms so that

governments deliver on their SRHR commitments. When citizens are engaged and create awareness, and women and girls feel empowered to act as agents of change, local and national leaders hear their demands.

Mishra, Santosh Kumar. "Sexual and Reproductive Health and Rights and Post-2015 Agenda: An Investigation into Development Scenario." *Women Health International*, 2:1 (2016):114. <https://www.elynsngroup.com/journal/article/sexual-and-reproductive-health-and-rights-and-post-2015-agenda-an-investigation-into-development-scenario>.

This paper aims to examine the role and importance of SRHR holistically in the development scenario within the context of their linkages to other fundamental human rights, as well as with the global poverty and hunger eradication objective; and put forward essential recommendations for them to be given their rightful place in the post-2015 agenda. In order to achieve sustainable development, peace and justice for all, SRHR have to be an integral part of all discourse and planning for a better world.

Santhya, K.G. and Shireen J. Jejeebhoy. "Sexual and Reproductive Health and Rights of Adolescent Girls: Evidence from Low- and Middle-income Countries." *Global Public Health*, 10:2 (2015): 189-221. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4318087/>.

This paper reviews the evidence on SRHR of adolescent girls in low-income and middle-income countries (LMIC) in light of the policy and programme commitments made at the International Conference on Population and Development (ICPD), analyses progress since 1994, and maps challenges in and opportunities for protecting their health and human rights. Findings

indicate that many countries have yet to make significant progress in delaying marriage and childbearing, reducing unintended childbearing, narrowing gender disparities that put girls at risk of poor SRH outcomes, expanding health awareness, and enabling access to SRH services.

United Nations Population Fund (UNFPA). *Universal Access to Reproductive Health: Progress and Challenges.* UNFPA, 2016. http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_Reproductive_Paper_20160120_online.pdf.

The importance of reproductive health and access to family planning are now well recognised, to not only improve women's chances of surviving pregnancy and childbirth, but also to contribute to related issues such as gender equality, better child health, an improved response to HIV, greater education outcomes, and poverty reduction. This report profiles existing data around the main MDG5b indicators to identify progress achieved, and old and new challenges that could be addressed under the SDGs, particularly the nine targets under SDG3. The report highlights the most vulnerable and disadvantaged population groups, and their access to and use of reproductive health services.

World Health Organisation (WHO). *Consolidated Guideline on Sexual and Reproductive Health and Rights of Women Living with HIV.* Geneva: WHO, 2017. <http://apps.who.int/iris/bitstream/10665/254885/1/9789241549998-eng.pdf?ua=1>.

This guideline consolidates existing recommendations specific to women living with HIV along with new recommendations and good practice statements to support front-line health-care providers, programme managers,

and public health policy-makers around the world to better address the SRHR of women living with HIV. It is also meant to help countries to more effectively and efficiently plan, develop, and monitor programmes and services that promote gender equality and human rights, and hence are more acceptable and appropriate for women living with HIV, while taking into account the national and local epidemiological context. It discusses implementation issues that health interventions and service delivery must address to achieve gender equality and support human rights.

Youth LEAD. *Our Rights Matter Too: Sexual and Reproductive Health and Rights of Young Key Populations in Asia and the Pacific.* Thailand: Youth LEAD, 2015. http://www.aidsdatahub.org/sites/default/files/publication/Youth_Lead_Our_Rights_Matter_Too_2015.pdf.

This regional report was undertaken by Youth LEAD to highlight the inextricable link between SRHR and young key populations, and how the recognition, promotion and protection of these rights are instrumental to ending AIDS epidemic in the region. An overview of the sexual and reproductive health and rights (SRHR) needs, issues, and priorities of young key populations (YKP) in Asia and the Pacific are highlighted. The report addresses the gaps in knowledge on the SRHR needs of YKP in the region, offers recommendations based on a regional study, and contributes essential information for policy and advocacy efforts.

OTHER RESOURCES

Asian Forum of Parliamentarians on Population and Development (AFPPD).

Parliamentarian Resource Kit on SRHR and Population and Development Links in Asia and the Pacific in the Post 2015, 2nd Edition. AFPPD, 2016. <https://www.afppd.org/Resources/27-2nd-edition-parliamentarian-resource-kit.pdf>.

Association for Women in Development (AWID).

"Feminist Standpoints on the Global Gag Rule." Web article. AWID, 2017. <https://www.awid.org/news-and-analysis/feminist-standpoints-global-gag-rule>.

Barclay, Heather, Raffaella Dattler, Katie Lau, Shadia Abdelrhim, Alison Marshall, and Laura Feeny.

Sustainable Development Goals: A SRHR CSO Guide for National Implementation. International Planned Parenthood Federation (IPPF), 2015. http://www.ippf.org/sites/default/files/sdg_a_srrh_guide_to_national_implementation_english_web.pdf.

Galati, Alanna J. "Onward to 2030: Sexual and Reproductive Health and Rights in the Context of the Sustainable Development Goals." *Guttmacher Policy Review*, 18:4 (2015). https://www.guttmacher.org/sites/default/files/article_files/gpr1807715.pdf.

Guttmacher Institute. *Abortion in Asia.* Fact sheet. Guttmacher Institute, 2016. https://www.guttmacher.org/sites/default/files/factsheet/ib_aws-asia.pdf.

International Planned Parenthood Federation—East and South East Asia and Oceania Region (IPPF-ESEAOR). *No Crisis Too Great.* IPPF-ESEAOR, 2016. http://www.ippfeseaor.org/sites/ippfeseaor/files/2016-11/No_Crisis_Too_Great_o.pdf.

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Joffe, Carole. "What Will Become of Reproductive Issues in Trump's America?" *Reproductive Health Matters*, 25:49 (2017). Accessed May 19, 2017. <http://www.tandfonline.com/doi/full/10.1080/09688080.2017.1287826>.

New Zealand Parliamentarians' Group on Population and Development (NZPPD).

"Pacific Youth: Their Rights, Our Future." Report of the NZPPD Open Hearing on Adolescent Sexual and Reproductive Health in the Pacific, June 11, 2012. <http://www.familyplanning.org.nz/media/302823/pacific-youth-their-rights-our-future.pdf>.

Ravindran, T.K. Sundari. "Poverty, Food Security and Universal Access to Sexual and Reproductive Health Services: A Call for Cross-movement Advocacy against Neoliberal Globalisation." *Reproductive Health Matters*, 22:43 (2014). Accessed May 19, 2017. <http://tandfonline.com/doi/full/10.1016/S0968-8080%2814%2943751-0>.

Rutgers. *Essential Packages Manual: Sexual and Reproductive Health and Rights Programmes for Young People.* Rutgers, 2016. https://www.rutgers.international/sites/rutgersorg/files/PDF/Essential%20Packages%20Manual_SRHR%20programmes%20for%20young%20people_%202016.pdf.

The Lancet (Editorial). "Urbanisation, Inequality, and Health in Asia and the Pacific." *The Lancet*, 389:10077 (2017): 1370. DOI: [http://dx.doi.org/10.1016/S0140-6736\(17\)30941-8](http://dx.doi.org/10.1016/S0140-6736(17)30941-8). [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)30941-8/fulltext?elsca1=etoc](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30941-8/fulltext?elsca1=etoc).

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United Nations High Commissioner for Refugees (UNHCR). *Integrating Sexual and Reproductive Health into Health Emergency and Disaster Risk Management.* Policy brief. UNHCR, 2012. <http://www.unhcr.org/5077d9349.pdf>.

SELECTED ARROW RESOURCES

ARROW develops cutting edge publications. Below are key ARROW publications related to universal access to SRHR from the past five years. All ARROW resources from 1993 to the present can be downloaded at <http://arrow.org.my/publications-overview/>.

Abdul Cader, Azra, Dhivya Kanagasingam, and Sai Jyothir Mai Racherla. *SDG Alternative Report: Girls and the Sustainable Development Goals in Selected Countries in the Asia-Pacific Region.* ARROW, 2017.

Various Authors. Call for Action to Integrate SRHR into the Post-2015 Agenda. Available for Africa, Bangladesh, Cambodia, India, Indonesia, Lao PDR (in English and Lao), Pakistan, and Latin America and the Caribbean (in English and Spanish). ARROW, 2014-2016.

Various Authors. Country Profile Series on Universal Access to Sexual and Reproductive Health. Available for Bangladesh, Cambodia, China, India, Indonesia, Lao PDR (also available in Lao), Malaysia, Mongolia, Nepal, Pakistan, Philippines, and Sri Lanka (available in English, Sinhala, and Tamil). ARROW, 2014-2016.

Various Authors. Country Profile Series on Universal Access to Sexual and Reproductive Rights. Available for Cambodia, China, India, Indonesia, Lao PDR (also available in Lao), Malaysia, Nepal, Pakistan, Philippines, Sri Lanka, and Thailand. ARROW, 2014-2016.

ARROW. *SRHR in the 2030 Agenda: Looking Back, Moving Forward.* 2016.

ARROW. *Myanmar/Burma Country Study: Breaking Barriers: Advocating SRHR* (also available in Burmese). 2016.

Das, Arpita. *Universal Access to Sexual and Reproductive Health and Rights—Regional Profile: Asia.* ARROW, 2016.

Ravindran, T.K. Sundari. *An Advocate's Guide: Integrating Human Rights in Universal Access to Contraception.* ARROW, 2016.

Various Authors. Advocacy Brief on Climate Change and SRHR. Available for Bangladesh, Indonesia (in English and Bahasa Indonesia), Lao PDR, Malaysia, Maldives, Nepal, Pakistan, and the Philippines. ARROW, 2016.

Various Authors. Scoping Study on Climate Change and SRHR. Available for Bangladesh, Indonesia, Lao PDR, Malaysia, Nepal, Pakistan, and the Philippines. ARROW, 2016.

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ARROW. *Sexual and Reproductive Health and Rights in the Post-2015 Agenda: Taking Their Rightful Place* (also available in Bangla, Hindi, and Tamil). 2014.

ARROW. *Sexual and Reproductive Health and Rights beyond 2014: Opportunities and Challenges.* 2014.

ARROW. *Setting the Adolescent and Young People SRHR Agenda beyond ICPD+20.* 2014.

ARROW. *ICPD+20 Asia Youth Factsheet.* 2014.

Racherla, Sai Jyothirmal and Nurgul Dzhanayeva. *Country Profile on the Status of Sexual and Reproductive Health and Rights: Kyrgyz Republic* (also available in Russian). ARROW, 2014.

Ravindran, T.K. Sundari. *What It Takes: Addressing Poverty and Achieving Food Sovereignty, Food Security, and Universal Access to SRHR.* ARROW, 2014.

Turgabeci, Paulini and Bronwyn Tilbury. *Pacific Young People's SRHR Factsheet.* ARROW, 2014.

Woods, Zonibel. *Identifying Opportunities for Action on Climate Change and Sexual and Reproductive Health and Rights in Bangladesh, Indonesia, and the Philippines.* ARROW, 2014.

ARROW. (2nd ed.). *Sex and Rights: The Status of Young People's Sexual and Reproductive Health and Rights in Southeast Asia.* ARROW, 2013.

Ravindran, T.K. Sundari. *An Advocate's Guide: Strategic Indicators for Universal Access to Sexual and Reproductive Health and Rights.* ARROW, 2013.

Thanenthiran, Sivananthi, Sai Jyothirmal Racherla, and Suloshini Jahanath. *Reclaiming and Redefining Rights: ICPD+20 Status of SRHR in Asia Pacific.* ARROW, 2013.

Various Authors. *Reclaiming and Redefining Rights—Setting the Adolescent and Young People SRHR Agenda beyond ICPD+20.* ARROW, 2013.

DEFINITIONS

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Universal Access: Simply put, universal access “means that no one is deprived of being able to use appropriate services when needed. This is usually interpreted to mean that no one has to incur a large out-of-pocket expenditure at the time of seeking services; that services are geographically and socially accessible; and that service delivery points have the necessary personnel, supplies, and equipment. This is also interpreted to mean that suitable policies and budgetary allocations are in place.”¹ “It has also been defined as ‘the absence of geographic, financial, organisational, socio-cultural and gender-based barriers to care.’”²

The three dimensions of access are as follows:

- “Physical accessibility. This is understood as the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organisation and delivery that allow people to obtain the services when they need them.
- Financial affordability. This is a measure of people’s ability to pay for services without financial hardship. It takes into account not only the price of the health services but also indirect and opportunity costs (e.g., the costs of transportation to and from facilities and of taking time away from work). Affordability is influenced by the wider health financing system and by household income.
- Acceptability. This captures people’s willingness to seek services. Acceptability is low when patients perceive services to be ineffective or

when social and cultural factors such as language or the age, sex, ethnicity or religion of the health provider discourage them from seeking services.”³

“There are two sets of factors that influence access: ‘supply-side’ or health system factors which include affordability, availability, acceptability and quality; and ‘demand-side’ factors such as lack of information and decision-making power, restrictions on mobility, social exclusion and discrimination.”⁴

Universal Health Coverage: Target 3.8 of the Sustainable Development Goals focuses on “achiev[ing] universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.” UHC is currently a priority objective of the World Health Organisation (WHO).

WHO defines UHC as “ensuring that all people have access to needed promotive, preventive, curative, and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.”⁵

Further, WHO explains that UHC “embodies three related objectives:

- equity in access to health services—those who need the services should get them, not only those who can pay for them;
- that the quality of health services is good enough to improve the health of those receiving services; and

- financial-risk protection—ensuring that the cost of using care does not put people at risk of financial hardship.”⁶

An earlier WHO document also elaborates that achieving universal coverage

“involves progress in three dimensions:

- removing financial barriers to accessing care and providing financial protection from catastrophic costs to users of health care services;
- increasing the extent of health care coverage: what services are included in the Essential Services Package and provided at subsidised/no costs;
- increasing the extent of population coverage: who is covered.”⁷

It should be noted that “[u]niversal health coverage with people obtaining the services they want and benefiting from risk protection cannot happen unless there is universal health access, which is the opportunity and the ability of doing both things.”⁸ Indeed, “[u]niversal coverage is a necessary but not sufficient condition for universal access. Despite universal coverage, universal access may not be achieved because of other ‘supply-side’ barriers such as availability of service delivery points and of specific services; and also because of ‘demand-side’ barriers, including cultural factors, perceived quality and efficacy of services, and gender power relations which deter health-care seeking.”⁹

Government Accountability vis-à-vis the Role of the Private Sector:

In discussions of universal access and universal coverage, it is crucial to emphasise that the accountability and key responsibility for ensuring the health of the population lie with

definitions

governments. Activists and advocates need to be vigilant against the expanding role of the private sector in sustainable development, including in the delivery of health services. Considering that attempts at increasing public funding previously mainly focused on institutional delivery and that majority of sexual and reproductive health services are already predominantly with the private sector, this makes SRHR even further beyond the reach of everyone, except those who can pay.¹⁰

The increased role of the private sector has been further facilitated by the 2030 Agenda for Sustainable Development, as evidenced by the voluntary national reports at the 2017 High Level Political Forum (HLPF), where “93% of the countries had consulted the private sector in reviewing their national strategy and progress on the SDGs...68%... recognised private investment as a crucial alternative means to complement public expenditure on the SDGs, and 43%... stated efforts made by the country to develop more public-private partnerships on SDG implementation.”¹¹

Reproductive Health: “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a 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 last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access 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.”¹²

Reproductive Rights: “[E]mbrace 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 right documents.”¹³

Sexual Health: “A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”¹⁴

Sexual Rights: “[E]mbrace human rights that are already recognised in national laws, international human rights documents, and other consensus documents. They include the rights of all persons, free of coercion, discrimination, and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services; seek, receive, and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choose their 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.”¹⁵

Notes & References

- 1 Sundari Ravindran, *An Advocate's Guide: Strategic Indicators for Universal Access to Sexual and Reproductive Health and Rights* (Kuala Lumpur: ARROW, 2013), 15, http://arrow.org.my/wp-content/uploads/2015/04/Advocates-Guide_SRHR-Indicators_2013.pdf.
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- 3 David B. Evans, Justine Hsua, and Ties Boerma, “Universal Health Coverage and Universal Access,” *Bulletin of the World Health Organization*, 91 (2013): 546-546A, <http://www.who.int/bulletin/volumes/91/8/13-125450.pdf>.
- 4 T.K. Sundari Ravindran, “Thematic Paper 1.”
- 5 “Universal Health Coverage,” World Health Organisation, http://www.who.int/healthsystems/universal_health_coverage/en/.
- 6 Ibid.
- 7 World Health Organization (WHO), *Primary Health Care: Now More than Ever: World Health Report 2008* (Geneva: WHO, 2008), cited in T.K. Sundari Ravindran, *Reclaiming and Redefining Rights; Thematic Studies Series 2: Pathways to Universal Access to Reproductive Health Care in Asia* (Kuala Lumpur: ARROW, 2011), <http://arrow.org.my/publication/reclaiming-redefining-rights-pathways-to-universal-access-to-reproductive-health-care-in-asia/>.
- 8 Arpita Das, *Universal Access to Sexual and Reproductive Health and Rights; Regional Profile: Asia* (Kuala Lumpur: ARROW, 2016), http://arrow.org.my/wp-content/uploads/2016/10/Regional-Profile-Universal-Access-to-SRHR_Asia.pdf.
- 9 T.K. Sundari Ravindran, “Thematic Paper 1.”
- 10 Sundari Ravindran, e-mail message to author, June 23, 2017.
- 11 “Growing Role of the Private Sector in the 2030 Agenda,” GRI, August 9, 2017, <https://www.globalreporting.org/information/news-and-press-center/Pages/Growing-role-for-the-private-sector-in-the-2030-Agenda.aspx>.
- 12 United Nations, *Programme of Action Adopted at the International Conference on Population and Development Cairo, 5-13 September 1994, 20th Anniversary Edition* (New York: UNFPA, 2014), para 7.2, http://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf.
- 13 United Nations, “Programme of Action,” para 7.3.
- 14 This is a working definition, not an official WHO position. See: World Health Organization, “Sexual and Reproductive Health,” http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/.
- 15 Ibid.

SRHR OFF THE TABLE? Examining the Asia-Pacific Member States’ Main Messages at the HLPF

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During the negotiations for what would be subsequently called the 2030 Agenda for Sustainable Development, women’s rights activists stressed how crucial accountability was to the success of the new visionary agenda. We thus called for accountability mechanisms that were mandatory and universal, and which built on the existing human rights accountability mechanisms.^{1,2} However, governments shied away from the term “accountability” and settled for the less contentious “follow-up and review” (FUR), of which the High Level Political Forum (HLPF) is the key global platform. Further, member states only agreed to voluntary reporting, with the understanding that they will adapt the targets to national circumstances.³ At the 2016 Asia Pacific Forum on Sustainable Development (APFSD), Asia-Pacific member states also resolved that there would be “no additional reporting requirements” at the regional level.⁴

Two years down the line, what is happening with the follow-up and review process? At the Ministerial Segment of the HLPF held on 17-19 July 2017, 43 countries presented their Voluntary National Reviews (VNRs), nearly double the number that presented in 2016.⁵ Of these, 12 are from Asia and the Pacific region.

This year was an opportune time to hold our governments accountable to their commitments to sexual and reproductive health and rights (SRHR), since the HLPF reviewed the implementation efforts for Sustainable Development Goals (SDGs) 3 and 5 (Ensure good health and

wellbeing, and Achieve gender equality respectively), together with four other goals.⁶ It is thus worthwhile asking, was SRHR put on the table? Given the very limited time on the floor, the need to report on progress in establishing processes and mechanisms for implementing and monitoring the SDGs, as well as progress on the goals and targets, did governments even report on targets related to SRHR?

An examination of the main messages submitted by the 12 Asia-Pacific countries with respect to their reporting on SRHR-related targets reveals dismal results. Further analysis of the full reports will be needed; however, this initial look provides important indications of what countries see as their priorities. (See Table 1 for more details.)

We also need to be vigilant of the growing role and influence of the private sector in national SDG financing, implementation, and monitoring.

From the outset, we can see that it still is early days yet. Two years after agreeing on the 2030 Agenda and the SDGs, most countries are still in the process of (or have just completed) setting up various measures to implement and monitor these nationally, including identifying national priorities and developing monitoring frameworks. Hence, out of the 12 submissions, seven focused solely on sharing what they have done or are planning to do on these aspects, and did

not focus on progress made on the goals under review.

Disappointingly, of the five Asia-Pacific countries who reported on progress on the goals—India, Indonesia, Malaysia, Tajikistan, and Thailand—not one mentioned universal access to SRH care services (target 3.7), or universal access to SRH and reproductive rights (target 5.6). SRHR does not seem to be on the priority list of Asia-Pacific member states, perhaps indicative of how these targets were amongst the most contested during the post-2015 negotiations, and of how the HLPF input from the Asia-Pacific Forum on Sustainable Development did not mention SRHR as well.⁷

Moreover, Asia-Pacific member states find certain issues more palatable than others. In contrast to the lack of reporting on the two SRHR targets, all five countries who reported on their SDG progress either directly reported on maternal mortality (target 3.1) or reported on its maternity benefit programme. Only Malaysia reported on HIV (target 3.3), while only Indonesia reported on child marriage (5.3). None of the countries reported on violence against women and girls (target 5.2).

Given this scenario, activists and advocates have our work cut out in reminding governments yet again why addressing SRHR comprehensively (and not just maternal mortality) is crucial to achieving sustainable development. We need to hold governments accountable to all their commitments, including to universal access to SRHR. Moreover, we

factfile

need to find ways to bring back to the discussion key issues that either dropped out of the post-2015 negotiating table or did not make it in the first place, such as abortion, sexual rights, sexual orientation and gender identity and expression and sexual characteristics (SOGIESC), and comprehensive sexuality education. As expected, none of the countries mentioned these critical women's and young people's rights issues in their VNRs, but we need to encourage and push them to aim high. After all, the 2030 Agenda was meant to be an ambitious plan, and not a race to the bottom.

Civil society and social movements also need to question how inclusive and transparent the SDG nationalisation/localisation and the VNR processes are at the national level, even as engagement at HLPF itself poses challenges.⁸ While 11 out of 12 Asia and the Pacific countries mentioned they engaged civil society and NGOs as stakeholders, we need to ask what was the level of engagement, and how genuine and meaningful was it? Are civil society representatives part of formal structures for SDG implementation and monitoring? And if yes, who have been invited to the table? A select, privileged few, or a diverse set coming from various constituencies and issues of focus? During the HLPF, several interventions by Major Groups challenged governments' assertions that civil society had been consulted in these processes.⁹ We thus need to continue to demand for institutionalisation of civil society engagement at all levels. Indeed, the country pages in the Sustainable Development Knowledge Platform should include both government and alternative reports for increased transparency and more inclusive reporting.

We also need to be vigilant of the growing role and influence of the private sector in national SDG financing, implementation, and monitoring. With

the exception of India, all the other Asia-Pacific countries mentioned the private sector as key stakeholders to the agenda. Another analysis showed that 68% of all 43 VNRs recognised private investment as a complementary means to finance the SDGs.¹⁰ This emphasis on the importance of partnership with the private sector was also seen at the HLPF, where the SDG Business Forum was allocated the UN General Assembly Hall even as many civil society requests to hold events were declined.¹¹ The overall impact of this influence to sustainable development, on human rights, and on those who are most left behind, bears close watching.

In the face of ethno-religious nationalisms, declining funding, and other crises, more than ever, we need to affirm that there can be no true gender equality, social justice, and sustainable development, unless women are able to make informed decisions about their bodies, fertility, and sexuality.

Further, we need to utilise the various available avenues within the HLPF mechanism—including submission of inputs for the expert group meetings and by the major groups to monitor the progress of the SDGs, doing alternative or 'shadow' reports, being part of national delegations, lobbying with governments, and making direct interventions at the HLPF sessions—and advocate to make these more effective and meaningful. Building on lessons learnt from the 2017 HLPF, we need to start engaging with the governments who will be undergoing VNR in 2018 and push those who have yet to commit to do so.

Beyond the 2030 Agenda and its FUR mechanisms, let us not forget to pursue complementary avenues to holding

governments accountable, such as the sessions of the Commission on Population and Development (CPD) and the Commission on the Status of Women (CSW), and the much stronger human rights accountability mechanisms, such as the Universal Periodic Review and the CEDAW Committee. In doing all these, we need to collectively mobilise and be in solidarity with the global women's movement, as well as other social movements.

In the face of ethno-religious nationalisms, declining funding, and other crises, more than ever, we need to affirm that there can be no true gender equality, social justice, and sustainable development, unless women are able to make informed decisions about their bodies, fertility, and sexuality.

ASIA-PACIFIC COUNTRIES UNDERGOING VOLUNTARY NATIONAL REVIEWS IN 2018*

- Australia
- Bahrain
- Bhutan
- Lao People's Democratic Republic
- Singapore
- Sri Lanka
- State of Palestine
- Vietnam

To engage at the global and regional levels, follow:

- > ARROW: @ARROW_Women
- > The AP RCEM Women's Constituency and Thematic Working Group on Gender, Sexuality, and SRHR: @AP_RCEM
- > Women's Major Group: @Women_Rio20

* As of 15 August 2017. Check the "Voluntary National Reviews" page of the Sustainable Development Knowledge Platform for updates: <https://sustainabledevelopment.un.org/vnrs/>.

**TABLE 1. REPORTING ON SRHR-RELATED TARGETS IN ASIA-PACIFIC COUNTRIES'
MAIN MESSAGES FOR VOLUNTARY NATIONAL REPORTING AT THE HLPF 2017**

Targets/Indicators	Afghanistan	Bangladesh	India	Indonesia	Iran	Japan
Reported on SDG progress?	✗	✗	✓	✓	✗	✗
Reported on progress on 3.1 Maternal mortality ratio?	✗	✗	◊	✓	✗	✗
Reported on 3.3.1 AIDS?	✗	✗	✗	✗	✗	✗
Reported on 3.7 Universal access to sexual and reproductive health-care services, information, and education?	✗	✗	✗	✗	✗	✗
Reported on 5.2 Violence against all women and girls?	✗	✗	✗	✗	✗	✗
Reported on 5.3 Harmful practices, such as child, early and forced marriage?	✗	✗	✗	✓	✗	✗
Reported on 5.6 Universal access to sexual and reproductive health and reproductive rights?	✗	✗	✗	✗	✗	✗
Mentioned civil society/NGO engagement/participation?	✓	✓	◊◊	✓	✓	✓
Mentioned private sector engagement/participation?	✓	✓	✗	✓	✓	✓

- ◊ Reported on Maternity Benefit Programme
- ◊◊ No, but specifically identified engagement with religious and political leaders.

Notes & References

- 1 Intervention by the author on behalf of the Women's Major Group, which represents more than 600 women's rights organisations globally, at the February 2107 post-2015 inter-governmental negotiations. Read more at: <https://www.facebook.com/ARROW.Women/posts/831086936949512?match=YWNjb3VudGFiaWxpdkHk%3D>. The video is here: <https://www.youtube.com/watch?v=spGqy9dpTR4>.
- 2 For a comprehensive proposal on accountability and monitoring framework by the Women's Major Group, see: "Women's Major Group Recommendations for Accountability, Monitoring, and Review of the Post-2015 Agenda," May 18, 2015, accessed June 13, 2017, <http://www.twn.my/title2/unsd/2015/unsd150503.htm>.
- 3 Paragraph 7.4a of the 2030 Agenda for Sustainable Development states that follow up and review processes will "be voluntary and country-led, will take into account different national realities, capacities and levels of development and will respect policy space and priorities. As national ownership is key to achieving sustainable development, the outcome from national level processes will be the foundation for reviews at regional and global levels, given that the global review will be primarily based on national official data sources." See: *United Nations, Transforming Our World: The 2030 Agenda for Sustainable Development* (2015), accessed June 13, 2017, <https://sustainabledevelopment.un.org/post2015/transformingourworld>.
- 4 Economic and Social Commission for Asia and the Pacific, *E/ESCAP/FSD(3)/4 Report of the Asia-Pacific Forum on Sustainable Development on Its Third Session* (2016), accessed on June 13, 2017, http://www.unescap.org/sites/default/files/pre-ods/APFSD_2016_Report_English.pdf.
- 5 In 2016, these Asia-Pacific countries were reviewed: China, the Philippines, Republic of Korea, and Samoa. The countries under review at the 2017 HLPF are Afghanistan, Argentina, Azerbaijan, Bangladesh, Belarus, Belgium, Belize, Benin, Botswana, Brazil, Chile, Costa Rica, Cyprus, Czech Republic, Denmark, El Salvador, Ethiopia, Guatemala, Honduras, India, Indonesia, Iran, Italy, Japan, Jordan, Kenya, Luxembourg, Malaysia, Maldives, Monaco, Nepal, Netherlands, Nigeria, Panama, Peru, Portugal, Qatar, Slovenia, Sweden, Tajikistan, Thailand, Togo, Uruguay, and Zimbabwe. No Pacific country volunteered for the 2017 round. See more here: "Voluntary National Reviews," Sustainable Development Knowledge Platform, accessed June 13, 2017, <https://sustainabledevelopment.un.org/vnrs/>.
- 6 The other SDGs under review are Goal 1. End poverty; Goal 2. End hunger; Goal 9. Improve infrastructure, industrialisation and innovation; Goal 14. Conserve oceans, seas and marine resources; and Goal 17: Build partnerships for goal delivery.
- 7 There is no reference to SRHR or any of its components in the Asia-Pacific Forum on Sustainable Development (APFSD) Report to the HLPF. Only access to health is referred to, implying that SRHR is not seen as a priority by governments in the region. See: UNESCAP, "Input from the Fourth Asia-Pacific Forum on Sustainable Development to the High-level Political Forum on Sustainable Development: Note by the Secretariat" (2017), accessed 13 June 2017, http://www.un.org/ga/search/view_doc.asp?symbol=E/HLPF/2017/1/Add.1&Lang=E.
- 8 Bipalbi Shrestha, "Taking Stock of Gains and Losses—Thoughts from the 2017 High-Level Political Forum (HLPF)," August 1, 2017, <http://arrow.org.my/taking-stock-gains-losses-thoughts-2017-high-level-political-forum-hlpf/>.
- 9 Email by Sascha Gabizon to the Women's Major Group, July 22, 2017.
- 10 "Growing Role of the Private Sector in the 2030 Agenda," GRI, August 9, 2017, <https://www.globalreporting.org/information/news-and-press-center/Pages/Growing-role-for-the-private-sector-in-the-2030-Agenda.aspx>.
- 11 WILPF, "Beyond #HLPF2017: Integrating Feminist Peace in the 2030 Agenda," <http://wilpf.org/wp-content/uploads/2017/07/Second-High-Level-Political-Forum-2017-HLPF-Blog-report.pdf>.

Malaysia	Maldives	Nepal	Qatar	Tajikistan	Thailand
✓	✗	★	✗	✓	✓
✓	✗	★★★	✗	✓	✓
✓	✗	✗	✗	✗	✗
✗	✗	✗	✗	✗	✗
✗	✗	★★★	✗	✗	✗
✗	✗	★★★	✗	✗	✗
✗	✗	✗	✗	✗	✗
✗	✗	✗	✗	✗	✗
✓	⊙	★★★★	✓	✓	⌘
✓	✓	★★★★	✓	✓	⌘

 Yes, including inclusion in Technical Committee
 No. Listed national targets, not actual progress
 No, but mentioned it as a target
 Yes, as members of coordination and working committees for SDGs
 Yes, as members of the Committee for Sustainable Development (CSD)

Source: "Voluntary National Reviews," Sustainable Development Knowledge Platform, <https://sustainabledevelopment.un.org/vnrs/>.

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