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JULY 2014
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SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE POST-2015 AGENDA: TAKING THEIR RIGHTFUL PLACE

ARROW Advocacy Briefs

Sexual and Reproductive Health and Rights in the Post-2015 Agenda: Taking Their Rightful Place

ISBN: 978-967-0339-18-4

Published by:
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1.0 WHY SRHR?

Sexuality and reproduction lie at the heart of what it is to be human and alive. Not recognising this represents a serious failure on the part of society and governing institutions to understand and respect the whole person beyond just the physical.

Sexual and reproductive rights (SRR) are intrinsic human rights. They encompass respect for bodily integrity, the right to choose one's partner and the right to decide on sexual relations and having children, among other things. By eliminating sexual and reproductive rights from the development equation, we are denying the value of our very existence as well as that of future generations. Sexuality is as much a part, if not more, of being fully human and fully alive as needing food and water to live.

Sexuality and reproduction also lie at the foundation of families and communities. Article 23 of the International Covenant on Civil and Political Rights 1966 recognises that the families are fundamental group units of society and are entitled to protection by society and the State.

Sexual and reproductive rights (SRR) are intrinsic human rights. They encompass respect for bodily integrity, the right to choose one's partner and the right to decide on sexual relations and having children, among other things. By eliminating sexual and reproductive rights from the development equation, we are denying the value of our very existence as well as that of future generations. Sexuality is as much a part, if not more, of being fully human and fully alive as needing food and water to live. It is the essence of the joy of being alive and its meaning far broader than biological processes; it encompasses spirituality, human nature and social culture.

In the discourse on the setting of the post-2015 agenda, addressing the gaps, weaknesses and lessons learnt from the current Millennium Development Goals (MDGs) is imperative. One of the glaring gaps in the MDGs pertains to that of human rights, equity, democracy and governance. Sexual and reproductive health and rights (SRHR) fall squarely into this space.

SRHR are an often vaguely-understood and overlooked component in development; yet their role is fundamental to achieving "sustainable well-being for all" in "the world we want"— two popular catchphrases in the post-2015 debate. Although SRHR proponents have been advocating for the full recognition of these rights for years, they have yet to be given their proper place in the development agenda for the future we want.

The purpose of this brief is 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.

2.0 DEFINITIONS

The definitions of reproductive health, reproductive rights, sexual health and sexual rights are given in the table below. By virtue of these definitions, it can be seen that SRHR are interwoven with the right to life,[1] right to health, right to self-determination, right to diverse family,[2] right to livelihood, women's rights, children's rights and intergenerational rights, among others. The right to life and health in turn encompass the right to food and nutrition. By the same token, gender justice and social justice cannot be fully served without upholding SRHR. See section 3 on understanding the intersectionalities.

Table 1. Definitions Related to Sexual and Reproductive Health Rights

Reproductive Health	Reproductive health implies that people are able to have a responsible, satisfying and safe sex life, and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice, and to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of a healthy infant (WHO).
Reproductive Rights	Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (ICPD).
Sexual Health	Sexual health implies a positive approach to human sexuality and the purpose of sexual healthcare is the enhancement of life and personal relations as well as counselling and care related to reproduction and sexually transmitted diseases (adapted, UN).
Sexual Rights	Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; seek, receive, and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decision to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life (WHO working definition).

Source: Asian-Pacific Resource and Research Centre for Women (ARROW). 2009. *Reclaiming and Redefining Rights. ICPD +15: Status of Sexual and Reproductive Health and Rights in Asia*. Kuala Lumpur: ARROW.

3.0 THE CHALLENGES

3.1 Recognition of SRHR

Sexual and reproductive health and rights is a key development issue, yet it is an uphill battle to get the recognition and attention it deserves and to mainstream it into the core development agenda. One challenge in advancing SRHR is that they are considered fairly new, unfamiliar or secondary compared to seemingly more pressing (and familiar) issues. Many governmental and non-governmental sectors alike do not know where to place SRHR, or how to connect them in meaningful ways with poverty alleviation, food sovereignty, human rights, social justice or even climate change.

There are vague notions that SRHR have something to do with gender and therefore would fall under the purview of the gender justice advocates, but even many women's rights groups are not familiar enough with the topic to put it forward strongly and clearly enough to get it the recognition it deserves. In addition, sexual and reproductive rights violations are not just suffered by women, but also by people of diverse sexual orientation and gender identities and expression.

A common oversight is recognising that the suppression of SRHR is directly linked with serious societal problems, such as poverty itself, hunger, malnutrition, HIV and AIDS, and teenage pregnancies. Policy-makers can feel pressured to uphold yet another set of rights when they are already struggling to fulfil basic rights like the right to food. Governments of developing and least developed countries especially may understandably feel overburdened and inadequate in meeting yet more obligations. Ironically, what they fail to see is that fulfilling these rights will help them meet the very objectives they are struggling to achieve more effectively, like alleviating hunger and poverty. For instance, access to comprehensive sexuality education and contraception will help address issues like the rise in the number of teenage pregnancies, abandoned babies, population growth rates, and public healthcare costs, related to sexually transmitted infections, among other things.

SRHR constitute a fundamental aspect of development which has remained invisible and unarticulated for too long. Unless and until they become recognised as a critical component which will enable and support the realisation of other rights, however, development efforts will fail to serve the needs and rights of humanity adequately or fairly. Making the right intersections across the various components of the development agenda is crucial to its success.

Another reason holding back the progress of SRHR is the fact that the issue sits uncomfortably with many sectors. For example, in many countries and cultures, especially in the Global South, talking openly about sex is still taboo and patriarchy is still predominant. Customary norms that oppress girls and women continue to be widely practised and sexually "different" people are socially ostracised in most local cultures. The SRHR issue is also fraught with sensitivity in cases where religious or customary rules and even government policies conflict with certain tenets of SRHR.

SRHR is thus a difficult subject to introduce, explain and talk openly about, let alone advocate for. This is the social reality that presents obstacles to the full and proper discourse, expression and realisation of these critical rights.

3.2 Stock-Take: How Far Are We from the Goal?

3.2.1 MDGs and Health: Gains and Gaps

When the world leaders adopted the United Nations Millennium Declaration and set the eight Millennium Development Goals in 2000, they acknowledged that development had a long way to go in the face of growing global hunger, poverty, conflict, disease, and inequities, among other things.

Health is a critical component of sustainable development. The Global Thematic Consultation on Health Report[3] (GTCHR) describes health as *"a beneficiary of development, a contributor to development, and a key indicator of what people-centred, rights-based, inclusive, and equitable development seeks to achieve. Health is important as an end in itself and as an integral part of human well-being, which includes material, psychological, social, cultural, educational, work, environmental, political, and security dimensions. These dimensions of well-being are interrelated and interdependent."*

So, where are we in terms of the MDGs (Appendix 1) and Health? The status as of 2012 is given in Appendix 2. There are hits and misses discussed in the GTCHR. On the plus side, the health sector has been key in the development success of the MDG era; the health MDGs have raised the issue of global health to the highest political level, mobilised civil society, increased development assistance for health, and contributed to considerable improvements in health outcomes in low- and middle-income countries.

On the downside, the MDGs do not fully address the broader concept of development enshrined in the Millennium Declaration, which includes human rights, equity, democracy, and governance. They have in fact contributed to fragmented approaches between the different health MDGs; between the health MDGs and other MDGs, such as gender equality; and between the MDGs and priorities omitted from the MDG agenda.

A further shortcoming of the MDGs is that their focus on specific health outcomes has overshadowed the root causes of poor health and health inequity. While they did place strong emphasis on poverty reduction, other structural factors that impact health have been neglected. According to the GTCHR, these include the absence of punitive legal environments, inadequate social protection measures, insufficient investment in health, gender inequality, social injustice, stigmatisation and discrimination of marginalised groups, and unfavourable terms for trade and international debt.

Olivier de Schutter, UN Special Rapporteur on the Right to Food, opined that one important shortcoming in the formulation of MDG1 was that it was largely gender-blind and that gender considerations had been only partially mainstreamed throughout the eight MDGs.[4]

Moreover, the original MDG framework did not contain indicators on SRHR. It took five years of advocacy to get "Universal Access to Reproductive Health" included as MDG 5b. While progress on some sexual and reproductive health (SRH) indicators can be seen from 2000, for example, reduced maternal deaths in all sub-regions, the SRHR agenda remains largely unachieved.

Universal access to SRH services has been defined by WHO[5] as follows:

"The equal ability of all persons according to their need to receive appropriate information, screening, treatment and care in a timely manner, across the reproductive life course, that will ensure their capacity, regardless of age, sex, social class, place of living or ethnicity to:

- *decide freely whether and when to have children and how many children to have and to delay and prevent pregnancy;*
- *conceive, deliver safely, and raise healthy children and manage problems of infertility;*
- *prevent, treat and manage major reproductive tract infections and sexually transmitted infections including HIV/AIDS, and other reproductive tract morbidities such as cancer; and*
- *enjoy a healthy, safe and satisfying sexual relationship which contributes to the enhancement of life and personal relations."*

Current national aggregate data on key SRHR indicators reported for MDG purposes hides disparities within countries. This is validated by available national demographic and health surveys. The Asian-Pacific Resource & Research Centre for Women (ARROW) ICPD+15 monitoring study in 12 Asian countries in 2009[6] concluded that no one country had made progress on every single indicator of reproductive health and reproductive rights. This remained true in 2013 as indicated in ARROW's monitoring report on the status of SRHR in 21 countries in the Asia-Pacific region.[7]

The same 2013 report concluded that in spite of some progress in the recognition of universal health rights in South East Asia, universal access to SRH services was generally difficult to achieve. This was true even in countries where there were efforts to promote universal health coverage with barriers in both the supply and demand sides, including cultural factors and gender power relations. Its findings coincided with those of the GTCHR in that socio-economic inequalities played a determining role in access to contraception, maternal health services and other SRH services.

In light of the achievements and shortcomings of the MDGs thus far, the debate on what should go into the post-2015 agenda rages on. The GTCHR made several recommendations, including further reducing child and maternal deaths, controlling HIV, and advancing SRHR with a particular focus on youth.

3.2.2 *ICPD at the Crossroads*

Critical to the assertion of SRHR is the International Conference on Population and Development (ICPD, Cairo, 1994), which came up with a Programme of Action (PoA) stipulating several objectives and actions related to SRHR. In 2010, the UN General Assembly mandated a comprehensive review of progress towards meeting the Cairo commitments. The year 2014 is the target year for reviewing the commitments stipulated in the ICPD PoA, so this is a crucial time to address the gaps in the assertion of SRHR.

ARROW has consistently monitored the ICPD PoA for the Global South since 1994 with a focus on the Asia-Pacific region. In its latest review[8] of 21 countries in the Asia-Pacific region, key findings are reported against a set of indicators.

The review found that the difference between wanted fertility rates (WFR) and total fertility rates (TFR) were highest in Nepal, India, Bangladesh and Kiribati where women were having more children than they desired to have. Secondly, women continued to shoulder the burden of contraception while male involvement, as equal partners in decision-making on reproduction, as stipulated in the ICPD PoA, was limited at best in all 21 countries over the past 15 years. Unmet needs for contraception were highest in South Asia (15.6%), followed by South East Asia (13.4%).

Thirdly, adolescent births continued to be a challenge in the region, except for East Asia. In South Asia, early marriage, early childbearing and insufficient access to health services are the main causes of relatively high mortality among adolescent and young women. Fourthly, unsafe abortions remained a major contributing factor in the occurrence of maternal deaths in the region. Mortality due to unsafe abortions for South East Asia and South Asia was estimated at 14 percent and 13 percent of all maternal deaths, respectively. About 2.3 million women in the region were hospitalised annually for treatment of complications from unsafe abortions. While the number of women dying of pregnancy and childbirth-related complications was nearly halved (47%) from 543,000 in 1990 to 287,000 in 2010, it should be noted that South Asia had the largest number of maternal deaths outside of Sub-Saharan Africa. Only 8 of the 16 countries studied had 80 percent or more deliveries with skilled birth attendance and in eight countries; more than 50 percent of the women delivered with no skilled help.

The highest incidence of cervical cancer was in India, China, Bangladesh, Indonesia and Pakistan. Cervical cancer was found to be the most frequent cancer among women in Bhutan, Cambodia, India, Lao PDR, Nepal, and Papua New Guinea. Governments in the region were seen to be not at all able to adequately provide the necessary screening, preventive measures, treatment and care services for reproductive cancers.

As for HIV and AIDS, women (15+) living with HIV constituted the highest percentages in the Oceania region (56%), followed by South Asia (37%) and East Asia (28%). HIV-related stigma and discrimination remained constant barriers to universal access to HIV prevention treatment, care and support in the region.

Lastly, in terms of laws to protect the bodily integrity and autonomy of women, all except three of 21 countries in the region[9] had laws against rape, and in most cases, considered it as a crime. Provisions on anti-sexual harassment in the workplace existed in 11 countries. It should be noted, however, that the existence of a law is no guarantee of implementation or any redressal mechanism. Persons of diverse sexualities and gender identities and expressions still face stigma and discrimination with respect to SRH services. Half of the world's youth reside in the Asia-Pacific region, but there are few if any youth-friendly health services that assure confidentiality and which are non-judgmental and non-discriminatory to help young people make informed choices.

The monitoring study found that government uptake of ICPD guidelines in the region had been inconsistent; a shortcoming which must be rectified in the post-2015 agenda.

4.0
UNDERSTANDING THE INTERLINKAGES

The non-realisation and violation of sexual and reproductive rights (SRR), just like with other basic human rights, is largely rooted in the drivers of poverty. Poverty is caused by complex social, economic and political factors, and it should be measured using the Multidimensional Poverty Index (MPI), which includes aspects of health, education and living standards. As per the 2013 Human Development Report,[10] 1.56 billion people (in the 104 countries covered) live in multidimensional poverty while the 2013 MDG progress report for Asia and the Pacific states that over 740 million people in the region live in abject poverty.[11] The MPI measure of poverty shows that women and marginalised sectors represent the majority of the poor.

Poverty is the cause as well as the consequence of poor health and well-being. The *"poor are more likely to fall ill, but less able to find prompt and appropriate medical help, care and support to deal with their ill-health because of the systems put in place to deal with illness."*[12] Poverty compromises the potential of people to fully realise their SRR throughout their lives in many ways, such as inadequate food, undernutrition, anaemia, disease, low educational attainment, poor quality shelter, sexual abuse, intimate partner violence, and poor access to SRH services.

As for food security, a poor individual is less likely to have access to adequate and nutritious food. The four pillars of food security are availability, access, utilisation, and stability. This means that all people at all times must have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active healthy life.[13]

The reality is that the actual number of people suffering from hunger and food insecurity has decreased only marginally since 1990. An estimated 870 million people presently suffer from hunger and chronic undernourishment, 563 million of whom live in Asia.[14] In terms of the original MDG target of halving the percentage of people suffering from hunger by 2015, progress has been very inconsistent across the different continents and within countries. The UN Special Rapporteur on the Right to Food, Olivier de Schutter declared in 2013 that the new global target set at the 1996 World Food Summit to halve the absolute number of hungry people by 2015 (rather than the percentage) is *"today out of reach by far."*[15]

One in three people in the world suffer from malnutrition which is also called "hidden hunger,"[16] and women and children from the low-income sectors of society in

developing countries are the most adversely affected.[17] Malnutrition results in poor growth and development. For girls, this often results in complicated labour and having low birth-weight babies. Chronic undernutrition can lead to infertility. It is estimated that half of all pregnant women worldwide suffer from iron deficiency anaemia[18] and this is made worse with repeated pregnancies, which deplete whatever little body reserves are available. Postpartum haemorrhage is the commonest cause of maternal death in developing countries. [19]

In general, poor nutrition and malnutrition affect sexual health through adverse effects like sexual dysfunction in men and women, tiredness, illness, lack of desire, and painful intercourse, among others.[20] Good nutrition is particularly critical to people living with HIV and AIDS who have to deal with a compromised immune system.[21]

In his paper on Advancing Women's Rights in the Post-2015 Development Agenda and Goals on Food and Nutrition Security, de Schutter points out that the realisation of the sustainable development goals is closely connected with the realisation of basic human rights based on the principles of equality and non-discrimination.[22]

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de Schutter cites the finding of the Global Thematic Consultation on Addressing Inequalities that situations of deprivation are often associated with discrimination based on factors such as gender, age, caste, race, ethnic and indigenous identity, minority status, (dis)ability, place of residence, marital and family status, HIV status, and sexual orientation. Amongst the multiple forms of discrimination, gender-based discrimination was found to remain *"the single most widespread driver of inequalities in today's world."*[23]

Women and girls are subject to discriminatory laws or social or cultural norms which come from certain stereotypes about gender roles, a major contributing factor in the feminisation of poverty. Women make up about 70 percent of the world's poor and the number of rural women living in poverty has doubled in the last 20 years.[24,25]

Poor women generally have unequal access to land and other productive resources, and to educational and economic opportunities, such as decent wage employment. They also have unequal bargaining power within the household and are burdened with gendered labour resulting in drudgery and time-poverty. Furthermore, they are usually marginalised from decision-making at all levels.

Cross-country comparisons show that in all regions, women perform the bulk of unpaid work in what is referred to as the "care" economy: the minding and education of children, fetching water and fuel-wood for the household, purchasing and preparing the food, cleaning, or caring for the sick and the elderly, among others.[26]

Data from demographic and health surveys for selected countries of the Asia-Pacific region have established that women from the lowest wealth quintile suffer a considerably poorer SRH status as compared to their better-off counterparts.[27] The former are more likely to live in poor quality shelters, work in unsafe and unhealthy conditions, and suffer violence at the hands of intimate partners and others, causing them poor health, injury, disease, and even death. For example, in the places where poor women live, there is lack of good sanitation facilities, making it difficult for the management of menstruation,

often resulting in urinary tract and reproductive tract infections. The lack of clean water also affects the use of barrier methods of contraception such as female condoms and diaphragms.[28]

Lowly educated or uneducated poor women, especially those living in remote places, have been found to have less access to modern contraception and other SRH services.[29] The burden of contraception still lies heavily on women and poor women are more likely to experience unwanted and multiple pregnancies. This in turn leads them to seek unsafe abortions, which in many cases results in their death or lifelong disability. The incidence of these is especially high among unmarried adolescents.[30]

Early and child marriages, a platform for the erosion of SRR of girls and women, are another consequence of poverty.[31] Poor families, especially in South Asia, marry their daughters off at an early age because they are seen as a financial burden. Early and child marriages feed the vicious cycle of persistent poverty. Such marriages and the resultant adolescent pregnancies deprive young girls of education and employment opportunities, leaving them in poor bargaining positions and excluding them from critical decision-making. They rob them of their childhood, impose on them the burden of household responsibilities at a tender age, and expose them to the risk of marital violence, with little or no power to negotiate on sexual and reproductive matters. These conditions increase their chances of a risky pregnancy and childbirth and with these, infant and maternal morbidity and mortality.

In agriculture, where women farmers and farm workers form a large part of the informal and thereby, 'invisible' sector, women are particularly vulnerable to oppression and abuse. In particular, women are more susceptible to the effect of hazardous chemical pesticides. Women may absorb pesticides through the skin more readily than men and they have a higher proportion of body fat which becomes a reservoir for fat-loving pesticides, some of which are known carcinogens and endocrine disruptors. [32] Exposure to pesticides increases the risks of miscarriages, infertility, cancers, and bearing children with deformities.[33,34] Taking just one case in point, a number of studies have linked breast cancer in women with their exposure to pesticides.[35,36]

The state of affairs where the rich grow richer and the poor grow poorer is largely due to the dominant economic system that runs the modern world—neo-liberalist capitalism, which perpetuates hunger, poverty and inequity. For instance, in agriculture, the agrochemical and seed industry has driven the current toxic model of food production, which has resulted in widespread pesticide poisonings, farmer impoverishment and environmental damage, among other things.[37]

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Another example is the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which has increased the cost of drugs creating further financial barriers to access to healthcare. [38] Women have been more negatively impacted by trade liberalisation than men.[39] On average, women are reported to incur higher out-of-pocket expenditure than men, more likely because of their greater need for healthcare related to reproduction and chronic diseases.[40] Using services for delivery and reproductive tract infections, for example, can cost up to or more than a household's average monthly income for those living below the poverty line.[41]

5.0 THE WAY FORWARD

From the foregoing discussions, critical considerations for the post-2015 agenda become clear. On 2 June 2014, the Open Working Group (OWG) on Sustainable Development Goals (SDGs) released a Zero Draft of the first list of Proposed Sustainable Development Goals to be attained by 2030 (see Appendix 3).

The non-negotiables for sustainable and equitable development must be equality and non-discrimination which encompass the protection of women's rights and women's empowerment. Within these, SRHR must be articulated, recognised and asserted.

SRR violations not only affect individuals, but the well-being of their families and communities as well. The suppression and violations of these rights have intergenerational consequences on health, perpetuate poverty, keep the victims from participating fully in public life, and prevent them from making informed SRH decisions.[42]

Any attempt to make progress towards universal access to SRH services will have to take into account the social determinants of health: poverty, hunger and malnutrition, social and economic inequities, unemployment, poor living and working conditions, and the disadvantages that women face as a result of ingrained gender-power inequalities.[43]

Another cross-cutting issue that needs to be addressed in such an objective is the fragmentation of the ICPD's comprehensive SRH agenda into narrow silos of 'maternal health,' 'HIV and AIDS' and 'other sexual and reproductive health needs,' which have so far received far too feeble investment or political commitment. As long as this fragmentation continues, there can be little hope of achieving universal access to SRH services and with that, little hope of effectively achieving well-being for all. There is a need not only to revive the ICPD agenda, but to expand it to include the needs of population groups which have been overlooked and neglected within this agenda, such as people of diverse sexualities, those with disabilities and the aged.[44]

Universal access to healthcare services, which invariably include SRH services, would bring many benefits. For one thing, a healthier population would, in the long run, reduce public expenditure on health and loss of work days due to sickness. Greater population well-being will contribute to higher productivity, economic growth, and poverty reduction.

Universal access to SRH services will help reduce unwanted pregnancies, maternal deaths, sexually transmitted infections and diseases, and the host of ill effects discussed in foregoing sections which the poor suffer from not having their SRR upheld.

The way forward requires political will and public commitment to stopping the present cycle of impoverishment, inequity and rights violations along with ineffectual strategies that have failed to stem these.

Several considerations and recommendations for policy-makers and civil society organisations in asserting and advancing the SRR of each and every human being are discussed below. These incorporate some of the key calls by the UN Special Rapporteur on the Right to Food in his paper on Advancing Women's Rights in Post-2015 Development Agenda and Goals on Food and Nutrition Security.[45]

There are many issues raised by civil society in response to the new SDGs in the Zero Draft. Some of these concerns and recommendations, along with those put forward by the Post-2015 Women's Coalition in its "Feminist Response and Recommendations (to the) Proposed Goals and Targets on Sustainable Development for the post-2015 Development Agenda," are also included in the calls below.

5.1 For Policy-Makers

5.1.1 *Addressing Hunger and Poverty Holistically*

Any poverty goal must uphold our moral obligation to ensure every human being an existence of dignity. Poverty eradication strategies must tackle the intersecting and structural drivers of inequities and the various forms of discrimination based on gender, age, class, caste, race, ethnicity, sexual orientation, gender identity, geographical location and disability. In particular, they must address the feminisation of poverty.

As SRR are embedded in the human rights agenda, eradicating hunger and poverty is key to the advancement of such rights. For one thing, small-scale agroecology is a proven pathway for reducing poverty and hunger (including hidden hunger[46]) in poor countries. This was one of the key findings of the International Assessment of Agricultural Knowledge, Science and Technology for Development (IAASTD) in 2008 on the state of food and agriculture in the world. The report further declared that "business as usual is not an option"[47,48] referring to the current corporate toxic model of agriculture which began with the Green Revolution in the 1960s.

The validation of agroecology was reiterated in a report written in 2012 by the Overseas Development Institute (ODI) under the commission of the Hunger Alliance.[49] The report's core recommendations for smallholder agriculture to have a stronger impact on nutrition were to empower women farmers; promote home gardens and small-scale livestock and fish rearing; and complement agricultural programmes with education and nutrition communication, health services, clean water and sanitation. In order to make these recommendations work, the report made four main calls to policy-makers (excerpted below):

- Encourage smallholder agricultural development by making sure that the rural investment climate is conducive to investment and innovation. Provide rural public goods, roads and other physical infrastructure. Improve access to inputs, insurance and finance for smallholders. Develop and promote innovations for marginal farms. Recognise and protect the rights of small farmers to their land.

- Patterns of agricultural development need to be steered towards more diversified food production. Promote home gardens, with small-scale livestock and fish rearing. Complement this with communication on nutrition, health and child care.

- Back up smallholder agricultural programmes with primary healthcare, clean water and sanitation, other direct interventions for nutrition, and female empowerment. Address female disadvantages in farming through recognising and strengthening women's rights to fields and common property resources; directing attention to women's needs in farming and finding ways to support them; and in general, developing innovations both on field and in domestic tasks, such as water supply and fuel collection, that are appropriate for women and will save them time. Make sure that girls living in rural areas are educated right through to the completion of secondary school.

- Provide greater political support for improving food security and nutrition. Regular national surveys of nutrition and food security should be conducted, at least once every five years, preferably every three years.

For world leaders, the calls in the report were:

- Scaling-up public support for small-scale environmentally sustainable agricultural systems.

- Increasing support for women small-scale producers.

- Promoting improved, more accountable and joint country-led nutrition and food security strategies and approaches.

All of the above must be grounded on the principles of food sovereignty which encompass the people's rights to

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decide what to grow and how to grow it; to a safe environment; to access to land, seeds and other productive resources; and to gender justice. In particular, access to productive resources must cover not just access, but also ensure ownership and fair distribution of such resources. All these rights should be legally enforced and protected in a non-discriminatory manner.

5.1.2 *Women's Empowerment*

The ODI report mentioned above cited the empowerment of women as the single most important thing that governments can do to meet the UN Secretary's Zero Hunger Challenge. This, it recommended, should be done by helping the millions of poor women in developing countries grow more food in their tiny plots of land in and around their homes and giving complementary support in nutrition, sanitation and health. *"Improving women's access to—and control of—land, water, firewood and other productive resources, and their access to credit, micro-insurance, secondary education and rural extension services; and allowing women to make decisions regarding the household budget, and protecting women from pressure to renounce optimal breastfeeding practices" were labelled as "game-changers"* in the fight against global hunger and malnutrition.[50]

Women's empowerment is more than just enabling girls and women to go to schools and universities, to get jobs or run for public office; it is about confronting and dismantling existing inequitable power structures. Enhancing the leadership and participation of women in rural institutions is crucial in the empowerment process.[51] Women must be given a far greater role in decision-making from household and community to governmental level.

Removing the obstacles that women and girls face and empowering them are fundamental to the eradication of hunger. We cannot conclude that power has shifted in any meaningful way until we can provide equal opportunity, equal access, equal power and equal citizenship to women.[52] This requires reforming discriminatory legal provisions as well as challenging the gendered division of roles that the social and cultural norms impose on them.

Discussed below are elements deemed as critical in freeing women from the social, economic, cultural and psychological bondages that keep them downtrodden and which will enable them to realise their rights including their SRR.

Access to Education and Employment

Access to education and employment can enable women to earn adequate incomes and this is essential in ensuring their independence and well-being. Access to education in itself, however, will not ensure access to employment for women unless it is accompanied by efforts to break down gender stereotypes in terms of the types of employment that can be performed by women, as well as the roles of women and men in carrying out family responsibilities.

The gender divide in educational enrolment and completion has to be first acknowledged and addressed, such as ensuring gender-sensitive and non-discriminatory learning environments. Against this backdrop, better comprehensive education for girls and women, including sexuality education, can and will result in more economic opportunities for the latter on and off farm leading to greater economic independence and a stronger bargaining position within households and communities. This will lead to improved nutrition and welfare of households. Such provision of education will also contribute to better self-esteem, rights assertion, informed decision-making on sexuality-related issues and self-protection against harassment and violence.

In addition, States must ensure that women get fair and equitable employment terms such as equal compensation and opportunities, reasonable work hours in formal and non-formal workplaces, hygienic and safe work environments for women workers, supportive legislation

for pregnant women and working mothers, and workplace protection from sexual harassment and abuse.

Right to Nutrition

The brain development of children and their physical size have been found to depend on the quality of their nutrition during their first 1,000 days of life. The effects of malnutrition are inter-generational; a girl malnourished as an infant will in all likelihood have a baby with a low birth weight.[53] This underscores why adequate nutrition for pregnant and lactating women must be treated as a priority in all food and nutrition security programmes.

It has been long established that breastfeeding, especially in the first two years of a baby's life, is the best way to feed infants. Governments should ensure that information about the benefits of breastfeeding is widely disseminated and that employment practices enable working women to continue breastfeeding after resuming work.

Women and girls comprise an estimated 60 percent of the world's undernourished.[54] To turn this figure around, improved diets need to be ensured along with universal access to education (including comprehensive sexuality education), health services (including sexual and reproductive health), water and sanitation.[55]

Relief from Drudgery and Time Poverty

Time poverty is one of the major obstacles to women's empowerment and their access to education and employment. It has been estimated that reducing the time spent by the women in the Indian State of Gujarat to fetch water by just one hour a day would allow them to increase their incomes by 100 USD per year. [56]

In developing countries and especially in rural communities, women are underserved by public services.[57] Governments should provide public services in a way that recognises the importance of relieving women and girls from mindless drudgery and time poverty. These include the establishment and/or expansion of childcare services and public transportation systems and the improvement of access to cleaner energy sources for household needs.

Food Sovereignty and Gender Justice for Women in Agriculture

It is difficult for women to be economically independent and achieve food sovereignty when, in many countries, they have little rights to property ownership. For rural women to thrive as food producers, gender-sensitive agricultural policies are required. These should abide by the FAO Voluntary Guidelines for the progressive realisation of the right to adequate food in the context of national food security (Guideline 8.6) through women's full and equal participation in the economy and the right of women to inherit and possess land and other property, and their access to productive resources, including credit, land, water and appropriate technologies.[58]

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Priority should be given to gender-responsive taxation and subsidies that support the infrastructure needed to enable women to engage in sustainable production, transport their produce, access warehousing and other storage facilities, and receive a fair price for their products.[59]

5.1.3 Equality and Non-Discrimination

The population-weighted mean Gini coefficient (a common measure of inequality) for the Asia-Pacific region rose from 33.5 to 37.5 from the 1990s to 2013.[60] World leaders have agreed that new development goals and targets must be rooted in upholding universal human rights, including women's rights, and the principles of equality and non-discrimination.[61]

The Global Thematic Consultation on Health Report[62] (GTCHR) makes special mention of the rights and inclusion of marginalised, disadvantaged, and stigmatised

groups. These are generally people with disabilities, migrants, and ethnic minorities, as well as sex workers, people using drugs, transgender and homosexual people, and poor female youth. Many of these are also key HIV-affected population groups. The GTCHR categorically states that further progress in improving health and well-being can only be made by reducing inequities (especially gender inequalities), all forms of discrimination and human rights violations.

Policy-makers should thus institute the collection of data which will capture situations of discrimination and marginalisation as well as other causes of lack of access to basic rights and services. Furthermore, the post-2015 development agenda must create an *"enabling environment for transformative social schemes that break the cycle of discrimination and fight hunger by empowering women."*[63] States must dare to go beyond piecemeal actions and act to holistically and systematically pursue transformative food security strategies which challenge and change cultural constraints and redistribute roles equitably between women and men.

In particular, SRH programmes need to be based on a human rights framework, including the right to be free from discrimination, coercion and violence as well on the principles of bodily integrity, dignity, equality and respect for diversity as part of affirmative sexuality.

5.1.4 *Education*

Education is a fundamental component in achieving equity and equality. Efforts to improve access to education must prioritise and address the difficulties faced by marginalised groups in enrolling and completing education. Furthermore, education should be provided through the human rights perspective and promote principles like gender equality, non-discrimination, tolerance, and non-violence. [64] This aspect remains largely absent in the current education agenda which typically focuses on indicators like school completion and literacy rates.

Another important component of education which has also been on the back-burner is universal access to evidence-based, comprehensive sexuality education that is *"high quality; non-judgemental; incorporates elements of human rights, tolerance, gender equality, and non-violence; and is available in various formal, informal, and non-formal settings."*[65] Comprehensive sexuality education is the best way to achieve universal access to SRHR in the future by providing the youth with life-saving information and skills and enabling them to apply the concepts of human rights and non-discrimination in their decisions and interactions in building a better world.

5.1.5 *State Accountability*

Governments are accountable to uphold the United Nations Universal Declaration of Human Rights (UDHR) of 1948. These rights are interrelated, interdependent and indivisible. SRHR were enshrined in the International Conference on Population and Development (ICPD) and its Programme of Action (PoA). States party to this are also bound to abide by it.

In view of the fact that food and nutrition security cannot be accomplished in isolation from addressing inequality and discrimination, strong accountability mechanisms must be a part of the post-2015 development framework. This will ensure the monitoring of the situation of women and other disadvantaged groups so as to determine whether development approaches are truly being empowering, enabling and equitable.

Learning from the experience of the MDGs, the post-2015 agenda must pay due attention to rectifying inequality and discrimination in all its forms, bearing in mind that gender inequality and gender-based discrimination are the main obstacles to inclusive and sustainable development. The post-2015 framework should not allow the usual targets to overshadow or omit the rights of women and other marginalised groups. New goals and targets must therefore be designed to progressively eliminate disparities between the most marginalised sectors and the general population as well as between countries and regions.[66]

In terms of the new SDGs, the Post 2015-Women's Coalition calls for *"political action. . .to overturn current discriminatory, oppressive and violent social, political, and economic systems and develop, invest in, and implement those that create an enabling environment for women's rights, equality, and sustainable peace."*[67] It further states that *"goals and targets should reflect international human rights standards and include reference to the rule of law through the principles of non-retrogression, progressive realisation, and common but differentiated responsibilities."*

5.1.6 *Universal Access to High Quality SRH Services*

Universal access to high-quality sexual and reproductive health (SRH) services faces two formidable barriers. The first is legislative restrictions that restrict the access of adolescents and young people to SRH services, and the second is health system blindness to gender-power inequalities in society.[68]

The GTCHR[69] made the following recommendations: *(1) include specific health-related targets as part of other development sector goals; (2) take a holistic, life-course approach to people's health with an emphasis on health promotion and disease prevention; (3) accelerate progress where MDG targets have not been achieved and set more ambitious targets for the period to come; and (4) address the growing burden of non-communicable diseases (NCDs), mental illness, and other emerging health challenges.*

In addition, the report called for efforts to accelerate progress on the MDG health agenda. These should build on national and global efforts that have already resulted in significant progress in reducing child and maternal deaths and controlling HIV, tuberculosis, malaria, and neglected tropical diseases.

It says: *"The new agenda should be even more ambitious, and reaffirm the targets of ongoing initiatives such as: ending preventable maternal and child deaths; eliminating chronic malnutrition and malaria; providing universal access to sexual and reproductive health services, including family planning; increasing immunisation coverage; and realising the vision of an AIDS- and tuberculosis-free generation."* In particular, the report emphasised that SRHR must be addressed. It stressed that young people required special attention, including comprehensive sexuality education as well as protection from sexual violence and abuse.

Universal access to SRH services needs to be seen within the context and the larger goal of universal access to healthcare. Narrow approaches that focus on one specific area in isolation such as reproductive health or HIV and AIDS can result in inefficient investment of resources in weak healthcare systems that fail to meet their goals. There are various ways to strengthen healthcare systems, some of which are listed below.[70]

- Reduce the proportion of health expenditure from out-of-pocket payment and increase the proportion of government spending on SRH services.
- Implement a system of tax revenue-based funding aimed at universal rather than targeted coverage with adequate financial protection for a reasonably wide range of SRH services. For countries with a narrow tax base, they could begin with a smaller set of essential services with a commitment to progressively widening the package over time.
- Invest substantially in increasing the availability and improving the distribution of SRH services across rural/urban locations within the country.
- Consult communities about appropriate and acceptable healthcare and services. In many instances, this can resolve cultural and social barriers to access. For example, negotiation about acceptable birthing procedures can increase the level of trained attendant-assisted births.
- Address gender-based inequalities which deter access to healthcare services through greater health system responsiveness. Some examples would be making services available at suitable locations and timings, integrating different sexual and

> *For the new SDGs, universal healthcare "for all" should include "women, adolescents and young people, those with diverse sexual orientation and gender identities and other marginalised groups."[71] Moreover, this should be a time-bound target, i.e., by 2030, universal access to quality information, education, services and care at all stages of the human lifecycle, across all levels of healthcare, locations (home, community and health facilities) and times (including conflicts, disasters, migration and displacement) should be achieved.*

reproductive health and other needed services, and facilitating women's informed participation in their own healthcare.

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5.1.7 Calls from Civil Society

Many civil society groups (CSOs) have emphasised the need for the new SDGs to ensure continued, sustained investments in women's SRHR by governments and donors in fulfilling their official development assistance (ODA) commitments and reallocations towards the poorest and most vulnerable countries.

There are many groups petitioning for the advancement of SRHR along with other human rights. One important platform is the Post-2015 Women's Coalition,[72,73] and its "Feminist Response and Recommendations (to the) Proposed Goals and Targets on Sustainable Development for the Post-2015 Development Agenda."[74] Some of their concerns and calls have been incorporated into the recommendations discussed above.

Another recognised collective platform of CSOs is the ASEAN Civil Society Conference/ASEAN Peoples' Forum (ACSC/APF). In a session on "Building Cross-movement Alliances for Food Sovereignty, Ending Poverty and SRHR in the ASEAN" held in March 2014 in Yangon, Myanmar,[75] the following calls to governments were raised:

- *Given the status of uneven progress on SRHR in the ASEAN, governments must show political commitment and provide sustained financial investments to ensure SRHR for all, including women, young people, people of diverse sexual orientation, gender identities, and gender expression, people with disabilities, migrants, displaced peoples, sex workers, indigenous peoples, and other marginalised groups. These include reviewing, amending and implementing laws and policies to uphold human rights, including sexual and reproductive rights, and ensuring universal access to comprehensive, affordable, quality, gender-sensitive health services at all stages and across all locations, to achieve the highest standard of sexual and reproductive health; services include contraception; safe abortion services; services to ensure maternal health and nutrition; diagnostic and treatment services for STIs, HIV and AIDS, infertility and reproductive cancers; counselling; and comprehensive sexuality education.*

- *Ensure the right to and access to adequate, culturally appropriate, nutritious and safe food for all. Pursue a common policy of food sovereignty, and increase investment in rural infrastructure, technology, research, education for small-scale farmers, including women. Review and withdraw unjust free trade agreements; put a stop to land grabbing; provide equitable access to and control of water and land; promote sustainable agricultural practices; regulate investments in agriculture; and implement a truly just land reform and administration program to secure land rights and tenure of peasants, fishers and indigenous peoples. Develop cooperation among agriculture producers in the region and consumers; pursue sustainable agriculture to address resource degradation arising from monocropping and the impacts of climate change.*

- *Support development of intersectional analyses and research on food sovereignty, poverty and SRHR. Ensure meaningful engagement of civil society in shaping the future of ASEAN, and create platforms for cross-movement alliance building.*

5.2 Cross-Movement and Multi-Sectoral Alliances

Because SRHR is such a cross-cutting issue, there is a need to bridge the divide across movements through strong alliances. The dangers of addressing global challenges in silos have been elucidated above. Twenty years after governments committed to the ICPD POA and 19 years after they agreed to the MDGs, we find that many countries in the Asia and the Pacific region still fall short of achieving most of the critical development goals.

It is time for a new agenda for action towards achieving universal access to SRH services, one that strikes at the root causes of poverty, inequity, hunger, and disease. Therefore movements advocating for SRHR, poverty eradication, food sovereignty, the right to adequate food and nutrition, and other human rights need to forge alliances to counter the powers that promote neoliberal globalisation and corporate-based 'solutions.'

As mentioned in section 4.1 above, one such platform is the Post-2015 Women's Coalition. Another collective platform of CSOs is (also mentioned in section 4.1) is the ASEAN Civil Society Conference/ASEAN Peoples' Forum (ACSC/APF). It works on issues such as sustainable peace, development, justice and democratisation which affect the people in ASEAN countries.

One other platform for cross-movement alliances is the Global Network for the Right to Food and Nutrition.[76] This is an initiative that mobilises CSOs and international social movements, including peasants, fisherfolk, pastoralists, indigenous peoples, and food and agricultural workers to hold states accountable for their obligation to realise the right to food and nutrition. It recognises the invisible structural violence perpetrated by states and corporations that impedes the realisation of women's and girls' rights.[77]

The ICPD+20 and MDGs+15 review processes provide opportunities to revitalise and strengthen the SRHR agenda. It is time to integrally link the SRHR agenda with other socio-political development agendas and work together across social movements to achieve the collective goals of poverty reduction, food sovereignty, and SRHR for all. CSOs would be wise to adopt a broad-based and integrative approach wherever possible in terms of rights advocacy so that solutions will be holistic and successes, multi-tiered. After all, in so many ways, we are all serving the same cause and the same people: the poor, marginalised, oppressed and disadvantaged, against the same forces of neoliberalist, imperialist, capitalist greed. Our wins and losses are intertwined.

A better understanding of the complex linkages of the various issues we face today is needed to ensure that the new development agenda is able to adequately address the challenges and the gaps. Towards this end, ARROW launched a multi-year project in June 2012 on "Revitalising and Strengthening the SRHR Agenda through Inter-Movement Work to Impact the ICPD+20 and the MDG+15 Processes."[78]

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As part of this project, ARROW organised a meeting on "Intersectional Understandings: A Regional Meeting to Build Inter-movement Linkages in Poverty, Food Sovereignty, Food Security, Gender and SRHR in South Asia" in Bangkok from 10-11 September, 2013. This was one of the first initiatives that brought together activists, advocates, and organisations and networks working on poverty, food sovereignty, food security, women's rights, gender justice, and SRHR issues in and across Asia-Pacific. The meeting deliberated on the intersectionalities of issues and sought to find common grounds to influence the post-2015 development agenda.

The meeting resulted in the Bangkok Cross-Movement Call on Poverty, Food Sovereignty, and SRHR[79] which was endorsed by the participants. The Call affirmed that achieving social justice for all requires addressing issues of poverty, hunger, landlessness, gender inequality, their root causes, and SRHR, together. It recognised that the rights to adequate food and nutrition are intrinsically linked to all other human rights, including the rights to water, housing, education, property, decent work, livelihood, social security and social welfare. Only if individuals are able to enjoy good health and well-being will they be able to participate effectively in all domains of the society: economically, socially, politically and culturally. Similarly, the rights to adequate food and nutrition cannot be separated from women's self-determination, autonomy and bodily rights, and the right to health.

...[A]chieving social justice for all requires addressing the issues of poverty, hunger, landlessness, gender inequality, their root causes, and SRHR, together.... [T]he rights to adequate food and nutrition cannot be separated from women's self-determination, autonomy and bodily rights, and the right to health.

The Call underscored the urgency of the implementation of existing instruments and agreements on human rights; the repeal of laws and policies that criminalise and marginalise specific groups in society; monetary, financial and trade reforms; and the creation and implementation of strict, gender-sensitive, anti-corruption policies. It also called for investing in public goods such as agriculture, health (including SRHR), and education which will benefit all especially the poor and marginalised. It further called for ensuring the right to adequate, culturally appropriate and safe food and nutrition for all while giving specific attention to specific groups of women such as the pregnant, the lactating, and those living with HIV and AIDS, who have specific food needs.

Collective platforms/programmes like those mentioned above are important and effective avenues to put forward the voice of the people and the calls of civil society. They need to be given due recognition and legitimacy in international arenas to ensure the exercise of democracy, equity, justice, transparency, participation and accountability.

6.0 TAKING SRHR SERIOUSLY

Can we truly make a better world for all? Yes. The question for world leaders now is really: how far are you willing to go to make this a reality? Are you willing to choose the road less travelled but infinitely better for the people of the world?

The right way as well as the wrong way has been clear for decades. It is simply that the powers that be have not really listened or if they have, then they have not acted strongly enough. For example, evidence of the benefits of small-farm agroecology has been overwhelming, yet agri-corporations still hold rein over food and agriculture. The threats to human health and the environment by chemical pesticides and genetically engineered/modified crops/food have also been raised repeatedly by reputable experts and studies, yet we find their use escalating rather than decreasing. The same powers that be spend thousands of dollars doing a study on the state of agriculture in the world (the IAASTD) then choose to ignore its findings and recommendations.

Gender advocates have battled for years for women's rights, citing how crucial women are to feeding the world while human rights activists, including those calling for SRHR to be recognised, have put forward compelling arguments, with evidence, to show that upholding these rights is fundamental to the goals of sustainable development, social justice and peace. It is not that the decision-makers do not know what is right; it is simply that they have chosen otherwise and the poor continue to pay the price for this as well as the environment. It is a well-known fact that the current climate crisis is largely

due to human activity, mainly, industrialisation, modern (corporate) agricultural practices and deforestation.
Why do we need to justify the importance and relevance of SRHR as if they were somehow less crucial to the whole objective of creating a better world for all? Are we only comfortable about talking about food and jobs as if these were all a human being needed to be fulfilled or happy? Does talking about sexuality make us uncomfortable? If so, then let us be embarrassed about being human, being passionate, enjoying sensations and feelings, falling in love, getting married, having children, and the very *celebration of life*. Everyone, yes, even the poor, have a right to all of these.

Every human being is born to be free, to be fully alive. And if we cannot enjoy the gift of life, then why live? Is it right to think that a person should be satisfied with just having enough food to stay alive and not hope to be able to celebrate life in all its fullness? Take SRHR out of the equation of creating "sustainable well-being for all" and we reduce humankind to a race of walking zombies.

To say that it is high time that SRHR took their rightful place in the human rights equation is actually an understatement: it is long overdue and the poor have already suffered—and continue to suffer—for this unconscionable delay. If we are truly serious about sustainable development, peace and justice for all, sexual and reproductive health and rights have to be an integral part of all discourse and planning for a better world.

If we are truly serious about sustainable development, peace and justice for all, sexual and reproductive health and rights have to be an integral part of all discourse and planning for a better world.

ENDNOTES

[1] The right to life is a prerequisite to claim and enjoy all other human rights, including sexual and reproductive rights. Sexual and reproductive rights are intrinsic to the attainment of a good quality of life and well-being. Everyone has the right to live a life of full dignity. It is an intrinsic right of all human beings. Advocating for the right to life does not "belong" exclusively to any one sector.

[2] At this juncture, it is pertinent to discuss the meaning of "family" as there is currently considerable debate over the term. Although the conventional family unit generally is taken to mean a male father and a female mother bonded together in matrimony along with children from this union, the reality is various forms of families exist in society today such as families without children, single-parent households, families of divorced individuals, same-sex-parented households, child-headed families, joint families, extended families, intergenerational families, and families headed by AIDS orphans or their grandparents, among others. If we limit the "right to family" only to conventional families, we ignore and negate the existence of the other forms of family and this is not being realistic. Then these other units fall through the cracks of exclusion which we create. It is not a matter of whether we believe, on moral or other grounds, that they should not exist. State protection of families from human rights violations should be inclusive and not exclusive.

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[42] For more on the links between women's rights and the right to adequate food and nutrition, see the report on 'Women's rights and the right to food', presented by the Special Rapporteur on the Right to Food at the 22nd Session of the United Nations Human Rights Council. [A/HRC/22/50], 2012. Retrieved from www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/AHRC2250_English.PDF; and Bellows, A.C., Valente, F.L.S., & Lemke, S. (Eds.) Gender, Nutrition and the Human Right to Adequate Food: Towards an Inclusive Framework. New York: Taylor & Francis/Routledge. (dop: 2014). For information on the intergenerational cycle of growth failure, see chapter 3 of the 6th Report on World Nutrition Situation by UNSCN, retrieved from www.unscn.org/files/Publications/RWNS6/report/SCN_report.pdf.

[43] Ravindran, T.K.S. 2012. Universal access to sexual and reproductive health in the Asia-Pacific Region: How far are we from the goal post? Thematic Paper 1. In *Beyond ICPD and the MDGs: NGOs Strategising for Sexual and Reproductive Health and Rights in Asia-Pacific Region and Opportunities for NGOs at National, Regional, and International Levels in the Asia-Pacific Region in the Lead-up to 2014: NGO-UNFPA Dialogue for Strategic Engagement*. Kuala Lumpur: Asian-Pacific Resource and Research Centre for Women (ARROW).

[44] Ravindran T.K.S. 2012.

[45] de Schutter, O. 2013.

[46] The USAID, World Bank, Global Alliance for Improved Nutrition and the Micronutrient Initiative have identified diet diversification as the principal solution in tackling hidden hunger. (USAID et al. 2009. Investing in the future: A united call to action on vitamin and mineral deficiencies, retrieved from *http://www.unitedcalltoaction.org/documents/Investing_in_the_future_Summary.pdf*)

[47] The IAASTD study was initiated by the World Bank. It was launched as an intergovernmental process under the co-sponsorship of the FAO, GEF, UNDP, UNEP, UNESCO, the World Bank and WHO. More than 400 experts from all continents and a broad spectrum of disciplines worked together for four years with the aim of answering the following question: "How can we reduce hunger and poverty, improve rural livelihoods and facilitate equitable, environmentally, socially and economically sustainable development through the generation of, access to, and use of agricultural knowledge, science and technology?" The report was released in 2008.

[48] UNEP. http://www.unep.org/dewa/assessments/ecosystems/iaastd/tabid/105853/default.aspx

[49] Overseas Development Institute (ODI). 2012. *Small Scale, Big Impact: Smallholder Agriculture's Contribution to Better Nutrition*. Commissioned by the Hunger Alliance. London: ODI. http://ow.ly/ksoC5.

[50] Overseas Development Institute (ODI). 2012.

[51] Enhancing leadership and participation of women in rural institutions is one of the four pillars of the initiative "Accelerating Progress Toward the Economic Empowerment of Rural Women" launched in September 2012 jointly by the UN Entity for Gender Equality and the Empowerment of Women (UN Women), the Food and Agriculture Organisation of the UN (FAO), the International Fund for Agricultural Development (IFAD), and the World Food Programme (WFP).

[52] Thanenthiran, S. 2012. *Seizing the Pivotal Moment: NGOs Strategising for Sexual and Reproductive Health and Rights in Asia and the Pacific Post-2014, Special Edition, Volume 18*. Kuala Lumpur: Asian-Pacific Resource and Research Centre for Women (ARROW).

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[54] UN Economic and Social Council (ECOSOC). 2007. Strengthening efforts to eradicate poverty and hunger, including through the global partnership for development. *Report of the Secretary-General. UN doc. E/2007/71*. New York: ECOSOC. And World Food Programme (WFP). 2009. *WFP Gender Policy and Strategy: Promoting Gender Equality and the Empowerment of Women in Addressing Food and Nutrition Challenges*. Rome: WFP, p.6.

[55] Post-2015 Women's Coalition. 2014. Feminist response and recommendations (to the) proposed goals and targets on sustainable development for the post-2015 development agenda. Working Draft. http://www.post2015women.com/wp-content/uploads/2014/06/Post2015WC_FeministResponseRecommendations_06242014.pdf.

[56] de Schutter, O. 2013.

[57] Razavi, S. 2007. *The Return to Social Policy and the Persistent Neglect of Unpaid Care.* Geneva: United Nations Research Institute for Social Development.

[58] de Schutter, O. 2013.

[59] Post-2015 Women's Coalition. 2014.

[60] UN Economic and Social Commission for Asia and the Pacific (UNESCAP), Asian Development Bank (ADB) & United Nations Development Programme (UNDP). 2013.

[61] At the *Rio+20 Summit in 2012* and reaffirmed in the *Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda* (May 2013). The Human Rights Council and the Office of the United Nations High Commissioner for Human Rights have also advocated for the incorporation of equality in the post-2015 agenda, both as a stand-alone and cross-cutting goal.

[62] Global Thematic Consultation on Health. 2013.

[63] de Schutter, O. 2013.

[64] Post-2015 Women's Coalition. 2014.

[65] Post-2015 Women's Coalition. 2014.

[66] The suggested global goals set by the UN high-level panel on the post-2015 development agenda in the spring of 2014 underline the human rights dimension of food and nutrition security in proposed target 5(a): "End hunger and protect the right of everyone to have access to sufficient, safe, affordable, and nutirious food." The high-level panel also suggested a self-standing goal to "Empower Girls and Women and Achieve Gender Equality," with four associated targets. However, there is no specific target reflecting the gender dimension. Simply, referring to "equality of opportunity" as an overall concern, requiring that all indicators "should be disaggregated with respect to income (especially for the bottom 20%), gender, location, age, people living with disabilities, and relevant social group" seem insufficient. *(United Nations. 2013c. A New Global Partnership: Eradicate Poverty and Transform Economies through Sustainable Development, The Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda.)*

[67] Post-2015 Women's Coalition. 2014.

[68] Ravindran, T.K.S. 2014. What it takes: Addressing poverty and achieving food sovereignty, food security, and universal access to sexual and reproductive healthcare services. *Bridging the Divide: Thematic Paper Series on Linking Gender, Poverty Eradication, Food Sovereignty and Security, and Sexual and Reproductive Health and Rights.* Kuala Lumpur: Asian-Pacific Resource and Research Centre for Women (ARROW).

[69] Global Thematic Consultation on Health. 2013

[70] Ravindran, T.K.S. 2012.

[71] Post-2015 Women's Coalition. 2014.

[72] The Post-2015 Women's Coalition is a coalition of feminist, women's rights, women's development, grassroots and social justice organisations working to challenge and reframe the global development agenda.

[73] Post-2015 Women's Coalition. 2014.

[74] For the full working draft, see http://www.post2015women.com/wp-content/uploads/2014/06/Post2015WC_FeministResponseRecommendations_06242014.pdf.

[75] This was a joint session organised by ARROW, the Asia-Pacific Network on Food Sovereignty (APNFS), the Asia Pacific Forum on Women, Law and Development (APWLD), Asian Rural Women's Coalition (ARWC), and Pesticide Action Network Asia Pacific (PAN AP) at the ACSC/APF.

[76] See www.fian.org/news/article/detail/launch_of_global_network_for_the_right_to_food_and_nutrition/

[77] This ethos is enshrined in the Network Charter, which states that "[s]tructural violence and discrimination against women are often invisible or ignored, magnifying the violations of women's rights and hindering their capacity to participate actively in the realisation of the right to adequate food and nutrition. Network members support women in their struggle for equal rights with men, for their right to self-determination, for their sexual and reproductive rights, including the right to choose their partners and whether or not they want to procreate." *(www.fian-nederland.nl/pdf/GNRtFN_-_Formatted_Charter.pdf)*

[78] More information on the project is available at: www.arrow.org.my/?p=revitalising-and-strengthening-the-srhr-age. In October 2013, an international group of 93 scientists, academics and physicians (European Network of Scientists for Social and Environmental Responsibility; ENSSER) issued a statement, asserting that there is no scientific consensus on the safety of GM foods and crops. The statement was made in response to sweeping claims that GM crops and foods are safe. In reality, many unanswered questions remain and in some cases, there is serious cause for concern. For the full statement, see: http://www.ensser.org/increasing-public-information/no-scientific-consensus-on-gmo-safety/)

[79] The full call and list of signatories can be accessed at www.arrow.org.my/?p=bangkok-cross-movement-call-on-addressing-poverty-food-sovereignty-rights-to-food-and-nutrition-and-srhr

Annex 1

Millennium Development Goals

MDG 1: Eradicate extreme poverty and hunger. Target 1C. Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

MDG 2: Achieve universal primary education.

MDG 3: Promote gender equality and empower women.

MDG 4: Reduce child mortality. Target 4A. Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

MDG 5: Improve maternal health. Target 5A. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio. Target 5B. Achieve, by 2015, universal access to reproductive health.

MDG 6: Combat HIV/AIDS, malaria, and other diseases. Target 6A. Have halted, by 2015, and begun to reverse the spread of HIV/AIDS. Target 6B. Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it. Target 6C. Have halted, by 2015, and begun to reverse the incidence of malaria and other major diseases.

MDG 7: Ensure environmental sustainability. Target 7C. Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.

MDG 8: Develop a global partnership for development. Target 8E. In cooperation with pharmaceutical companies, provide access to affordable essential medicines in developing countries.

Source: http://www.unmillenniumproject.org/goals/gti.htm#goal1

Annex 2

Progress on Health-Related MDGs

MDG 1: In low- and middle-income countries, the percentage of underweight children under five years of age dropped from 28 percent in 1990 to 17 percent in 2011. The MDG 1C target may be met, but improvements have been unevenly distributed between and within different regions and countries.

MDG 4: Globally, the number of deaths of children under five years of age fell from 12 million in 1990 to 6.9 million in 2011. The global rate of decline has accelerated in recent years: from 1.8 percent per annum during 1990-2000 to 3.2 percent during 2000-2011. Despite this improvement, the world is unlikely to achieve the MDG 4A target by 2015.

MDG 5: While the proportion of births attended by a skilled health worker has increased globally, fewer than 50 percent of births are attended to in the WHO African region. Despite a significant reduction in the number of maternal deaths—from an estimated 543,000 in 1990 to 287,000 in 2010—the rate of decline is just over half that needed to achieve the MDG 5A target by 2015. In 2008, 63 percent of women aged 15-49 years who were married or in a consensual union were using some form of contraception while 11 percent wanted to stop or postpone childbearing but were not using contraception.

MDG 6: Globally, new HIV infections declined by 24 percent between 2001 and 2011. In 2011 an estimated 2.5 million people were newly infected with HIV, of whom 70 percent live in Sub-Saharan Africa. More people are living with HIV: an estimated 34 million people in 2011. A little over 8 million people in low- and middle-income countries received anti- retroviral therapy in 2011, but there is still a long way to go to achieve universal access. Malaria mortality rates have decreased by more than 25 percent globally and by more than 33 percent in the WHO African region over the past decade. Fifty countries are on track to reduce malaria case incidence by more than 75 percent by 2015; however, these countries represent only 3 percent of the global estimated cases. It has been estimated that more

than one million lives have been saved in the past decade, 58 percent in the top ten highest burden countries. Use of insecticide-treated nets and indoor residual spraying has greatly increased, and will need to be sustained in order to prevent the resurgence of disease and deaths caused by malaria. There were an estimated 8.7 million new cases of tuberculosis (TB) in 2011, of which about 13 percent involved people with HIV. Globally mortality due to TB has fallen 41 percent since 1990 and is forecasted to reach 50 percent by 2015, except in Africa and Europe. Treatment success rates have been sustained at high levels, at or above the target of 85 percent, for the past four years. However, the incidence is falling very slowly, and the trend may be reversed due to the spread of multidrug-resistant and extensively drug-resistant TB strains. The "neglected tropical diseases" are a group of 17 diseases that affect more than one billion people worldwide in the poorest, most marginalised communities, causing severe pain, permanent disability and death. Control, elimination, and even eradication of these diseases are feasible. Dracunculiasis, for example, with fewer than 1,058 cases reported in 2011, is on the verge of eradication without the use of any medication or vaccine.

MDG 7: Globally the water target has been met, but this masks inequalities between and within countries: 31 of the 50 Sub-Saharan African countries are still off track. Moreover, several countries extract river water and pump it untreated to taps in the home. Such water supply is improved, but not safe. Sanitation remains severely off track: 70 percent of the population of Sub-Saharan Africa lacks access to improved sanitation; 41 percent of the population of South Asia still practises open defecation. This has significant consequences for health and for the achievement of the health MDGs. The continued high burden of diarrhoeal diseases and the increase in outbreaks of cholera demonstrate the importance of the links between water, sanitation, and hygiene (wash) and health.

MDG 8: Progress on most of the targets is not on track, including 8E. Effective treatments exist for the majority of conditions causing the global chronic disease burden, yet universal access remains out of reach. Many low-income countries still have a scarcity of medicines in the public sector, forcing people into the private sector where prices can be substantially higher. Prices of generics in the private sector averaged five times international reference prices, ranging up to about 14 times higher in some countries. Even the lowest-priced generics can put common treatments beyond the reach of the poor.

Source: Excerpted from http://www.who.int/mediacentre/factsheets/fs290/en/_

Annex 3

List of Proposed Sustainable Goals to be attained by 2030

2 June 2014

1. End poverty in all its forms everywhere
2. End hunger, achieve food security and adequate nutrition for all, and promote sustainable agriculture
3. Attain healthy life for all at all ages
4. Provide equitable and inclusive quality education and life-long learning opportunities for all
5. Attain gender equality, empower women and girls everywhere
6. Secure water and sanitation for all for a sustainable world
7. Ensure access to affordable, sustainable, and reliable modern energy services for all
8. Promote strong, inclusive and sustainable economic growth and decent work for all
9. Promote sustainable industrialisation
10. Reduce inequality within and among countries
11. Build inclusive, safe and sustainable cities and human settlements
12. Promote sustainable consumption and production patterns
13. Promote actions at all levels to address climate change
14. Attain conservation and sustainable use of marine resources, oceans and seas
15. Protect and restore terrestrial ecosystems and halt all biodiversity loss
16. Achieve peaceful and inclusive societies, rule of law, effective and capable institutions
17. Strengthen and enhance the means of implementation and global partnership for sustainable development

Source: http://sustainabledevelopment.un.org/content/documents/4044140602workingdocument.pdf

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

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

Advocacy Brief

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This publication was produced as part of a grant by

the David & Lucile Packard FOUNDATION

ARROW's work is also made possible through core funding/ institutional support from **the Ford Foundation** and

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