BREAKING THROUGH THE DEVELOPMENT SILOS

Sexual & Reproductive Health & Rights, Millennium Development Goals and Gender Equity

Experiences from Mexico, India and Nigeria

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FOREWORD

The 1994 International Conference on Population and Development (ICPD) was a major turning point in the population and development debate, shifting the focus of policy-makers, researchers and advocates towards respect for human rights and promotion of equality and health, in particular, sexual and reproductive health and rights (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. However, the advent of the Millennium Development Goals (MDGs) in 2000 as the key and compact global policy frame for development assistance presented a huge challenge to the implementation of the more expansive ICPD and the BPFA programs. As evidence of the difficult policy environment, the Cairo goals were excluded from the MDG roadmap adopted in 2001.

In 2005, when this project was conceptualized, DAWN was beginning to be alarmed by the resurgence of population control programs and rhetoric in some developing countries that had played an influential role in the adoption of the Cairo agenda. Moreover, we were concerned over what might predictably be an 'uneven' realization of ICPD and BPFA outcomes across the developing world. Five years later, DAWN, using preliminary data from the studies in this book, declared the ICPD as "one of the biggest policy victims of the MDGs" (see the DAWN statement, "Maternal Mortality: In Need of Rescuing from the Depths of the Silo", on pages 203-205 of this book).

The aim of this global project was to examine how certain national MDGs / anti-poverty agendas and programs in the economic south affected the implementation of policies and programs specific to SRHR and gender equality goals. Research was conducted in three developing countries where capacities, structures and socio-cultural and political dynamics hugely varied, namely, Mexico (Latin America), India (South Asia) and Nigeria (Africa). Designed as policy oriented research, the country studies had an additional objective of building the knowledge of sexual and reproductive health and rights advocates at both national and global levels.

The research process included two global research meetings. The first held in Rio de Janeiro in March 2009 happened during the first six months of data gathering and led to adjustments in the research guidelines and methodologies, particularly towards greater consistency in the analytical frameworks used across the country studies. A year later, in August 2010, the second meeting took place in Bangalore. With preliminary reports on hand, researchers shared their data and insights on the functionalism engendered by the MDG ethos including the fragmentation and isolation of important social and economic development issues linked to SRHR and gender equality and equity. By then, it was becoming clear that what initially had appeared to be a problem of mismatched policy goals and state practices or a disjuncture between global and local discourses on the MDGs should be described more aptly as "siloization".

DAWN, in collaboration with the global women's health and human rights movement, particularly activists in the economic South), remains committed to the implementation, protection and expansion of the original ICPD agenda nationally, regionally and internationally. It is hoped that the country studies presented in this book will provide useful evidence to support global advocacy on SRHR and gender equality in the context of the upcoming Cairo+20 and MDG+15 review processes in 2014 and 2015.

Josefa "Gigi" Francisco
General Coordinator

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Foremost to thank are the women who ably steered this project through its various crucial stages: Sonia Correa, former DAWN Research Coordinator on SRHR, whose passion for SRHR advocacy catalyzed and animated the project; Carolina Ruiz for leading the project team and DAWN through the MDG+10 review process; and Gita Sen for providing the intellectual stimulation from beginning to end and expectedly stepping into the shoes of project coordinator at a crucial time when the project needed synthesis and integration.

Our heartfelt appreciation, of course, goes to the women researcher-writers and DAWN collaborators: Erika Troncoso for the Mexico report; Renu Khanna with Anagha Pradhan and Lakshmi Priya for the India report; Ngukwase Surma and Mary Okpe for the Nigeria report; and Bhavya Reddy for co-writing the overview of this book with Gita Sen. We thank them for their fervent commitment to sexual and reproductive health and rights that permeates the intellectual outputs found in this collection.

This book would not have been completed without the valuable contribution of the following women: the academic reviewers of our research drafts, namely, Asha George, Graciela Freyermuth, and Onemya Afulukwe; our long-time DAWN editor and friend, Seona Smiles; our team of copyeditors- Anjani Abella and Eika Rosario, and cover design and layout artist, Keow Abanto. DAWN is deeply grateful to each one of you who had generously shared your time and expertise toward the production of this book.

Lastly, we are extremely thankful to the MacArthur Foundation for their generous support to yet another significant project in our continuing advocacy among women in the economic south.

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CHAPTER 1: OVERVIEW

Bhavya Reddy and Gita Sen

Introduction

The past two decades have seen a number of efforts at the global level by governments, international and national organizations and civil society to adopt a more multidimensional approach to development defined by freedom, empowerment and the fulfillment of human rights. These efforts came to fruition through several UN agreements in the 1990s (DAWN, 2009). Despite this, there have been many questions raised whether these efforts went far enough or deep enough. In particular, there has been serious concern about the results of the Millennium Summit of the year 2000. Though the Millennium Declaration, born of that Summit, upholds several core human rights principles, the Millennium Development Agenda defined by eight Millennium Development Goals (MDGs) has faced considerable criticism for a number of limitations and omissions. Among the dominant critiques is the argument that that the MDG measure of extreme poverty as people living under $1 per day favors the lowest common denominator benchmark for progress, masking much higher proportions of people recognized by more comprehensive and meaningful measures of poverty. The application of uniform targets and indicators to countries at different stages of growth has also been faulted for being unsupportive and lacking relevance to divergent development trajectories. Others have argued that funds and political will channeled to highly selective, narrow subjects undermine support for systems strengthening and inter-sectoral approaches to sustainable development.

Along with many other members of civil society, Development Alternatives with Women for a New Era (DAWN) has challenged the targeted, technocratic approach implicit in the MDGs, cautioning against the consequent emergence of development 'silos'(DAWN, 2010). Gender equality by the MDG definition is confined to one goal with targets and

indicators for women's political representation, education and employment, de-linked from its instrumentality and inherent necessity to fulfill all other MDGs. DAWN, like others, has also been deeply concerned about the MDG agenda's regression of the complex and integrated approaches to addressing women's rights and sexual and reproductive health and rights drawn from the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women, Beijing. The failure to address gender-based violence, abortion rights, sexual health and rights, including gender identity and sexual orientation, or the needs and rights of young people, and instead defining reproductive health solely under the purview of maternal health is among the critical omissions under the MDGs.

Despite these weaknesses, it must be recognized nonetheless that the MDGs have to some extent synthesized diverse development priorities and been a tool to hold governments accountable for meeting the most basic needs of populations, and for galvanizing a considerable amount of political will to meet measurable targets. The extent to which national governments prioritize the MDGs and they impact national agendas however varies greatly across regions and countries.

In this context, DAWN carried out this research and analysis project in order to assess the policy relevance of the MDGs, to examine the interplay among policies to address poverty, gender and sexual and reproductive health and rights (SRHR), and to evaluate their implementation in African, South Asian and Latin American regions. The countries chosen for the analysis were Nigeria, India and Mexico (the three large focus countries for the MacArthur Foundation's Population Program)[i]. The core objective was to determine the extent to which the MDGs agenda is integrated into policy frameworks and debates, has favored the adoption of SRHR policies, or fostered the strengthening of pre-existing SRHR initiatives.

Methodology

The project did not envisage doing primary research but was intended to analyze policy documents, and conduct key informant interviews. It was recognized early on that policy analysis for the three countries would face major challenges of diversity and variability. The basic approach, therefore, was to bring together country level research teams that would work collectively to develop a methodology that would be common but highly flexible in order to adapt to country and regional specificities in policy environments, actual policies, and the associated politics.

Shortly after the constitution of the Research Team in June 2008, country-level research initiatives and consultations began in September 2008. Country-level research efforts included the following: a) reviewing, adjusting and adapting research guidelines to contextual and spatial specificities; b) consolidating the country-level research teams; c) gathering and selecting key policy documents pertinent to the research; d) conducting preliminary analyses on materials compiled; e) identifying key informants to the research; and, in some cases f) conducting interviews with identified key informants.

In March 2009, the members of the Research Team convened in Rio for a Research Meeting that was meant to serve as a platform for updates and a discussion of the preliminary findings of country research teams. In light of new information gathered by the research teams in the first six months of the research process, the Research Meeting also served as a site for a) revisiting research guidelines; and b) rearticulating and defining language used by the research project to provide clarity and consistency in the analytical and methodological trajectories of the research. In mid-2010, the Research Team came together again in order to consolidate and analyze the findings on the basis of draft country reports, and to develop the core arguments for DAWN's advocacy at the UN 'High-level Plenary Meeting of the General Assembly' (better known as the MDG Summit) held in September 2010 in New York.

The study in India was based on a review of the secondary literature, together with available data for a wide set of indicators that were tracked for the years 1990, 1995, 2000 and 2005. The indicators were broadly in respect to the macro-economic environment, poverty, SRHR and gender equity. Of the 28 states and union territories, Tamil Nadu and Gujarat – two large states in the south and west of the country respectively - were chosen for state level study. Interviews with government officials at national and state levels regarding MDGs, poverty, gender equity and SRHR programs were conducted, coverage of these issues in national and state level newspapers was monitored, and a review of social movements at state and national levels was done. Discussions about government programs were held with targets groups from low income neighborhoods in Chennai in Tamil Nadu and Baroda in Gujarat[ii].

The study in Nigeria reviewed health sector policies between 1999 and 2008 with reference to SRHR, and adolescent sexual and reproductive health (SRHR), and their coherence with the ICPD Programme of Action (PoA). Policies related to poverty alleviation in the same period were also reviewed to assess the degree of their integration with SRHR policies. Both sets of policies as well as the overarching health sector reform were reviewed for coherence with the nation's millennium development approach and agenda. State level research was conducted in Kaduna, one of the two Nigerian states that host the Millennium Cities Initiative and the Millennium Villages project initiated by Columbia University's Earth Institute. Interviews were held with government officials at local and state levels as well as civil society organizations working on SRHR.

For the Mexico study, the research tracked the progress on SRH indicators at the national and state levels. Legal frameworks of abortion laws in the country were reviewed and abortion services provided in Mexico City were monitored. Three types of national social programs- conditional cash transfer programs, social service programs and infrastructure programs were examined. To assess the impact of social programs on women's lives, focus group discussions (FGDs) and in-depth interviews were conducted in Puebla, with

beneficiaries of *Opportunidades* and *Seguro Popular* [iii]. Newspaper content analysis was conducted to assess the coverage of MDG discourse in the national daily *Reforma.*

Background

India was a relevant choice for DAWN's SRHR analysis because of its long history of action on population and development. It was the first country to introduce a national family planning program in the 1950s.Through the decades, family planning programs have adopted a number of approaches, some involving serious challenges to reproductive rights and human rights more generally, most notoriously during the period of the so-called 'Emergency' in the mid-1970s. The UN International Conference on Population and Development in 1994 had its impact on many countries and India was no exception. It energized both civil society and the government, and as a result, the central Ministry of Health and Family Welfare introduced a new population policy in 2000, marking a shift from demographic targets per se to an approach more sensitive to human rights and development (National Commission on Population, 2000). Although the bogey of population control through family planning targets, incentives and disincentives still keeps rearing its head (albeit under less harsh terminology and names), in parallel some key aspects of reproductive health have begun to receive attention. The introduction of the Reproductive and Child Health Program followed by the National Rural Health Mission has meant that, in the past 15 years or so, safe motherhood - a long neglected subject - and infant health have become central to policies and programs (NRHM, 2005).

Nigeria has in many ways been, among the three, the country that has gone the farthest in the adoption of the MDGs into policy. As in the other countries, the ICPD had a major impact in Nigeria, especially on civil society, and a number of organizations strengthened their focus on adolescent SRH and the empowerment of young people. However the presence of military governments limited their scope and impact. The year 1999 marked a shift to a democratically elected government after years of military rule in the country.

Followed shortly thereafter by the Millennium Summit in 2000, this led to important changes. Since its inception, the MDG agenda has been very closely followed by Nigeria's national poverty eradication strategy and health sector reform. The government has also created a number of policies to address SRHR and adolescent SRHR in addition to its ratification of the Continental Framework on Sexual and Reproductive Health Rights in 2005, which addresses SRH in the fullest context defined by the ICPD with respect to the life-cycle approach[iv] (The African Union Commission, 2006).

Of the three countries, Mexico has probably had the longest and most clear support for sexual and reproductive rights from civil society. Partly due to its location in Latin America with its long history of feminist movements and struggles against dictatorship, the country has been at the crossroads of progressive thinking and action in support of human rights, and sexual and reproductive rights in particular. In a region where the conservative influence of the Catholic Church through both its ecclesiastical and its lay arms (the Opus Dei) has been historically very powerful (despite the challenges posed by the liberation theology movement), Mexico has had the historical advantage of its own Revolution having been as much against the Church as against the state in the 19th and early 20th centuries. Thus, Mexico has witnessed longstanding efforts in support of abortion rights and was a key player in the ICPD, with resultant progress in the area of SRHR. However, in 2000 a significant shift in political power occurred after decades of one-party rule to a right-leaning government. Macro-economic changes and consequent health sector reform have had implications for commitments to SRHR. The growing influence of the Catholic Church as well as the newer evangelical fundamentalist churches, as in the rest of Latin America, has begun to pose major challenges to the secularity of the Mexican state, including its support for sexual and reproductive rights and health. There is a growing tension between the agenda of these conservative forces and the gains made by progressive feminists and LGBTQI[v] movements towards safe and legal abortion, and gay rights including civil unions and marriage.

All three of the countries of DAWN's study are large federal republics, represent the most populous countries in their regions, and are among the large economies of the world. Since the signing of the Millennium Declaration, they have all experienced various degrees of liberalization and increasing privatization of social sectors. Despite being at different stages of economic and social development, all three countries have high levels of poverty and indices of inequality, and acute regional disparities in areas of human development. Maternal mortality has been a critical issue and will continue to be on their national development agendas. Adolescents, youth and populations at reproductive age make up a large portion of their population structures, which presents both opportunities and challenges for sustainable development, and demands attention from SRHR policy and the formulation of the rights agenda. Given this background, DAWN's analysis aimed to explore and clearly spell out the tensions, disjunctions and disconnections that occupy the interface of the agendas for the MDGs, gender equity and sexual and reproductive health and rights.

Political and economic landscape

Since independence from the British in 1960, multiple periods of military and autocratic rule coupled with persistent corruption have critically challenged Nigeria's experience with representative democracy. Being oil-rich did not translate to lowering endemic poverty, while economic stagnation, deteriorating welfare and civil unrest characterized the development landscape for much of the country's post-independence history. While revenues from oil increased in the decades that preceded the Millennium Declaration, poverty worsened, and by 2000, national government figures placed 65.6% of the population below the poverty line (Government of the Federal Republic of Nigeria, 2008). The year 1999 marked a significant political shift as, after 16 consecutive years of military rule, power was handed over to a democratically elected government. The People's Democratic Party (PDP), an economically neoliberal right-wing government, has been in power since then, winning four consecutive presidential elections. In the past ten

years, democratic processes have been slow to gain strength and legitimacy, and opposition forces in the political sphere remain weak and fragmented.

In Mexico, the Revolutionary Institutional Party (PRI) ruled hegemonically from the 1920s. The winds of political change began to blow in the 1980s, and since 2000 the right-wing National Action Party (PAN) has been in power, winning two consecutive elections. With a conservative national government and the growing political influence of the Catholic Church, the fact that the *Districto Federal* (which includes Mexico City) is governed by the left-wing Party of the Democratic Revolution (PRD) since 1994 has been critical to shaping more progressive agendas (Batthyany and Correa, 2010). In the same year its membership in the North American Free Trade Agreement (NAFTA) took effect, and Mexico became the first Latin American member of the Organization for Economic Cooperation and Development (OECD), furthering thereby its position in the global political economy. Since the signing of the Millennium Declaration, Mexico has adopted various reforms due to fiscal restrictions that have altered the functioning of the health system and social protection mechanisms administered through over 120 federal welfare programs. Some of Mexico's welfare programs have become viewed as trend-setters, such as the conditional cash transfer program, *Progresa / Oportunidades* (United Nations, 2009). Mexico was also harshly impacted by the global economic / financial crisis of 2008, which further increased the pressure for fiscal belt-tightening. Though public sector workers are covered by a social security financed health system and higher income groups choose from a bourgeoning private health sector, public spending on health has seen a decrease, adversely impacting the functioning of the public health system, which serves a large section of population and the majority of the poor. Efforts towards universal coverage of health insurance in reality reach only 62.3% of the population (National Population Council, 2009).

In India, the economic liberalization that began in the 1980s and took clear shape in the early 1990s saw decisive and sustained changes towards a more liberal market economy. Between 1998 to 2008, the country's GDP grew at 7.2%. But despite becoming one of

the fastest growing economies in the world, the proportion of people below the poverty line has decreased only marginally. As per World Development indicators, the headcount poverty ratio at $1.25 indicated a decline from 54% in 1990 to 42% in 2005, but the absolute number of poor people has grown. Poverty estimates have been the focus of major ideological battles between neoliberal reformers and others, since the trends in poverty are viewed as indicators of the failure or success of economic reforms. In this regard, the Planning Commission's estimate of poverty in 2005 at 27.5% generated considerable debate. As a consequence, the government was forced to set up an independent committee headed by a senior economist, Professor Suresh Tendulkar in 2009 to look into the estimates. The Tendulkar Committee, while agreeing that there has been a downward trend in the headcount ratio, significantly raised the rural poverty estimates to 41.8% in 2004-05 (Planning Commission, 2009). It is clear from these new estimates that the fruits of high economic growth are largely accruing to the urban areas, and the gap between the urban and rural populations has grown significantly.

Income inequalities have increased in the last decade, and in states such as Gujarat where the private sector has been fuelling significant economic growth, the decrease in income poverty has not translated to a corresponding decline in human poverty[vi], nor has it improved consumption inequalities in rural areas. Increasing inflation, high levels of corruption and outstanding debts at the country level are current issues, with inflation and corruption lessening the impact of poverty reduction strategies.

In terms of health, out of pocket expenditure on health is responsible for pushing large number of people into impoverishment in India (Balarajan et. al, 2011). Yet the government has allowed the private health sector to proliferate alongside stagnant budgetary allocations to the public health sector. Public private partnerships (PPPs) and health insurance models are increasingly looked at as method to improve healthcare coverage in hard to reach and remote areas, which in effect impedes access, especially for economically marginalized groups.

Public spending on health makes up only 20% of the total health budget in India but importantly, the failure of decentralized spending and underutilization of allocated funds is one of the identified impediments to federal budgetary increases on health. In Nigeria, a major constraint in improving healthcare has been attributed to the three-tier functioning of the public health system with the responsibility of tertiary, secondary and primary healthcare given to federal, state and local governments respectively. Though improving primary healthcare has been a priority in the nation's health sector reform, political will is concentrated at the centre, dissipating as it moves to state and local governmental levels. Also, given that Nigeria is a new democracy, it has a lower capacity to effectively utilize decentralization for programmatic action.

Therefore when health systems are subject to decentralization, this can have exacerbating effects on existing regional disparities and urban-rural divides. While decentralization is known to improve access to services, especially where women's mobility is limited, evidence from Latin America suggests that at local levels the mind-sets of health providers are influenced by dominant cultural norms (Batthyany and Correa, 2010) which can negatively impact health-seeking behavior for SRH services. In all countries, the effective functioning of referral systems is affected, with the movement from basic to complex services divided between local and state governments (Batthyany and Correa, 2010). This is compounded by poor provisioning of public health services in the distribution of manpower, drugs and equipment at the local level, increasing thereby the burden on secondary and tertiary care.

All three countries are characterized by declining or stagnant public spending on health at the federal level, weak political will towards implementation of public services at local levels and unregulated privatization of health services, creating a considerable challenge for poverty reduction and improvements in human development.

MDG Adoption into policy environment

Nigeria

In efforts to rebuild the nation after military rule, the Nigerian government entered into arrangements that resulted in high donor dependency in order to qualify for debt relief. The Poverty Reduction Strategy Paper (PRSP) prepared for the International Monetary Fund (IMF) was based on implementing mechanisms of deregulation, privatization, liberalization and improving transparency and accountability. Called the National Economic Empowerment and Development Strategy (NEEDS), the PRSP invited international donor funds and technical expertise to help resurrect deteriorating human development indices. Though a number of poverty alleviation policies have been adopted since independence, NEEDS was to initiate a comprehensive reform agenda for the nation, and corresponding documents for all 36 states and local constituencies were created. The MDGs were a central theme of NEEDS, and at this juncture, beginning with the National Poverty Eradication Program (NAPEP) in 2001, policies in turn began being framed in line with the Millennium agenda.

The health sector reform initiated in 2003 under the overarching framework of NEEDS directly reflects the health issues addressed by the MDGs, and the National Health Policy revised in 2004 promotes the very same targets and deadlines of the health related MDGs. Political will towards the MDG agenda was strengthened further in 2005 when the government negotiated an $18 billion debt relief package conditioned on MDG-related, pro-poor expenditure. In the same year, the Office of the Senior Special Assistant to the President on the MDGs (OSSAP-MDGs) and a Virtual Poverty Fund (VPF) were set up to manage and direct all debt relief gains (DRGs) towards MDG-related expenditure. The OSSAP-MDGs works directly or indirectly with federal and state ministries in addition to state MDG offices set up in all states. A significant portion of the DRGs is directed to the Conditional Grants Scheme, which allows states to avail of additional funds in areas defined by the OSSAP-MDGs. In 2007, former president Yar'Adua's 7-point agenda for development explicitly prioritized the MDG agenda, and the National Assembly set up

committees specifically related to the monitoring and evaluation of MDGs. Between 2006 and 2008, the UNDP undertook an extensive costing exercise for the country in eight key sectors (agriculture, health, education, roads, energy, water resources, environment and housing) to define what it would cost the federal, state and local governments and private sector to achieve the MDGs. In 2006 and 2008 two states in Nigeria were chosen to host the Millennium Villages Project and the Millennium Cities Initiative, introduced by Columbia University's Earth Sciences Institute, to become models for MDG achievement. There is therefore considerable evidence of very strong political will towards achieving the MDGs in Nigeria. Not only do the MDGs have an institutional home, but funding for a number of state programs are largely leveraged by DRGs mandated for the MDGs. The MDG agenda is thus strongly integrated into government structures, policymaking and programmatic action.

India

In India the MDGs are mentioned only fleetingly in some national policies and programs and are completely absent in others. With five of the seven major international donors in India focusing on poverty reduction and the achievement of the MDGs, donor emphasis on the MDGs appears much greater than the government's. Nonetheless the national Planning Commission doubled the total budget for poverty reduction between the Tenth Five Year Plan (2002-2007) and the Eleventh Five Year Plan (2007-2012). The current Plan's 27 national targets reflect coherence with the poverty reduction indicators of the MDGs, but do not align on areas of gender inequality and reproductive health. Indicators to increase women's empowerment do not correspond to MDG indicators, with no national target to increase women's participation in non-agricultural work and the ratio of women to men's earnings (Khanna, 2011).

Reproductive health falls under the National Rural Health Mission (NRHM), India's flagship public health initiative, which was launched in 2005. While MDG 5 is mentioned in the program and maternal and child health has been at the core of its efforts, there

are no direct references made to MDG targets. But despite these disconnects, the current Five Year Plan sets out to address social security for the poor; universal primary education and enrolment in secondary education; the gender gap in education enrolment; adult female literacy and women's agency; nutrition; infant mortality; maternal mortality, reproductive health; HIV/AIDS, tuberculosis, malaria and other communicable diseases; and safe drinking water and sanitation (Planning Commission, 2008). This reflects large areas of overlap between national and Millennium development agendas.

Among the two states studied in India, Tamil Nadu's Eleventh Five Year Plan, while not mentioning the MDGs, has 20 monitoring targets that include 7 MDG targets and indicators, thereby showing even greater cohesion than the national plan. On the whole, there is very limited usage of MDG discourse in policy and a disjunction in targets and indicators, suggesting that national policymaking processes are not strongly influenced by the Millennium agenda. Yet several issues championed by the MDGs are addressed by a number of corresponding national and state policies and schemes which are thus furthering the achievement of the MDGs, although they may not explicitly say so.

Mexico

As in India, the MDGs have not formally entered national policy discourse in Mexico, but in this case, they also appear to have had negligible policy impact. Classified as a middle income country, Mexico's national figures show the country having achieved some MDGs, with the government raising the criteria under poverty, health and education to exceed the scope of MDG indicators. While this is true at the aggregate level, human development disparities within and between states are very pronounced, with 30% of all inequality (based on health, education and income) concentrated in 5 of the 32 states (Reyes, 2007). The MDG agenda therefore may be more relevant to the states with poorer development indicators. At the federal level, the Council for Evaluation of Social Development Policy (CONEVAL) is responsible for determining the nationally defined measurement of poverty which takes into account education gaps, access to health

services, basic household services, nutrition, social security, household size and quality and 'social cohesion' in addition to per capita income (Oportunidades, 2010). Long standing poverty reduction strategies such as Progresa (2007), later known as Oportunidades (2002) that have coordinated interventions in health, nutrition and education have not seen modifications to align with MDG targets, but they nevertheless cover areas of maternal and child health and primary and secondary education. In 2009, Chiapas, Mexico's poorest state amended its state constitution to be based on the eight MDGs (UNDP, 2010), and has been carrying out a MDG adoption strategy in its State Development Plan, but there is little evidence of this coherence with the MDG agenda being reflected nationally.

A newspaper content analysis conducted in a nationally circulated Mexican daily showed that there was a rise in articles that mention the MDGs only in 2005, coinciding with the mid-term country report, but there was little media response to the MDGs in the first years of launching or in other years. Only 34% of articles in the tracking years referred to the MDGs in relation to Mexico, which could further corroborate the lack of ownership of the MDG agenda (Troncoso, 2010). A prioritization of maternal and child health, however, has intensified since the 1980s as a result of structural adjustment and market-oriented reforms that altered Mexico's approach to social development from universal protection to targeted assistance (Batthyany and Correa, 2010). This has inadvertently created greater coherence with the health priorities of the MDG agenda.

It is worth noting that the MDG framework is centrally defined by the subject of poverty, and regardless of the degrees of influence of the MDG agenda on the policy environments of Mexico, Nigeria and India, poverty alleviation plays a substantive role in national discourses on development. The following section discusses key poverty reduction strategies employed in the three countries, the ways that they have impacted gender equity and their scope for addressing women's health, including SRHR.

Poverty reduction strategies and women's health and empowerment

Using gender as a lens is critical for assessing progress in the area of poverty alleviation. The impact of poverty is more severe on women in that they earn less than men, are in more vulnerable forms of labor, are less educated, consume less, and have fewer means to overcome poverty. The specific ways poverty impacts women have been recognized directly or indirectly by policy in these countries. However, whenever there has been poorer recognition of the gendered implications of poverty, poverty reduction strategies have had a negative impact on women or have contributed to only superficial improvements.

Government poverty reduction strategies that impact women have largely adopted three approaches in India and Nigeria and Mexico, (a) reservation for women in social welfare programs, (b) targeted income generating programs for women through self-help groups, and (c) women as beneficiaries of conditional cash transfer (CCT) programs. These approaches have had varied implications for women's health and empowerment and have been limited in addressing SRHR.

Reservations: India and Nigeria stipulate roughly 30% as a minimum reservation for women in government programs. In India this has resulted in some favorable outcomes in the national wage employment and self-employment programs. Women have exceeded the mandated proportion of beneficiaries making up nearly 50% in the National Rural Employment Guarantee Scheme (NREGS) and over 70% national self-employment scheme. NREGS, the wage employment scheme for rural families living below the poverty line, has contributed somewhat to equalizing wages between men and women. And in a country where poverty is caste and ethnic-specific, it has also been sensitive to the inclusion of socially marginalized groups (scheduled caste and scheduled tribes). Although the establishment of bank accounts for the payment of wages has been largely in the name of a male household member in some states (Khanna, 2011) it has been found to increase women's self-collection, retention and decision making power

over the usage of a portion of their wages (Pankaj and Tankha, 2010). This is crucially important in a country where one in five women lacks control over her earnings. It has also resulted, albeit unintentionally, in greater consumption effects compared to cash payments given directly to the male household member (Pankaj and Tankha, 2010). Yet a number of limitations in terms of women's health and empowerment are still observed. In some states single, divorced or separated women have been excluded from enrolment due to narrow criteria for household eligibility (Pankaj and Tankha, 2010), thereby excluding the most economically vulnerable. The long hours of physically intensive work, poor provision of crèches and toilets combined with the absence of any health supplement has contributed to lower participation rates of younger women with children. With a backdrop of high levels of anemia for women at reproductive age across India, in some cases the scheme has been perceived to even worsen women's health (Khanna, 2011).

Self Help Groups: Women comprise the majority of the national self-employment scheme in India, which has contributed to increasing women's access to micro-credit and income through the creation of more than 3.7 million self-help groups (SHGs) responsible for bringing over 92 million families, according to government estimates, above the nationally defined poverty line since its inception in 1999. Nonetheless, it has failed to significantly impact women's ownership of assets and has not challenged gendered divisions of labor. The usage of loans attained from self-help groups based on micro-studies has also been gendered, with loans being used for *dowry* for female children of beneficiaries, and towards education more often for male children. Though some group members have additional roles as village health workers and members of patient welfare committees, SHGs have largely been underutilized for health promotion activities, especially in the area of SRHR. Policy efforts to increase women's ownership of assets have been made through the implementation of *Indira Awaz Yojana*, a national rural housing scheme for the poor, but there were operational challenges as the housing titles were allotted to women or in the joint name of the wife and husband when men largely continue to own the land. No national level data exists on women's ownership of assets,

therefore tracking progress in this area is a challenge although some effort is now being made by researchers to fill this gap (Swaminathan et. al, 2011).

Conditional Cash Transfers: Adopted by the Mexican government since 1997 and more recently in Nigeria, conditional cash transfer (CCT) programs are based on the principle that compensating for monetary and opportunity costs of education and basic healthcare will aid poor families in investing in human capital to overcome intergenerational poverty (Holmes and Slater, 2007). *Oportunidades*, Mexico's key poverty reduction program, has been estimated to support nearly a quarter of the population (25 million). It has been credited with lowering poverty, improving the educational attainment of children, and the health of families by making women the recipients of CCTs in exchange for ensuring regular school attendance by children and preventive health-care visits. It is gender sensitive insofar as being more incentivized for female educational attainment and that much of the preventive healthcare is related to maternal and child health. The interventions in health specifically involve nutrition for infants, children and pregnant or lactating women and preventive and promotive healthcare includes mandatory family planning education for women and youth in order to avail of the financial benefits of the program. But barriers in the selection process are evident in the Opportuninades program as well. Bias and corruption coupled with narrow eligibility criteria (i.e. primary education enrolment of children, condition of houses etc.) have contributed to leaving out some of the most marginalized women. Crucially, making women the principal beneficiaries of cash transfers, though widely accepted as being more efficient in improving the well-being of households, has been criticized for making women 'household poverty managers', utilizing the existing gendered division of labor by reinforcing women's roles defined purely as mothers and caregivers (Batthyany and Correa, 2010).

Nigeria's CCT program, In Care of People (COPE), reflecting similar guidelines, was initiated by the National Poverty Eradication Programme (NAPEP) in 2007 and is funded in part by MDG-DRGs. Although the program language does not mandate women as

beneficiaries for the CCTs, they are found to usually bear the responsibility as a result of the focus on child health and children's education attainment. Nigeria's program however makes efforts to target women-headed households, households headed by people living with HIV/AIDS (PLWHA) and victims of vesico-vaginal fistulae (VVF), offering not only cash transfers but skills training and micro-enterprise start-up funds (NAPEP, 2010), reflecting awareness of the economic impact of sexual and reproductive morbidity. CCT programs therefore can have scope for addressing poverty more holistically, especially the nexus of poverty and health.

Millennium Villages: Although the MDG agenda permeates key policies and programs for poverty alleviation in Nigeria, closer examination of the country's Millennium Villages Project in the state of Kaduna was undertaken by the DAWN project in order to see whether an 'ideal' MDG model for poverty reduction has the capacity to adequately address women's health and empowerment and incorporate SRHR holistically. Assessment of the project has shown that it significantly impacted female enrolment in primary education, increased women's access to micro-credit, skills and agricultural inputs and improved women's involvement in community decision-making processes. The beneficiary identification system addresses polygamous marriages with the second and third wives of men, typically the more marginalized and less empowered, identified as heads of individual households entitled to equal agricultural inputs.

On the other hand even though primary healthcare has been made available and accessible to women and husbands are required to accompany their wives on at least one antenatal care (ANC) visit during pregnancy, services related to SRH are restricted to maternal healthcare and family planning. The Project has also been faulted for not addressing adolescent SRHR despite the high prevalence of early marriage. A new partnership between the Millennium Villages Project and the United Nations Population Fund (UNFPA) launched in December 2010 (UNDP, 2010) could potentially widen the scope of SRHR addressed under the project but this is yet to be assessed. The MVP model is considered a success and is being scaled up. But aside from its insufficiency in

addressing a life cycle approach to SRHR, the initiative remains highly donor driven with 70% of the funding coming from donors. The sustainability of its achievements therefore remains in question (Surma and Okpe, 2010).

HIV / AIDs: In both Nigeria and India, there has been comparatively greater recognition of the linkages between poverty and HIV/AIDS compared to other areas of SRH, with the exception of VVF in Nigeria which has been addressed through income generating activities and the CCT program. Nigeria's World Bank funded national FADAMA Project with the Ministry of Agriculture for poverty reduction includes the dissemination of information on HIV/AIDS as part of their capacity building activities. Also, as mentioned before, the CCT program in Nigeria targets households headed by PLWHA. At the state level, Kaduna's Ministry of Poverty Alleviation has had limited coordination with the state Ministry of Health in terms of programmatic planning and action, yet appears to work with the State Agency on HIV/AIDS. In the Indian state of Tamil Nadu, SHGs have been used to promote HIV/AIDS awareness but not broader women's health and SRHR issues. The recognition of the impoverishing effects of HIV/AIDS due to loss of work and economic opportunities is therefore better recognized than other SRH morbidities.

The Nigerian picture exhibits a multitude of programs, policies, ministries and agencies that are all working toward poverty alleviation, but with very little coordination and some level of duplication. The existence of silos in funding is also a barrier to implement integrated approaches to poverty and SRHR at the government level, even though there have been successful interventions among civil society organizations that look at poverty alleviation more comprehensively. Poverty reduction strategies on the whole have failed to adequately address the relationship between poverty and health more generally and sexual-reproductive health and rights more specifically. While budgets for poverty alleviation have increased in India and Nigeria, public spending on health has been stagnant or decreased in all countries. Given fiscal restrictions and varying prioritization of the MDG agenda, the next section will examine how SRHR is addressed by the three countries, and developments that have prevented or promoted advancements in SRHR.

Fragmentation of SRHR

All three countries - Nigeria, India and Mexico - have large populations at reproductive age and fertility remains high in some regions within these countries and more pronounced among particular ethnic and caste groups. National contraceptive prevalence rates range from 15% in Nigeria to 72.5% in Mexico, but unsafe abortion is still among the leading causes of maternal death in all countries. The three countries also have comparably large populations between the ages of 10-24, standing at 29%, 30% and 34% of the total population of Mexico, India and Nigeria respectively (PRB, 2006). Early marriage is widely practiced in Nigeria, in some of the poorer states and districts of India and parts of Mexico. It usually goes hand in hand with poor knowledge about sexuality and reproduction, and lack of empowerment and agency for girls and young women to assert their rights. In such contexts in particular, comprehensive approaches to addressing SRHR that include, *inter alia*, information and education, and access to services are critical to meeting the sexual and reproductive health needs, and securing the rights of these young people. To what extent the MDG agenda has actually focused attention on these needs is unclear.

Adolescent fertility rate (births per 1,000 women 15-19 yrs)

Country	2000	2009
Mexico	74	63
Nigeria	135	118
India	88	64

Source: United Nations Population Division, World Population Prospects

SRHR to MCH & HIV/AIDS: Despite varying degrees of MDG influence on policy agendas there has undoubtedly been increased attention to maternal and child health in the last decade. The increasing focus on MCH in Nigeria is in part due to the unacceptably high prevalence of maternal and infant mortality. Even after the inception of the MDGs, maternal mortality, IMR and under-five mortality continued to rise in the early 2000s. By 2005, the maternal mortality ratio stood at 1,100 per 100,000 live births, one of the highest in the world, and infant mortality at 79.49 per 1000 live births, justifying the

need for a strong MCH focus in public health programs. As mentioned, the CCT adopted by Nigeria in 2007 has been focused on child health services, specifically immunization against childhood diseases. The Integrated Maternal, Newborn and Child Health Strategy introduced in the same year includes the Basic Health Insurance Scheme that would provide free services for pregnant women, newborns and children under five. The state of Kaduna, as a site for more intensive and coordinated action towards the attainment of the MDGs, has introduced the flagship program for free MCH services supported by the OSSAP-MDGs. In addition there is also the Safe Motherhood Programme, National Vital Registration System and the Making Pregnancy Safer Initiative. But with high fertility and adolescent fertility, poor contraceptive prevalence, early marriage, polygamy and the practice of female genital mutilation (FGM), there are wider determinants to women's health that are clearly not being addressed by systematic policy.

Concurrent with the rise in MMR and IMR and the sanctioning of MDG-DRGs, developments to revive commitments to the ICPD took place in Africa through the Continental Framework on SRH Rights in 2005. The Continental Framework, operationalised through the Maputo Plan of Action, includes the SRH components of the MDG agenda by promoting the increase of access to quality safe motherhood and child health services, the integration of HIV/AIDS services in primary healthcare, and has since acknowledged the reproductive health target and indicators under MDG 5b[vii]

Though the Maputo Plan shows coherence with the MDGs, it goes far beyond the MDG framework by promoting a life cycle-approach to SRHR, addressing adolescent SRHR, advocating for an increase in health spending on SRH and emphasizing the importance of addressing poverty and SRHR as mutually reinforcing. It is important to note that one of the nine areas of action under the Maputo Plan, strengthening community based SRH services, was dropped from Nigeria's corresponding national Plan of Action. Nevertheless, a host of national policies on gender, reproductive health and adolescent SRHR have been developed in the last decade in Nigeria, revealing a rich SRHR policy environment in the MDG era. Despite this, maternal health has seen more policies

converted into programmatic action. Given the environment of lowered public health spending, MCH has received financial backing through DRGs, indicating a clear correlation between the institutionalization of the MDG agenda and implementation of MCH initiatives. There is no available disaggregated data on health spending for SRH, yet it is clear that political will and funding is being channeled towards the SRH components of the MDG agenda (Surma and Okpe, 2010) i.e. MCH and HIV/AIDS, and not to the other elements of the Maputo Plan of Action. Sexual and reproductive health and rights activists in Nigeria continue to lobby with the government to implement the country PoA of the Maputo Protocol.

As discussed before, India has had a long and contentious history of family planning programs and the National Population Policy 2000 was critical to the explicit incorporation of SRHR into policy. Unfortunately, due to the distribution of powers in a federal system, and because health is actually a subject of state level responsibility, a number of states have adopted targeted approaches to reducing fertility enforced through a number of disincentivizing mechanisms, reflecting the traditional belief that population growth is an impediment to social and economic development. Conversely, the state of Gujarat has developed a more gender sensitive population policy, thanks to the long term involvement of civil society advocates in favor of SRHR. India's World Bank funded Reproductive and Child Health Program (RCH), first introduced in 1997 was also considered an outcome of its commitments to the ICPD. Apart from safe motherhood and child health the program is meant to address broader SRH needs including treatment of RTI/STIs and adolescent reproductive health education.

Since 2005, the RCH merged with the larger National Rural Health Mission (NRHM) which has a strong leaning towards MCH. Furthermore, monitoring indicators for the RCH program have been limited to IMR, MMR and contraceptive prevalence rates. Infertility care has been nearly absent within the program and as of 2008, and only 3% of women had access to pap smears and 2% to mammogram services. In line with its focus on MCH, the NRHM instituted the *Janani Suraksha Yojana* (JSY), a national maternity benefits

scheme which operates as a CCT program. The scheme provides cash transfers in return for women choosing institutional delivery and is meant to enhance access for socially and economically marginalized groups such as *dalits* and tribals[viii].

Despite its achievements in raising the rates of institutional deliveries in the country, studies have shown that the poorest and least educated women have less chance of becoming recipients. A strict eligibility criterion excludes women who are under the age of 19 and those with more than two children – an unfortunate throwback to the use of disincentives intended to promote late marriage and family planning. It fails to address more fundamental issues of women's limited control over their own fertility, excluding some of the most marginalized and vulnerable sections of women and undermining reproductive rights in the process.

Even in the face of limitations of SRHR policy and programs in India, sexual rights have gained some legitimacy through legislation with same-sex relation being decriminalized in 2009 as well as the decriminalization of sex work[ix]. In the state of Tamil Nadu the health of transgender communities is beginning to be addressed with a state welfare board set up for this purpose, reflecting a significant step toward recognizing alternate gender identities. Free medical check-ups for sex workers, men who have sex with men (MSM), transgenders and free sex-reassignment surgery (male to female) for transgenders are also said to be provisioned in specific hospitals in the state capital. On the national platform however, there is still great discomfort in addressing sexual rights. Even the decriminalization of sex work and same sex relations is perceived to be more influenced by the government's efforts toward HIV/AIDS prevention, rather than rooted in the assertion of the sexual rights of individuals (Khanna, 2011).

While there has been political will and funding to address HIV/AIDS which has necessitated dialogue on sexual health, largely through the National AIDS Control Program (NACP), this has not been integrated into a comprehensive SRHR framework. Though practically all other national programs under the Ministry of Health and Family

Welfare have been merged under the NRHM, the NACP still functions independently with state offices across the country. Donor support and government funding increases have also been greater for HIV/AIDS compared to basic services such as immunization, contraception and other aspects of maternal health care. Counseling largely remains in the area of prevention of HIV/AIDS, and though the NACP addresses the human rights issues of PLWHA, the reproductive health needs of women living with HIV/AIDS are not mentioned. In 2005 the Protection of Women from Domestic Violence Act was passed, but the effects of physical and sexual violence on pregnancy and the spread of STIs/HIV is not addressed by the NACP or the Reproductive and Child Health Program. Women are to undergo compulsory HIV screening during ANC, but there is no screening mandated for their partners. Condoms still make up a very small portion of contraceptive usage among sexually active populations, female sterilization being the most common method adopted (Khanna, 2011). Therefore it appears that a holistic SRHR framework is not being upheld by any policy or program but is instead caught between two silos - maternal health and HIV/AIDS.

In India non-governmental actors have played an important part in shaping the SRHR policies in the country. A civil society review of the ICPD in 2008 brought together diverse organizations and networks working on gender, health and rights and population issues which facilitated constructive engagement and strengthened dialogue between civil society and government on a number of cross cutting issues. On the whole, the most significant opportunity for coherence between these issues has and will be through the emergence and the ongoing developments of rights based legislations (realized through pressure from social movements). This has already resulted in the right to work; protection from domestic violence; and women's participation in local government among other legislations (Khanna, 2011). The right to food, health and non-discrimination for people with HIV/AIDS could influence the SRHR policy environment once passed, but there is little progress in such a direction thus far.

Mexico's active role in the ICPD and Beijing conferences and an ICPD follow up commission (made up of state agencies, feminist NGOs and academics) led to several progressive actions in the area of SRHR. Policy was impacted and in turn expanded to cover not only areas of prenatal, postnatal care and maternal morbidity but reproductive rights within family planning programs, post-abortion care, cervical cancer screening and gender-based violence (Batthyany and Correa, 2010). Unfortunately health sector reform beginning in the early 2000s reduced universal healthcare shrinking the broader scope of SRH to basic insurance packages limited to MCH. Subsequently, the reproductive health policy introduced by the conservative National Action Party also focused heavily on infant and maternal mortality. In this new political climate, higher insurance premiums were enforced for women at reproductive age due to institutional delivery and obstetric risks (Batthyany and Correa, 2010) and stringent cutbacks were observed in the availability of SRH services for adolescents. In addition, reproductive health problems that are more likely to affect older women such as cervical cancer were also poorly addressed by the public health system (Langer and Catino, 2006). Therefore commitments to a life-cycle approach to SRHR advocated by the ICPD were left unfulfilled.

A national survey conducted in Mexico showed a decrease in the number of women obtaining contraceptives from the public sector (both the Mexican Social Security Institute that covers private sector workers and the Institute for Social Security of State Workers) and an increase in the private sector. In 2006 32% of women obtained contraceptives from private services compared to 28% in 1997, and with adolescents, this figure rose to 50%. The study also showed that among adolescent women, 94.5% obtained contraception for birth spacing (Troncoso, 2010).

However, even within a climate of fiscal restrictions for public health services and growing religious conservatism, some positive achievements for SRHR have taken place. The emergency contraceptive was included in the national family planning guidelines, and despite strong religious opposition, same-sex marriage as well as first-trimester abortion were legalized in the Federal District, with varying degrees of liberalization of

abortion laws in other parts of the country. In response to this achievement however, religious conservative forces have strengthened, pushing constitutional changes in 17 states that recognize life from the moment of conception. The resistance to abortion rights is contradictory to efforts to improve maternal health. In the context of rises in chronic illnesses such as obesity, diabetes and hypertension, pregnancy can present a risk to women's right to health without the option of safe and legal abortion. This is reflected in the rise in indirect obstetric deaths[x] between 1990 and 2008. A civil society-government partnership has been launched (initiated by Mexico's civil society) called 'Maternal Mortality Watch' which has set out to analyze public policies, monitor maternal health programs, and increase accountability for reducing maternal mortality (Troncoso, 2010).

Abortion: Despite efforts by governments to improve maternal health in all three countries, and given the contribution of unsafe abortion to maternal mortality, safe and legal abortion is still far from universally accessible. Though India has been a pioneer in the area of legalizing abortion with the passage of the relatively liberal Medical Termination of Pregnancy Act in 1971[xi], lack of access to safe abortion services and post-abortion care is still a critical issue. In Mexico abortion rights have been a part of the feminist agenda since the 1970s and although there has been progress, a number of legal restrictions remain for the majority of the country. The nation has some of the highest abortion rates in the world with an estimated 800,000 abortions taking place every year, of which a very small portion are legal abortions performed in hospitals (Juarez et. al, 2008). In the nine months that followed the legalization of first-trimester abortion in the Federal district over 53,000 abortions were conducted, of which only 17% were for married women but 47% were in the 18-24 age group. Overall between 2000 and 2008 Mexico has seen a rise in hospitalizations due to unsafe/induced abortions. In Nigeria, teenage pregnancy is on the rise and it is estimated that nearly 610,000 induced abortions are performed every year and 10,000 women are estimated to die of complications due to unsafe abortion annually (SOGON, 2004). Though a number of policies related to women's and adolescent empowerment and SRHR have been

formulated in Nigeria since 1995, the conditions for legal abortion are still restrictive. Mortality and morbidity related to unsafe abortion is a big concern when reproductive health care is predisposed to childbearing within marriage (as it largely is in these government programs). The SRHR framework, already fragmented by an MCH focus, has been weakened further through the separation of abortion rights from its role in fulfilling safe motherhood and SRHR.

Adolescent health: The final aspect of the fragmentation of SRHR is in the manner that adolescent health and rights are addressed in India, Nigeria and Mexico. Despite the proportion of young people in the three countries, the incidence of early marriage, childbearing and rate of adolescent fertility; adolescent SRHR is not being seriously addressed or meaningfully linked with broader SRH outcomes. All three countries have programs in place that address adolescent health, and with varying degrees of directness, adolescent sexual and reproductive health and rights. In Mexico 'Youth with Opportunidades' focuses on incentives for adolescents to finish high school before 22, which involves mandatory educative workshops on SRHR in order to receive their financial benefits (Opportunidades, 2010). In Nigeria the 'HIV/AIDS Family Life Education' program was developed as a result of a number of policy initiatives around adolescent SRHR, however there has been reluctance to implement the program due to public reaction and opposition from faith based organizations. Despite the Adolescent Health Policy and the National Youth Policy coming into effect in 2007, there is also no dedicated budget for programs targeting adolescents and youth. In India the current Five Year Plan aims to empower adolescent girls through awareness on health, nutrition, skill development and 'youth affairs'. The National Youth Policy articulates adolescent sexuality in reference to HIV/AIDS, STDs and reproduction. But in terms of action, adolescent reproductive health education under the Reproductive and Child Health Program is poorly implemented and the SRH needs of boys do not appear to be addressed by any programs. As mentioned earlier, under the National Rural Health Mission, adolescent mothers (women below the age of 19) are excluded from the conditional cash transfer program for institutional deliveries. The Integrated Childhood

and Development Services (ICDS), a long standing nutritional program for women (largely targeting pregnant and lactating women and infants) has introduced a scheme to improve the nutritional status of adolescent girls, thereby expanding the MCH focus. But the adolescent health component of the ICDS has had the lowest implementation rates. HIV/AIDS on the other hand has to some extent presented a platform and the basis for governments to justify the need for adolescent SRHR education. In more proactive states like Tamil Nadu, youth groups are planned for use to spread awareness about HIV/AIDS. In all countries however, the incorporation and implementation of adolescent SRHR programs is influenced by the political parties in power in individual states, in addition to other moral-conservative and religious forces.

The lack of opportunities to access information on SRHR, safe SRH services, and the lack of agency and empowerment, especially among young women are coupled with poor economic conditions for young people too. In Nigeria, youth unemployment has been rising since 1999 and continued through the MDG era, with urban youth unemployment being the most pronounced (FGN, 2007). Youth unemployment in India also increased between 1993-4 and 2004-5 (Planning Commission, 2008). In Mexico, 15-19 year olds make up the largest group not registered with any health insurance system (44.8%) and as mentioned earlier, the climate of fiscal restrictions has resulted in severe cutbacks for SRH services for adolescents. Therefore the needs, health and rights of young people in all three countries seem to be marginalized by a lack of prioritization in the planning and implementation of programs, even when they are adequately addressed by policy (as in the case of Nigeria). Though adolescents are included in programs to address HIV/AIDS in India and Nigeria, this does not apply to safe motherhood programs in all countries, with great ambivalence around the subject of adolescent motherhood.

Limited progress on MDGs

None of the three countries are on track to achieve the MDGs related to poverty and health, although MDG 6 related to halting the spread of HIV/AIDS is likely to be achieved in India and Nigeria. According to the UNDP, Nigeria may also achieve the goals on

universal basic education (MDG2), ensuring environmental sustainability (MDG7) and developing a global partnership for development (MDG8). But the UNDP also states that a critical barrier to planning for achievement of the MDGs is the lack of up to date data on most of the indicators and limited funding for data generation and management.

In India, the state of Tamil Nadu is on track to achieve MDGs 3, 4 and 5. According to data from the National Family Health Survey (2005-6) there is no gender disparity in IMR in Tamil Nadu unlike India as a whole, and there is higher enrolment of girls than boys in secondary education (class 10-12). Tamil Nadu has increased investments in the public sector in health, unlike the state of Gujarat, which has allowed comparatively more privatization in healthcare, including PPPs for maternal healthcare financing. While access to ANC in Tamil Nadu is almost universal and 90% women access PNC within two days of delivery, the rest of the country shows a different picture. The state of Gujarat in which part of the field work for the DAWN research was done reflects the slower progress in the rest of the country. For instance, the proportion of women receiving full ANC in Gujarat actually decreased between 2002-4 and 2007-8 (IIPS, 2010), and the quality of obstetric care under Gujarat's PPPs has been heavily critiqued (Khanna, 2011).

Progress on the MDGs is measured based on national averages, which mask a number of disparities. As Kabeer (2010) argues, a number of intersecting inequalities within countries based on geographical region, ethnicity, class and in India, caste need to be addressed for the MDGs to be effectively achieved. In 2008 in India '*Wada Na Todo Abhiyan'* (translated as the 'Do Not Break the Promises' Campaign), a network of over 4000 development organizations across 31 states produced a citizen's report on the achievement of MDGs (Wada Na Todo Abhiyan, 2010), providing evidence of regional disparities and the marginalization of socially disadvantaged groups. In a country where caste overlaps with poverty, a *Dalit* MDG Shadow Report has also been produced and shows how *dalits* lag behind in the achievements on MDGs (Khanna, 2011).

India is not the only country where regional disparities are significant. Primary education completion rates range from 2% to 99% in Nigeria (UNDP, 2010), where the northern and southern regions have concentrations of different ethnic groups. Institutional delivery in Nigeria can also range from as low as 8% in the Northwest part of the country to 74% in the Southeast. Regional disparities are seen in Mexico too where around 75% of the country's indigenous population is concentrated in the southern states of Chiapas, Oaxaca and Guerrero which are less developed and have higher incidence of poverty. Maternal mortality can range from 27 per 100,000 live births in the northern developed state of Nuevo Leon to 128 per 100,000 live births in Guerrero (Kabeer, 2010). In India even within states such as Tamil Nadu that are on track to achieving MDG 3, 4 and 5 scheduled castes (SC) and scheduled tribes (ST) lag behind national or state averages. In the state of Gujarat, malnutrition among ST women is a staggering 94% (compared to 32.2% for all women) and 83% of children are underweight. In Mexico, the likelihood of unsafe abortion for a woman with less than 5 years of education and of indigenous origin is nine times as high as a woman outside these conditions. Therefore national aggregates and population averages must be treated with caution as they can mask significant disparities in the achievement of MDG targets.

Conclusions

In India, Mexico and Nigeria, poverty reduction strategies have not challenged root causes of gender inequality, have perpetuated gendered divisions of labor, and have reinforced women's roles as mothers and caregivers. The interface between poverty and health, although acknowledged by a number of policies, has not been tackled effectively through poverty reduction strategies, and this has been especially true for women. Moreover they have been very limited in integrating poverty and SRHR, with the exception of conditional cash transfer programs, which have had mixed results.

Although the Maputo Plan of Action advocates the inclusion of SRH services into poverty alleviation strategies, and mainstreaming gender issues into socio-economic development, Nigeria does not appear to be meeting these commitments. While there

have been some initiatives in Nigeria to address the impoverishing effect of VVF and HIV/AIDS, efforts to address gender inequality and SRHR more generally through poverty alleviation strategies have been limited. With the MDG agenda influence being strong in Nigeria, the weak linkages between the health-related MDGs and gender equality have limited the implementation of holistic SRHR frameworks.

In India there has been some attempt to address the linkages between poverty and HIV/AIDS but this does not extend to action to address the relationship between the rest of SRHR and poverty. There is also little inter-sectoral collaboration in interventions to address poverty, gender equality and SRHR in India and there is a failure by governments to strengthen this link. Though social movements have contributed to broadening the space for discussion and action around social equity, they have also been fragmented in their approach to women's rights to be able to effectively address the linkages between poverty, gender and SRHR.

Mexico's multi-pronged approach to poverty reduction to some degree includes SRHR components, but it is limited to the areas of maternal health and family planning information, with the struggle for safe and legal abortion posing a significant threat to improving maternal health.

All three countries have seen a focus on maternal and child health with other SRHR issues, with the possible exception of HIV/AIDS, receiving much less attention. In particular, excessive emphasis on MCH may have undermined attention to the health needs and rights of young unmarried women and men. While all countries have programs to address adolescent SRHR, in India and Nigeria sexual health and adolescent health are intrinsically linked to the prevention of HIV/AIDS, and political will remains weak in effectively implementing these programs. It appears that the holistic framework of SRHR envisioned by the ICPD and Beijing Conferences have been reduced to the reproductive health needs of women under the rubric of maternal health.

Universal access to sexual-reproductive health by 2015 as defined by the ICPD Programme of Action is not being realized in any of the three countries. Gaps and inequalities need to be considered against the backdrop of age, sex, socio-economic status, education, and ethnic, geographic and caste backgrounds, which the existing MDG framework does not provide. Finally, with the growing spread of religious conservatism in many parts of the global South, the pressure against governments addressing such issues as abortion and young people's sexuality has been growing despite the inclusion of target 5b in the MDGs agenda. At the same time, support for SRHR has been growing in many ways in civil society, through legal systems, through national and international human rights instruments and institutions. In this lies the hope that the SRHR agenda will be fulfilled for this and coming generations.

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[i] The research team was headed by Sonia Correa, DAWN Global Research Coordinator for SRHR. Country specific research and individual country reports were produced by Ngukwasa Surma and Mary Okpe for Nigeria; Renu Khanna with assistance from Anagha Pradhan for India; and Erika Troncoso Saavedra for Mexico.

[ii] The choice of locations was largely dictated by expediency depending on where the country team coordinators were based

[iii] Puebla was the chosen site for FGDs and in-depth interviews because of its comparatively high maternal mortality levels, large numbers of beneficiaries of social programs, and poor ranking on the Human Development Index.

[iv] Components of SRHR in the Maputo Plan include: Adolescent Sexual and Reproductive Health (ASRH); Safe Motherhood and newborn care; Abortion Care; Family planning; Prevention and Management of Sexually Transmitted Infections including HIV/AIDS; Prevention and Management of Infertility; Prevention and Management of Cancers of the Reproductive System; Addressing mid-life concerns of men and women; Health and Development; the Reduction of Gender-based Violence; Interpersonal Communication and Counselling; and Health education. (The African Union Commission, 2006)

[v] Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex

[vi] The Human Poverty Index (HPI) was first introduced in the 1997 UN Human Development Report. HPI for developing countries is essentially a measure of whether people are being *deprived of:* a long and healthy life; depth of knowledge and understanding about the world around them; and a decent standard of living. It therefore represents an inverse correlation to the human development index (UNDP, 1997)

[vii] The original MDGs did not include any reference to sexual and reproductive health. Therefore women's groups spent a number of years advocating for an MDG target on universal access to reproductive health which was finally included in 2007 as MDG 5b. (Nowicka, 2010)

[viii] 'Tribals' is the accepted term in India for people who are viewed as the original forest dwellers, *dalits* the lowest castes.

[ix] Legal reforms to sex work in India have been in light of strong debate among sex worker unions, human rights, HIV/AIDS and other advocacy groups on the benefits of decriminalising vs. legalising sex work.

[x] Those deaths resulting from previously existing disease or disease that developed during pregnancy and which was not directly the result of obstetric conditions, but which was aggravated by the physiologic effects of pregnancy(UNFPA)

[xi] The Medical Termination of Pregnancy Act (1971) was amended in 2002 and 2003 to include approval of medical abortion, decentralizing regulation of abortion services to the district level and punitive measures to prevent unsafe abortion (Hirve, 2004).

CHAPTER 2: MEXICO CASE STUDY

MDGs and SRHR in Mexico Social Programs: So Near and Yet So Far

Erika Troncoso

Introduction

Despite interest sparked by the Millennium Development Goals (MDGs) in the international arena, Mexico has only seen a small impact throughout the decade. The MDGs began in the year 2000 with the signing of a major international agreement to eradicate poverty and some of its effects, such as maternal and child mortality. In that year, Mexico underwent an historic change in power: the party that had ruled the country's government for over seventy years – the Institutional Revolutionary Party (PRI) was unseated, and the right-wing party – National Action Party (PAN) took office. Ten years after these events, MDG5, which is related to maternal mortality continue to be unreachable in Mexico. Shifts in political power seem to have merely contributed campaign promises, instead of genuine structural reforms in the country.

When Mexico signed the MDGs, the country's economic growth looked auspicious. However, since the year 2000, the macroeconomic indicators for Mexico posted a downward trend. Largely, this was a result of the global economic crisis and that of being a dependent economy. The list of MDGs includes some that had already been achieved in Mexico, even before signing the international agreement. Two MDGs remain Mexico's current challenge: MDG 4, related to child health and under-five mortality rate; and MDG 5, related to maternal health. Even though MDG 4 will not be reached, the demographic trends and the continued implementation of public policies that privilege immunization and an increase in child schooling coverage are factors that will help bring Mexico closer

to this goal. MDG 5, linked to the challenges of the Cairo agenda, will be analyzed in detail below.

Sexual and reproductive rights have long been a topic of research in Mexico. However, little attention has been paid to the interaction between public policies, progress made on indicators and their presence in political discourse. This report assumes that the Millennium Development Goals are at the forefront of a global discussion, with public policy implications that can have an impact on women's health. In order to understand this relationship, this paper analyzed Mexico's progress towards reaching the MDGs in four distinct areas in 2010. First, in the background section, we analyzed the progress made on reproductive health based on the indicators used by the country to enable us to identify the strengths and weaknesses women face in the public health system. In the background section, we also mapped out the maternal mortality trends from 1990 to 2008. Secondly, we conducted face-to-face interviews with beneficiaries and non-beneficiaries of social programs in a Mexican state in order to bring to the fore the voices of women. Then, through an analysis of the contents of Mexico's widely circulated newspaper – the *Reforma* – we examined the political discourse surrounding the MDGs to help us understand their impact on the design and implementation of public policies. Finally, we illustrated the progress on decriminalizing abortion in Mexico City in 2007. The selection of these topics was based on the implications of the MDGs on current public policies, set against a framework of health and comprehensive sexual and reproductive rights.

While the Mexican indicators on this topic demonstrate trends of improvement in the long term, in reality there are serious problems of inequity and progress takes place at a slow pace due to the absence of clear public policies that directly address the current situation. This study presents reproductive health data drawn from a recent survey, an analysis of maternal mortality trends, and future challenges.

The MDGs have been a frequent topic of discussion in international social policy and much has been written on them since 2000. One of the biggest successes achieved by the MDGs, beyond developing indicators with quantifiable impact, has been to standardize and introduce a common language across countries when discussing development. Despite this, we hypothesize that the use of this common language failed to influence the design of national public policies. In order to put this hypothesis to test, we conducted a newspaper content analysis on the topic of the MDGs in a national newspaper.

There are over 120 federal social programs in Mexico. Every Secretary of State is in charge of various programs. For example, the Ministry of Social Development (*Secretaria de Desarrollo Social – Sedesol*) is in charge of some of the largest and longest running programs such as *Oportunidades* and *Liconsa*. In addition, it is common for state governments to design and implement their own social programs that do not necessarily link up to federal programs. For the purpose of this report, we examined three types of social programs: money transfer programs; social service programs; and infrastructure programs. Challenges encountered in the research process include: a) difficulties faced in tracking beneficiaries, as well as the absence of a clear process and criteria that defines the target beneficiaries of government programs examined in this paper; and b) the consistent unavailability of impact evaluations that would have defined basic indicators used by programs, such as program cost-benefit analysis, the estimated time necessary to bring the target population out of extreme poverty, and attempts to coordinate with existing and complementary social programs).

Oportunidades is one of Mexico's oldest social programs[1] which, since 1994 and under various names, has provided monetary subsidies to families in extreme poverty. Since its inception it has continued to grow. Currently, more than five million families are program beneficiaries. Another Mexican social program is the Public Health Insurance Program (*Seguro Popular de Salud – SPS*)[2], an insurance scheme implemented by the Secretary of Health in 2000, which is part of the government's Social Health Protection (*Protección*

Social en Salud). There are a number of studies that evaluate the impact of *Oportunidades* and SPS. Civil society organizations are among those that have consistently monitored the impact of these programs, especially in terms of maternal mortality[3]. For the purpose of our research, we interviewed women from Sierra de Puebla in order to understand how these programs have had an impact on their lives, from their own view point.

Background Information

Over the past decades, Mexico has consistently experienced rapid demographic transition. To date, this demographic transition continues to take place[4]. Based on data drawn from Mexico's 2010 census[5], the population is at 112,322,757, with females accounting for nearly half of the population (INEGI, 2010). Adolescents make up 21.7% of the population, and approximately 53% of all females are in their reproductive age (15-49 years). This translates to over 2.5 million people in ages between 10 and 19. A total of 4,146,076 adolescent females live in towns with less than 15,000 inhabitants. Among the adolescent females falling in the age group of 15 to 19 years, 0.7% does not receive schooling, and 10.7% has only completed (or partially participated in) primary school.

Demographic trends are not uniform throughout Mexico as these depend on social and economic conditions in the states. Maternal mortality is considered an indicator of the level of development in states. In 2009, Guerrero and Oaxaca, two of the poorest states in Mexico showed higher levels of maternal mortality (106.2 and 95.3 per 100,000 births), in contrast with the national level of 62.8 per 100,000 births. According to official figures and national surveys, the total fertility rate in Mexico has steadily declined from 5.7 children per female in 1976, to 2.2 in 2009. Chiapas, Guerrero and Oaxaca have the highest fertility rates in Mexico (2.5-2.6 per female).

In spite of the government discourse that more than half the population has health insurance coverage, survey results showed that participation in any type of health service

barely reaches 62.3% of all Mexicans (National Population Council, 2009). 37.6% of the population is not registered in any insurance system, with a higher percentage of unregistered males (39.4%) than females (35.8%). The largest non-registered age group is 15 to 29 year olds at a rate of 44.8%. Looking at marital status and age group, single men and women between the ages of 15 and 29 have the highest non-registration rate: 65%. Among single men between 15 and 29 years old, seven out of ten (72%) are not registered in a single health institution, compared to six out of ten (58.3%) of single women in the same age group.

Of all adolescent women between 15 and 19 years old, 12.7% (688,544) have been pregnant. This percentage rises to 46% for young women between 20 and 24 years old. Among those who live in towns with less than 15,000 inhabitants, the proportion of women who have been pregnant increase to 13.5% for adolescents, and to 56.4% for young women. 11.6% of adolescents between 15 and 19 years old have one (9.8%) or more children. For every 1000 live births, 20% were born to women in this same age group.

The Global Fertility Rate (GFR) in Mexico is estimated to be 2.2 children for every woman in 2006-2008 compared with the National Survey of Demographic Dynamics (ENADIO) estimates of GFR at a little under 2.1 for 2006. Among women living in towns with less than 15,000 inhabitants, the GFR was estimated to rise to 2.8 in 2003-2005 and 2.7 in 2006-2008. The Specific Fertility Rate (SFR) among adolescents (15 – 19 years old) is estimated at 70.7 children per 1,000 adolescents in 2003 – 2005, and 70.4 in 2006 – 2008. However, among adolescents who live in towns with less than 15,000 inhabitants, the SFR rises to 93.4 children per 1,000 adolescents in 2003 – 2005, and 82.5 in 2006 – 2008. These numbers represent a setback with respect to the latest ENADID estimates that calculated a SFR of 82 in 1997, and 63 children per 1,000 adolescents in 2006.

Of all women between the ages of 15 and 49 who have been pregnant at least once, 52% (15,338,684) do not want more children; 4.6% (703,598) of them are women

between 15 and 19 years old. Of the women who do want more children, 38.1% (13,381,536) opt to wait 5 or more years after their last obstetric procedure. This group is among the many women in need of contraception in Mexico.

The ideal number of children for Mexican women is 3.3. Reproductive aspirations are strongly correlated to socio-economic variables: 14% of professional women believe that one is the ideal number of children; among women with no education, 29.1% believe that five or more children is the ideal number, whereas only 2.6% of women with higher education share the same ideal. Among women who speak indigenous languages, six is the ideal number.

There is a clear relationship between knowledge of contraceptive methods and socio-economic and demographic indicators. While only 2% of all women of reproductive age (15 to 49 years old) are unaware of contraceptive methods, this percentage is 3% among women between 15 and 19 years old, 15% among women who speak indigenous languages, and 17.5% among uneducated women. The same relationship exists between contraceptive use and socio-economic status. At the time of the survey, 49.9% of all women 15 to 49 year old were registered as using a contraceptive method, 14% use occasionally, and 36.1% have never used contraception. Among indigenous women, these percentages are 43.3%, 10.1% and 46.6%, respectively. Similarly, only 10% of adolescent women 15 to 19 years old currently use a contraceptive method, 6.7% are former users, and 83% have never used any form of contraception.

According to marital status, 72.5% of women of reproductive age who are in a relationship use contraception, 49.5% of women formerly in relationships, and 12.5% of women who are not in relationships use contraception. Among all contraception users in ages 15 to 49, over half use permanent methods (48.8% tubal ligation and 2.7% vasectomy), 28% use an intrauterine device (IUD), 14.2% hormonal methods, and 6.3% use traditional methods. Among adolescent contraceptive users, 62% use non-hormonal methods and 28.9% hormonal. It is important to note that 1.2% of the age group 15 to 49 have already undergone tubal ligation.

Of all women using contraception, the proportion that obtains contraception from the Mexican Institute of Social Security (IMSS)/ *Oportunidades* has shown a declining trend: 35% in 2009 vs. 41.4% in 1997 and 38% in 2006. Additionally, 4.7% obtain contraception from the Institute for Social Security and Services for State Workers (ISSSTE), and 7.9% from the Secretary of Health/ SPS. In the survey, 16.4% of women should co-pay a fee.

Finally, almost one in every three women (32%) obtains their contraception through private services (14.8% through private health services, and 17.1% in pharmacies or self-service stores) compared to approximately 28% in 1997. Nevertheless, a little more than half (50.9%) of adolescent women purchase their contraception in pharmacies or in private medical practices; only 14.7% obtain contraception through IMSS/ IMSS *Oportunidades*, 13.3% through nominal fees received from the Secretary of Health/SPS and 16.3% obtain it through SSA[6] nominal fees. Preventing pregnancy was the reason for contraception use among 54.1% of all contraception users, followed by birth spacing 38.3%, medical reasons 6.4% and other reasons 1.1%. Among adolescent women, 94.5% used contraception for the purpose of birth spacing, meaning that they had already given birth or have been pregnant.

It is important to highlight that 68.4% of former contraceptive users stated that they stopped using contraception due to "no longer needing it", 10.3% because they wanted to become pregnant, some 5% for fear of side effects, and only 0.4% because their partner did not want them to use contraceptives anymore. 81.2% of adolescents who stopped using contraception did so because they no longer needed it, and 4.3% because they are hoping to get pregnant.

Only 28.3% of women between 15 and 49 years old that used contraception at least once used it for the first time before their first pregnancy; 71.4% of women began taking contraception after having one or more children. The percentage of women who began using contraception before their first pregnancy dropped to 11% among indigenous women and a little under 4.2% among women with no education. However, the rate rises to 69.7% among women who, at the time of the survey, were between the ages of 15 and 19 years old.

Among adolescents, 25.4% stated they have had sex; 15.6% of them did not use any contraceptive method during the first time. The average age of women having sex for the first time among 15 to 49 years old, was 19.

Of all pregnancies, 95.2% had a prenatal check-up with a doctor, and 97.3% of all check-ups with a health professional, with an average of 7.4 total prenatal visits. Prenatal care provided by doctors in towns with less than 15,000 inhabitants was 91.5%, and 97.5% in towns with more than 15,000 inhabitants. Baja California and Nuevo León averaged the highest in prenatal visits with 8.5, and Chiapas having the lowest with 6.1. Official survey data does not refer to the percentages of births attended by physicians. 43.2% of all births were delivered by cesarean section. 1.8% of all live births weighed less than 4.4 pounds (2,000 grams).

Maternal Mortality

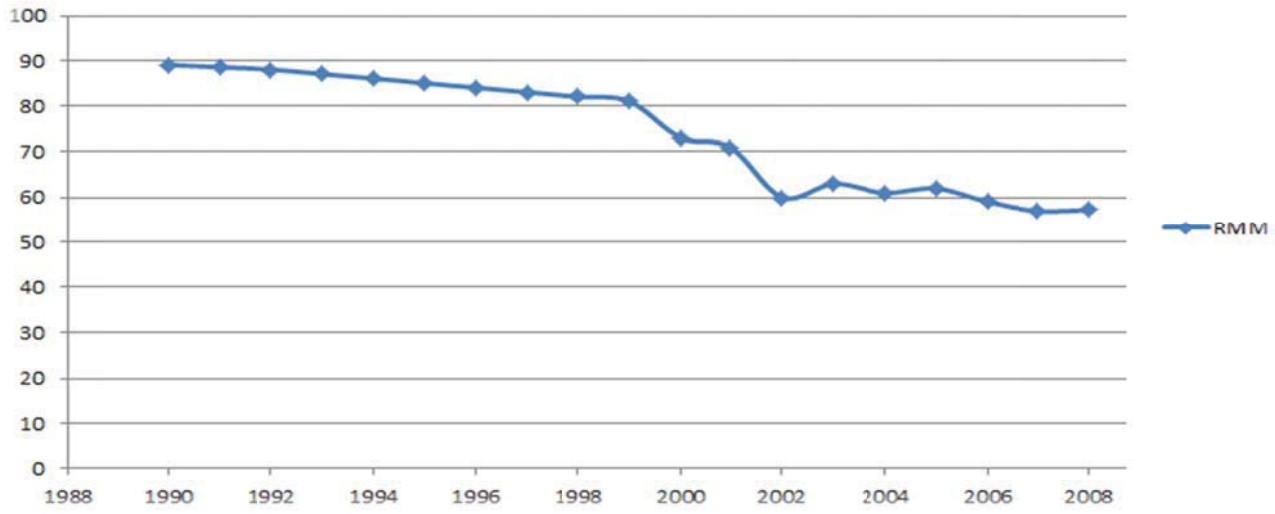
In terms of improving and guaranteeing women´s right to health, Mexico currently faces the challenge of establishing and implementing firm state policies grounded in ethical principles, gender-based perspectives, and with a genuine vision of human rights that includes formal or informal civil society participation in the evaluation and operationalization of policies. The morbidity and mortality of women continues to be an unaddressed public health problem, or in most cases, poorly addressed. Without a doubt improving this situation involves addressing several components, technical and scientific, based on evidence and best practices. However, above and before all, such a process requires having strong and clear political will, and implementing the efficient and transparent use of resources in all levels of government, from the federal to the local (state and municipal).

Over the past decades, maternal mortality has been identified as one of the best indicators of social, economic and political development in Mexican states. In 1990, the Maternal Mortality Ratio (MMR) in Mexico was estimated at 89 deaths for every 100,000

live births. In order to meet MDG 5 by 2015, this ratio is envisaged to reduce to 22.3, a 75% reduction from 1990 figures. However, over the past 18 years the ratio has only reduced to 35.7%, leaving the same percentage reduction to be accomplished by 2015, but this time with only seven years to accomplish it. In reality, and based on the current pace taken by government to attain MDG5, the goal ratio will only be achieved around mid-century.

Between 1990 and 2008, 25,150 women died in Mexico of causes connected to maternity. The trends in Maternal Mortality Ratio (deaths per 100,000 estimated live births) are illustrated in figure 1.

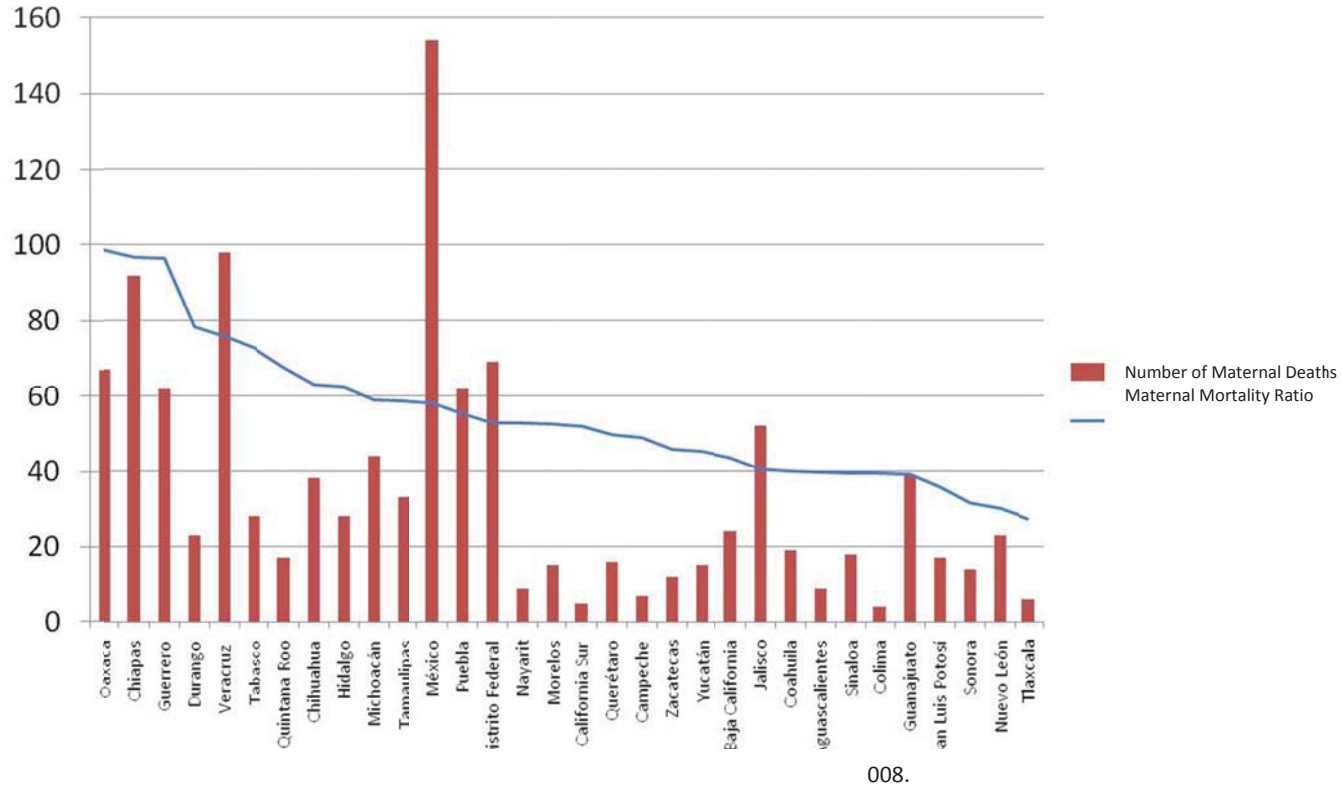
Figure 1 Maternal Mortality Ratio 1990 – 2008, United States of Mexico



Source: DGIS/ SSA, 2009.

In 2008, the last year of available official statistical data, the states with the highest MMR continue to be the most marginalized: Oaxaca (98.7), Chiapas (96.8) and Guerrero (96.5). Nevertheless, in absolute terms, the entities with the highest number of maternal deaths are the State of Mexico (154), Veracruz (98), Chiapas (92) and the Federal District (69). The high number of women residing in these states partly explains this.

Figure 2 **Maternal Mortality Ratio and number of maternal deaths per state, United States of Mexico**



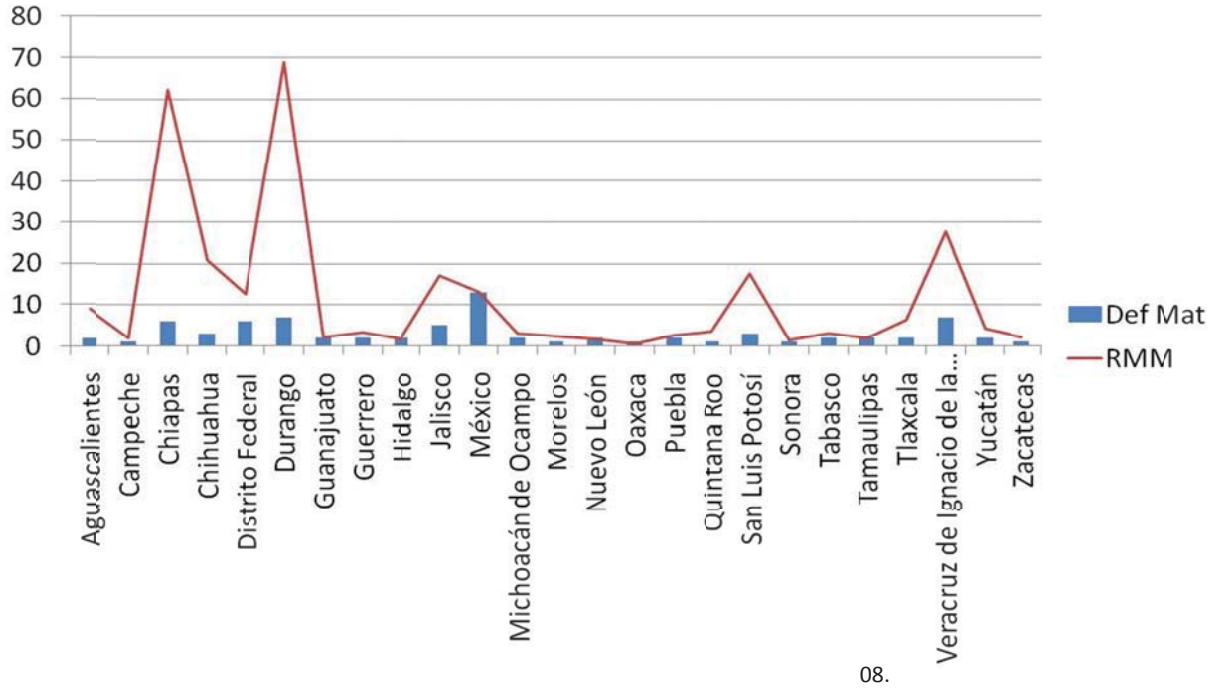
008.

Between 1990 and 2008, maternal death based on specific cause indicated a clear rise in indirect obstetric deaths – this refers to a complication arising during birth due to a pre-existing condition of the mother, in turn, leading to death. Further compounded by the prevalence of obesity, diabetes, hypertension, etc. and the rise of new illnesses such as influenza, all these pose a new epidemiological challenge for all pregnant women with chronic illnesses. Ill and whose pregnancy becomes a risk to health and life, women with such conditions should be given the option for safe and legal abortion despite widespread assertion that medicine and obstetric care can guarantee women a safe pregnancy and birth. The absence of such a system represents a further violation of women's right to health.

In past years, gestational hypertension was the leading cause of maternal deaths (24.2%). By 2008, hemorrhage reached a similar rate (24.3%). In all these years, abortion contributed to around 7% of all maternal deaths, without altering its relative contribution to maternal mortality. In sum, from 1990 to 2008, 1,790 women died from

abortions. In absolute terms, during the same period, one out of every four deaths was in Mexico City and the State of Mexico, and 57% of abortion-related deaths were concentrated in 6 states (Mexico City, State of Mexico, Chiapas, Guerrero, Puebla and Veracruz). However, in relative terms, in 2008 the states that had the highest MMR due to abortion were: Durango (68.8), Chiapas (62.2), Veracruz (27.7), San Luís Potosí (17.6) and Jalisco (17.0).

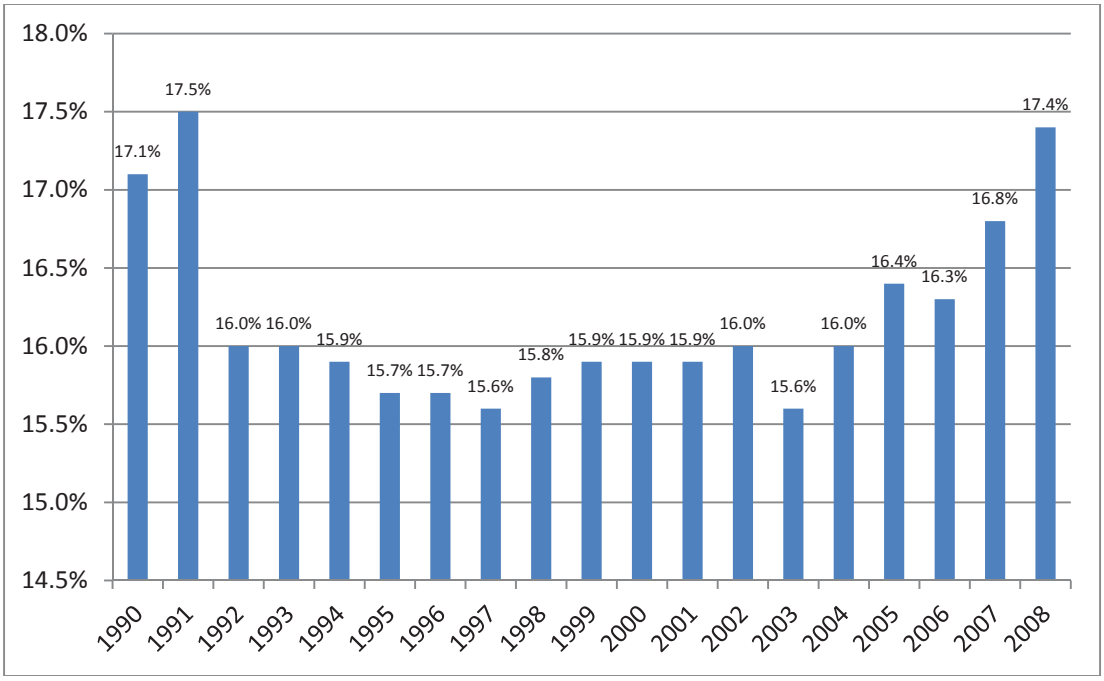
Figure 3 **MMR and the number of maternal death due to abortion, by state, United States of Mexico**



08.

For several years, dissemination of information on family planning methods has been inadequate in Mexico. The absence of (large) media campaigns to raise awareness has resulted in ignorance on family planning methods, and forms of teen pregnancy prevention methods available. General ignorance is further compounded by the lack of educational awareness on these issues amongst middle and high school teachers. This problem is manifested in the percentage of births of women less than 20 years old, showing an increase since 1998, while the 2008 percentage (17.4%) is similar to 1991 percentages (17.5%).

Figure 4 **Percentage of registered newborns according to the age of mothers under 20 years old, 1998-2008, United States of Mexico**



Source: Ipas Mexico powerpoint presentation using Ministry of Health official records, 2008.

The voice of women

Ten women were interviewed in the northern mountains of Puebla in order to understand if and how social policies effect women's lives[7]. Outlined below are the primary characteristics of the women interviewed:

Table 1: Primary characteristics of 10 women interviewees from the northern mountains of Puebla

Town of Origin	No. of Interviewees
Ayotzinapan (Town of la Junta Auxiliar de San Miguel Tzinacapan, Mpio de Cuetzalan del Progreso)	3
San Andrés Tzicuilan (Capital of Junta Auxiliar and San Andrés Tzicuilan del Mpio de Cuetzalan)	4
Pinahuista (Town of Junta Auxiliar de Yohualichan, Mpio de Cuetzalan del Progreso)	3
Ethnic Background	
Nahua	6

Born to at least one indigenous parent	4
Ages	
18 years old	1
19 years old	1
20 years old	1
24 years old	1
26 years old	1
29 years old	1
31 years old	1
32 years old	1
39 years old	1
44 years old	1
Number of Pregnancies	
1 Pregnancy	2
2 Pregnancies	2
3 Pregnancies	3
4 Pregnancies	1
7 Pregnancies	1
8 Pregnancies	1

All of the participants were aware of the Human Development Program *Oportunidades*, and half of them were beneficiaries of the program. The women also knew of the Public Health Insurance Program (*Seguro Popular de Salud - SPS*). There too was awareness on social development initiatives related to *Oportunidades.* even when the participants were not familiar with the program's official names. Widely-known initiatives included: a baby food distribution program for infants and pregnant women as well as SEDESOL's (The Ministry of Social Development) *Piso Firme* program and the Program of Social Assistance for LICONSA Milk (*Abasto Social de Leche Fortificada LICONSA*).

The beneficiaries of the Program of Social Assistance for LICONSA stated that the subsidized milk they received on a monthly basis (17 liters per month for children between the ages of 6 months and 12 years, at a cost of 4 Mexican pesos or US$0.30 per liter) while important, does not sufficiently cover the needs of the children in the program. All women interviewed were eligible to enroll in SPS due to being or having had been pregnant. Although, in the past years, some of them had paid to participate. None of the women interviewed had sufficient or correct information on how often they must re-enroll into the program or how the renewal process may be facilitated. The beneficiaries of SPS claimed that the program is an important service that enables them

to access medical services and medicines free of charge. However, they all concluded that there are multiple problems faced by the program, such as: shortage of medical supplies in the pharmacies of the health centers that operate the program; inadequate conditions of the health centers which lack equipment; and a severe shortage of general and specialized medical staff who can competently attend to their medical emergencies and basic needs.

The women interviewed who were not beneficiaries of *Oportunidades* expressed a desire to enroll in the program. Although they had tried to enroll, they were denied access on the basis of not meeting the program's requirements. For example, they did not have children in elementary school, and some were told that their houses did not meet the 'necessary' poverty conditions. Upon an examination of some women's living conditions, it was found that many of the study's informants lived in one or two room houses, with dirty floors, walls made of wood and tin, and cardboard roofs. Further, many did not have sewage systems, and access to public services was limited.

The lack of information on the *Oportunidades* registration process served as another barrier to program participation. There are three steps to the enrollment process:

1. *Oportunidades* health educators develop a list of interested participants.
2. The staff conducts home visits to verify the information provided.
3. Within a few weeks, eligible women are notified of their acceptance into the program.

In cases where women were denied the service, they were notified and supplied with explanations, such as those previously mentioned. The women themselves did not understand the explanations given, as their neighbors and other women they knew had similar living conditions, and were accepted into the program.

Beneficiaries and non-beneficiaries of the program reported a lack of clarity and high levels of distrust in the *Oportunidades'* selection process. The women mentioned that families with relatively 'better' economic conditions received program assistance, some of

them living in houses made of bricks, cemented block walls, with cemented floors. Ironically, some even owned cars. *Oportunidades* beneficiaries as well as non-beneficiaries unanimously agreed that while the assistance provided is of great help, this should be extended to families most in need.

Some *Oportunidades* beneficiaries reported that *Oportunidades* staff informed them that they were no longer eligible for the program on the grounds that: a) they have already been participants of the program for many years, and b) they are no longer in need of assistance. The criteria that define how long beneficiaries are able to participate in the program, as well as when are beneficiaries deemed no longer in need of help from the program were unclear. *Oportunidades* assistance also arrives a month late for reasons unknown to the beneficiaries. The funds are used to purchase food, electricity, and other basic necessities. With the scholarships the students receive, the funds cover school supplies, uniforms and transportation costs to and from school. Occasionally, these students also open a savings account in their names. Understandably, delays in disbursement greatly disrupt the day-to-day lives of beneficiaries and their families.

There were a few cases in which beneficiaries of SPS and *Oportunidades* provided voluntary payments to cover the maintenance expenses of their Health Centers (it should be mentioned here that there was no evidence of beneficiaries being pressured into making such payments). In one location, these were used to cover expenses such as the cleaning of the clinic, utilities (including the purchase of light bulbs), and other non-medical costs. In another town, the voluntary payments covered the installation of potable water. Another participant reported that in addition to paying for cleaning expenses, these were used to also cover the food costs of clinic staff (nurses and interns).

On regional public health campaigns, the interviewees reported familiarity on vaccination campaigns, followed by domestic animal-rabies control campaigns, and then a few campaigns for specific health topics such as healthy eye, eyesight promotion and anti-Cholera. Only in one town was a family planning campaign implemented – the Birth

Control Implant (IMPLANON) campaign. In regard to family planning and sexual and reproductive health, *Oportunidades* beneficiaries mentioned mandatory workshops they are required to attend in order to receive their financial benefits. Non-recipients knew that these workshops took place and believed they could attend as observers; at the same time, they also stated they did not normally attend.

Among the non-*Oportunidades* beneficiaries, only two of the study's informants knew what a pap smear is, and whether or not they had one. One of these women knew because she had an IUD, while the other woman because she was diagnosed with cervical cancer. After being discharged, the second woman stated that her health clinic failed to give her a pap smear and sent her to a hospital in a different municipality that they claimed treated cervical cancer. After she was discharged from the hospital, her municipality suspended the transportation assistance she relied on to make the over three-hour trip to the hospital for her half-yearly check-up appointments.

When they or their family members are ill, the women in this study generally go to their local health centers for health care. Due to the consistent lack of personnel and medical resources at their local clinics, or because they needed medical attention outside regular clinic hours, the women also sought out the services of particular physicians, bought their medicines at the pharmacies in the municipal capital, and used traditional doctors and medicines.

The health clinics in the towns of the women interviewed (towns relatively close to the municipal capital, with greater access to medicine, personnel and equipment compared to towns further away) rarely have doctors available to perform cesarean sections. Women already in labor (even in advance labor, up to 9 centimeters of dilation) are taken to hospitals such as Cuetzalan (20 minutes to 1 hour of travel time in a private vehicle), Zacapoaxtla (90 minutes from Cuetzalan in a private vehicle), or Teziutlán y Tlatlauquitpec (more than 3 hours from Cuetzalan in a private vehicle). Oftentimes, the women themselves and their families are made responsible for the transportation costs.

In the municipality where the study took place, collaboration between the hospital and midwives is reported to be moderately effective. In the towns, the midwives "adjust the baby" or "massage the baby" and in the hospital women in labor are treated with traditional medicine until their care is taken over by doctors. Despite high recognition of the important role played by a midwife during pregnancy, none of the interviewees believed that a midwife alone is capable of assist them in their births. Some of those interviewed, however, have had one or more of their births performed by a midwife.

The consistent lack of medical staff in the clinics owing to their frequent unavailability and absence, even during official working hours, was a common complaint. The health centers that provide services in the interviewees' towns must adopt a genuine human rights perspective that guarantees access to health services at the highest possible level. It is clear that the health centers in these towns, and often the hospital in the municipal capitals operate without the necessary infrastructure and equipment, nor the adequate supply of medicine in terms of both quantity and diversity. Also, without trained medical staff available to assist patients during pregnancy, birth and postpartum, it is obvious that the provision of health services demands for great improvements.

The public policies in place (in the interviewees' towns) that enable women and their partners to make free and informed reproductive decisions should be revised, more at the level of implementation, than at the level of development. In terms of abortion, none of the interviewees reported to have had a spontaneous or medical abortion. Abortion was observed to be a difficult topic to discuss, with the interviewees not providing any information. It can only be assumed that their knowledge on abortion was limited and/ or misguided. In the towns where the interviewees originated from, no one person who or place where an abortion was performed could be identified. Although some of the interviewees implied that "some women" had undergone operation, none of them provided further information on the matter.

The interviewees visited their local health clinics for their reproductive health care. Nine out of ten of all interviewees viewed the service as "standard", with only one indicating that the service was "good." Among the main problems encountered in health clinics were: a) the long waiting time; b) the insufficient availability of contraception; c) the lack of information for contraception users; d) the shortage of staff and specialists; and e) the frequent absence of physicians and interns.

Other major problems identified included:

1. The inability of their town clinics and the hospitals in the municipal capitals to deliver babies by cesarean section, and the implicit difficulties in transporting women in labor who need an unplanned cesarean section (there was one case in which a women was transported at 9cm dilated to a hospital in a neighboring municipality over 100km and 3 hours away).

2. Inconsistency in the practice of sexual and reproductive preventive medicine was reported. This is evident, for example, in how pap smears are organized for *Oportunidades* beneficiaries. One *Oportunidades* beneficiary who was discharged from cervical cancer treatment had to end her follow-up appointments due to the high travel costs associated with seeking treatment in a hospital located in another municipality. The same beneficiary reported that she was denied access to the health clinic situated in her town because of her failure to attend *Oportunidades* workshops, and in meeting other requirements.

The women who participated in the study provided the following recommendations in order to improve social programs:

1. The Liconsa program should provide more milk in order to effectively meet the needs of the beneficiary's children. Additionally, the program should conduct a qualitative analysis of the different types of eligible women in the program. Such an analysis will create the space for the unfettered inclusion of women who cannot breastfeed their children (less than 6 months old) in the program.

2. There is a great need for the SPS (*Seguro Popular de Salud*) to keep its health clinics well-stocked – with a greater selection and higher quantities of medicines. Doing so will save women from having to purchase medicines from private pharmacies as a second option. However, majority of the towns interviewed do not have pharmacies in the area, thus subjecting women and their families to travel far distances. As a consequence, women and their families tend to spend more in order to access the necessary medication. The women interviewed also recommended for the urgent redress of the unavailability of permanent staff and specialists in health centers for emergency situations, and ensuring that the staff in health centers fulfill their mandatory schedules. Finally, they also called for the better upkeep of clinics to ensure that the infrastructure and equipment can adequately and continue to provide the necessary health services.

3. The beneficiaries of *Oportunidades* validated the importance of the program and the need for its continued existence. They stressed that it should remain in operation, and that their aid should not be taken away. Non-beneficiaries of *Oportunidades* called for the expansion of the program to cover other groups who otherwise, are considered not eligible. Both groups recommended for the need to re-evaluate the program's eligibility criteria as there remain perceptions amongst the informants that there are some beneficiary families who do not necessarily need the aid being provided to them.

4. Finally, the participants of this study expressed their desire for a program that provides necessary staples for families in need, that plumbing and housing programs increase their scope and that there be programs for urban development and improvement (potable water, plumbing, pavement, electricity).

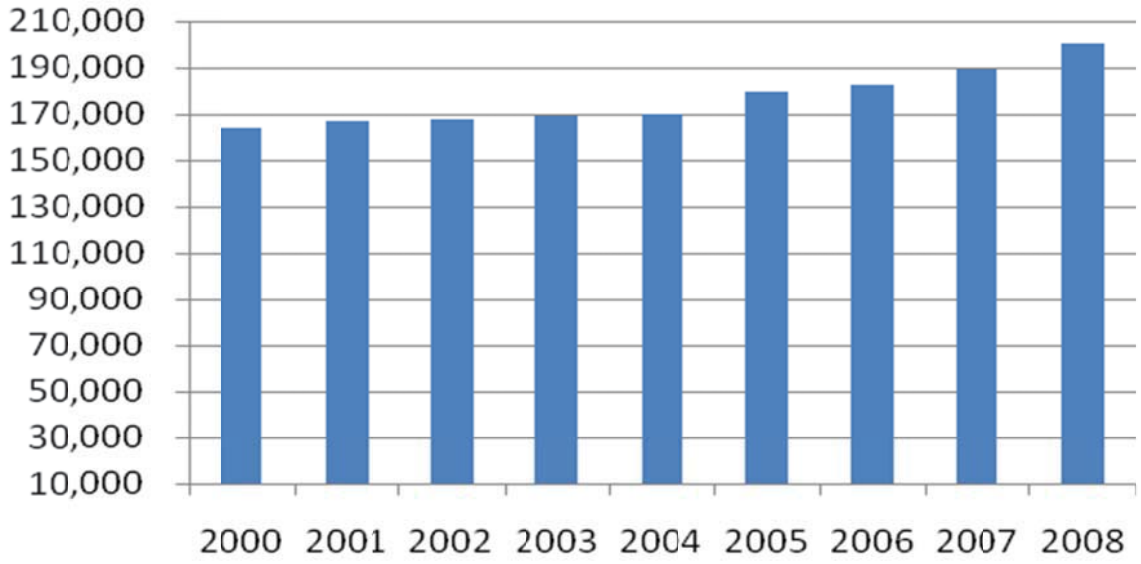
Abortion services: advances and setbacks

Barriers and restrictions to access voluntary abortion in Mexico is such that in reality, abortion is illegal for women, even in cases allowed by the law. In some states, abortion is legal only in cases of rape, while in others, it is also legal when the woman's life or health is in danger, or in the presence of fetal birth defects. Nonetheless, the occurrence of legal abortions conducted in public hospitals is extremely rare[8]. Despite legal restrictions, it is estimated that more than 800,000 women in Mexico will have an abortion every year (Juarez et al., 2008).

Given the legal restrictions, women opt for unsafe abortion, resulting in health problems that may end in hospitalization. According to official figures, the number of women hospitalized for pregnancy ending up in abortion – including miscarriages, molas and ectopic pregnancy[9] – has increased from year to year. Between 2000 and 2008, the number reached a total of 1,590,223 women hospitalized in public hospitals, an average of 485 women hospitalized every day (Schiavon et al., 2010). Of these hospitalizations, more than 86% are attributed to "unspecified abortions," under which unsafe abortions are generally classified. This occurs in spite of the presence of Mexico's restrictive legislation, and may worsen even more in the face of constitutional reforms that defend life from the point of conception, as recently passed in 17 Mexican states. Following the legalization of abortion in Mexico City (defined as legal before the twelfth week of pregnancy), opposition groups including the church and political parties, have made several attempts to change the abortion law in other states. In seventeen states, the opposition succeeded in changing local constitutions.

Additionally, restrictive legal conditions hinder the adequate training of health workers in the safe abortion technologies recommended by the World Health Organization (World Health Organization, 2003), such as Manual Vacuum Aspiration (MVA) and medical abortions, as well limit the registration of the most effective and safest medications in Mexico, such as Mifepristone. In the country's Secretary of Health hospitals, MVA was used to perform only an estimated 16% of all abortions in 2008.

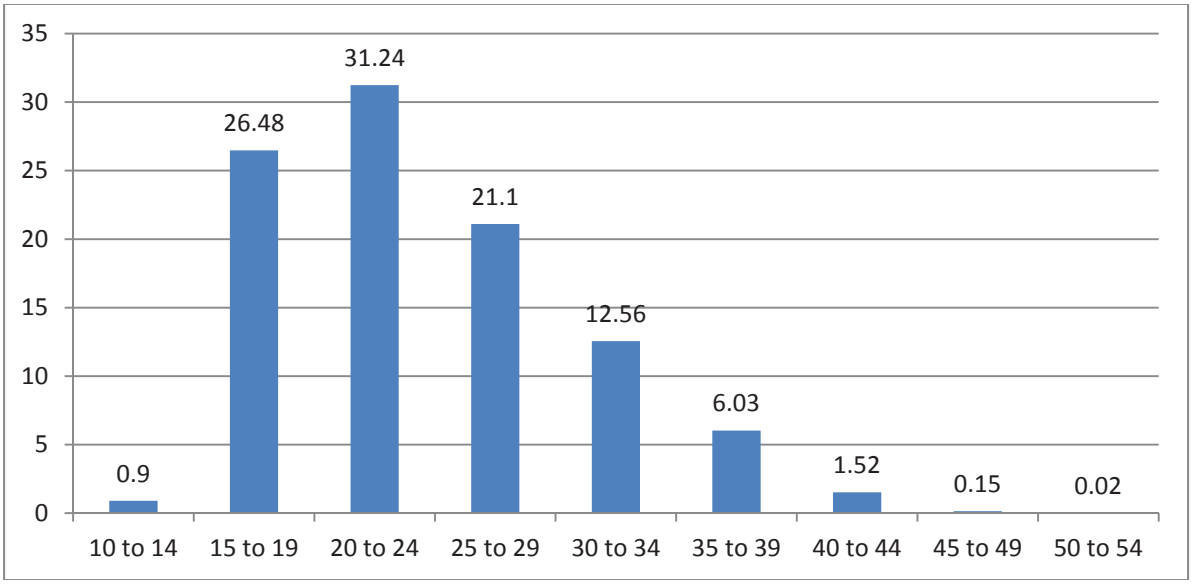
Figure 5 Hospitalizations due to abortion in Mexico, 2000-2008



Source: Ipas Mexico powerpoint presentation using Ministry of Health official records, 2008.

It is estimated that only one in six women who seek for an abortion, obtain hospital care. The remaining five do not have access to adequate medical attention (Juarez et al., 2008). The study also suggests that the number of hospital-treated abortions represent only the top of the iceberg of induced abortions. Moreover, it reported that induced abortions in Mexico have increased over the past decades to an estimate of a little more than 500,000 abortions in 1990 to 870,000 abortions in 2006, with a rate that rose from 25 to 33 abortions for every 1,000 women of reproductive age, one of the highest in the world. In 2008, in all of Mexico, adolescent women represented 27.4% of all hospital discharges due to pregnancy, birth and abortion, and almost one out of every 100 were girls 10 – 14 years old. This is a serious violation of the right to health for adolescents and young people.

Figure 6 **Percentage of hospital discharges for abortions, births and cesarean sections by age group, United States of Mexico.**



Source: Ipas Mexico powerpoint presentation using Ministry of Health official records, 2008.

In Mexico, the risk of death during pregnancy, birth and postpartum is largely associated with socio-economic conditions such as education, poverty and indigenous backgrounds. Poor women with less than five years of education and/ or are of indigenous origin have a higher probability of undergoing unsafe abortion – nine times higher compared to women with a different background (Sousa et al., 2009).

In April 2007, the Federal District of Mexico (also known as Mexico City) legalized first trimester abortion on request. After this momentous legal step, public facilities in the District faced the task of quickly meeting the demand for services. Legalization of induced abortion is only the first step in reducing morbidity and mortality from unsafe abortion, which causes approximately 47,000 deaths per year worldwide and is the cause of a large disability burden in lower income countries. Following the passage of the law, legal abortion services became available in public facilities in Mexico City within days. Under the Federal District's law, abortion services are offered free of charge at the District's Ministry of Health (MOH-DF) facilities to uninsured women residing in Mexico City. In Mexico, several public health insurance schemes are in effect, and public facilities administered under the federal government do not offer legal abortion services. Women

covered under federal or private insurance plans and those living outside Mexico City pay sliding scale fees for abortions at MOH-DF facilities, depending on household income.

Table 2: General information on legal abortion services from April 24 2007 to January 2011

	Data
Requests for abortion information	85,543 requests for information
Total number of legal abortions performed in the Federal District after the legalization on April 24, 2007 to January 31, 2011	53,278
Average number of procedures per month	1,183 procedures
Place of origin of abortion seeker	• 76 % residents of Mexico City (39,934 women) • 21 % residents of the State of Mexico (11,188 women) • 3 % residents of other states (1,680 women)
Procedure used	• Misoprostol alone: 53% 28,237 women • Manual and electric vacuum aspiration: 37%, 19,712 women • Dilatation and evacuation: 10%, 5,329 women
Civil status	• 53 % single • 21 % in union • 17% married • 5% not specified
Age groups	• 0.6% 11 -14 years old • 47.7% 18 - 24 years old • 22% 25 - 29 years old • 13% 30 -34 years old • 2.7% 40 - 44 a years old • 14% other
Legal abortions performed according to gestational week	• 80% ≤ 8 gestational weeks • 20% 9-12 gestational weeks
Contraception acceptance post abortion	• 83% acceptance • 17% acceptance

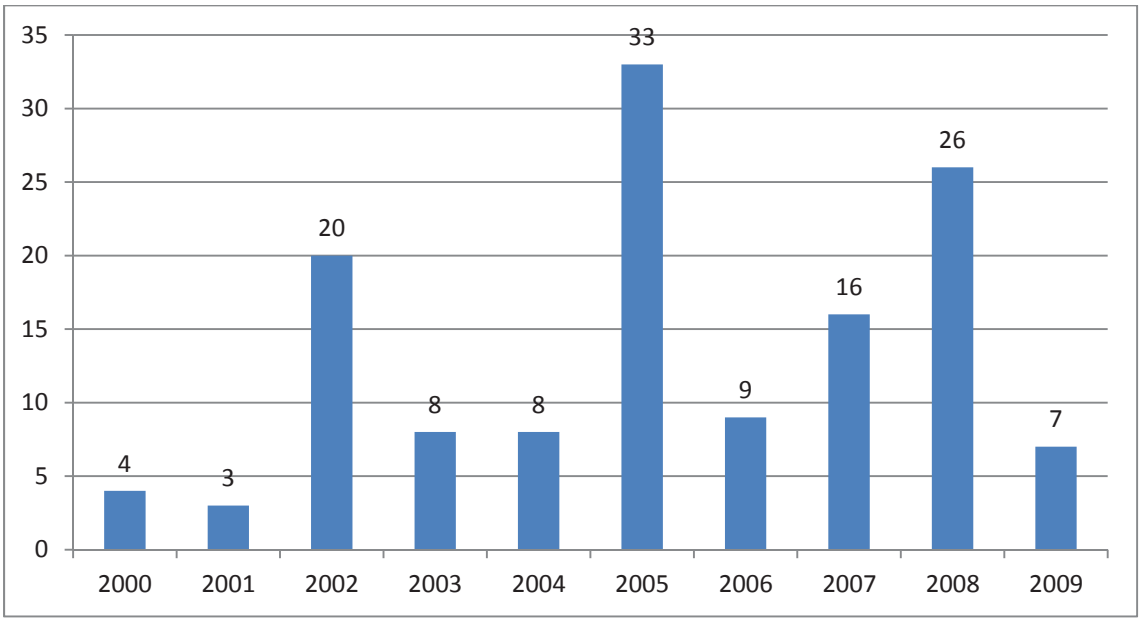
Source: Grupo de Información en Reproducción Elegida, 2011.

Newspaper Content Analysis

Until now, our research findings suggest that discussion of the MDGs in Mexico is more talk than a reality. To test this hypothesis, we conducted a newspaper content analysis in our attempts to examine political discussions surrounding the MDGs. This methodology limits potential biases or problems that could arise when conducting face-to-face interviews. We aim to obtain more detailed information by reviewing statements that stakeholders had shared with the media during the between years 2000 and 2009.

For this part of the analysis, the newspaper *Reforma* was reviewed for the number of times the Millennium Development Goals (MDGs) were mentioned between 2000 and 2009. *Reforma* was selected due to its large national circulation and because of its online archive dating back to 1993. Since 2000, figure 7 shows that there had only been 134 articles published on the MDGs. The highest number of articles appeared in 2005, coinciding with mid-term reports. We can expect that in 2010 there will be an increase in the number of articles published. In the first two years, only 7 articles were published.

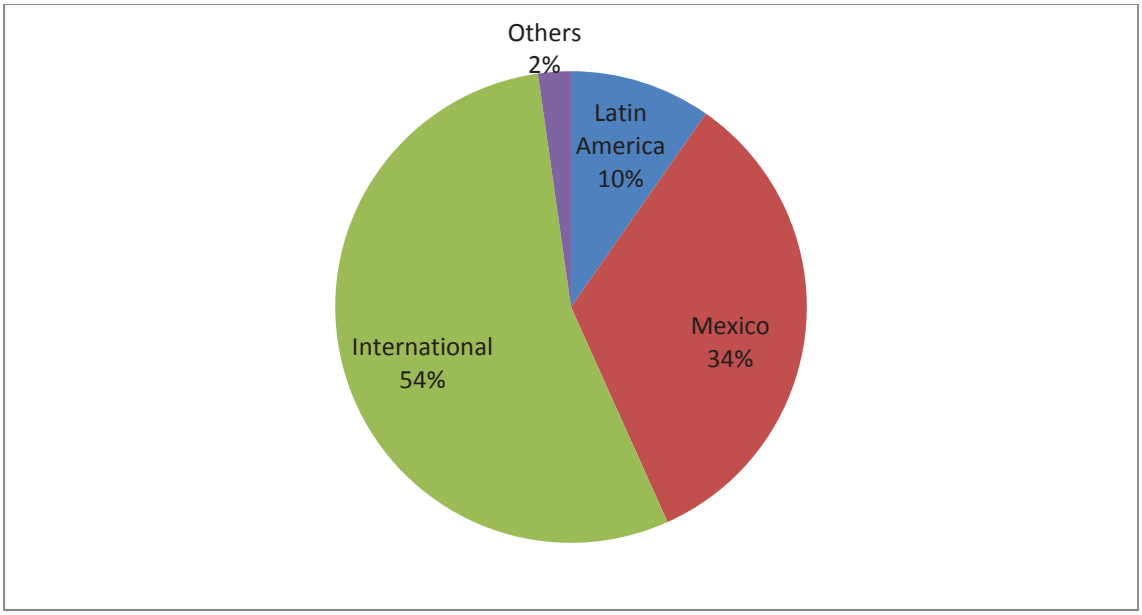
Figure 7 Number of articles per year



Source: Author's elaboration, 2012.

Focusing on the articles' geographic coverage, 34% of all articles on the MDGs were linked to local issues, with 54%, over half of the articles covering international interest. The remaining 10% of all articles were written in relation to Latin America (the region and/or its individual countries), and 2% for countries outside Latin America.

Figure 8: Geographical coverage of MDG-related articles in *Reforma*, 2000-2009



Source: Author's elaboration, 2012.

Conclusion

In spite of and contrary to the advances that Mexico experienced in the eighties and nineties, over the past years the Mexican Government has fallen behind. The lack of progress is evident in the most important reproductive health, fertility and contraceptive coverage indicators used in the latest National Survey of Dynamic Demographics (ENADID, 2009). In particular, the gaps and inequalities based on age, socio-economic status, education level and ethnic background provide a very disconcerting picture of the status and implementation of SRH in Mexico.

Access to health services, one of the most notable gaps, greatly depends on the ease with which the government enables a citizen to successfully progress from "ill to

healthy". Since the previous administration, Mexico established the Public Health Insurance Program (*Seguro Popular de Salud* – SPS), a financial strategy that should enable a family to join and gain access to complete medical benefits for a limited number of medical conditions. Nevertheless, there has been a lack of transparency in the use of financial resources, and limited medical coverage for the adolescent population – a group that should be economically active and thereby participating in SPS. Additionally, a previous study highlights how this affects access to free contraceptive methods in a growing percentage of the population, again primarily adolescent (Juarez et al., 2010). Documented evidence and best practices show what does work to reduce maternal mortality. These are: a) abortion in safe conditions, preferably, within an agreed legal framework; and b) an increase in contraceptive coverage (Campbell, 2006). Despite these, decision-making on public policies is immersed in ideological discussion. Family planning and pregnancy prevention, particularly among adolescents, involves guaranteeing the exercise of the right to decide when to begin motherhood and how to space children – a right outlined in Article 4 of the Constitution of the United States of Mexico.

As we can see in the section concerning content analysis, the MDGs have failed to enter the national discourse[10]. The governmental programs covered by this study, where there is no mention of the MDGs, illustrate this. These are programs that existed prior to, and after the signing of the MDGs, but have not fundamentally changed following Mexico's signing of the MDGs.

The findings of the study suggest the importance for government to reflect on its public policies and implement a strategy of education and contraceptive promotion; guarantee the supply of a variety of contraceptive methods, including emergency contraception; and meet the unmet needs of women and couples of all ages, ethnic backgrounds, socio-economic status and education level. Ensuring women's access to effective and low-cost contraceptives is one of the most cost-effective measures to reduce maternal mortality, prevent unplanned pregnancies, reduce a mother's exposure to risks to health and life

associated with pregnancy and birth, and reduce the need to turn to abortion. Where the state does not respond to these needs, and where contraceptive failure, sexual violence, and mental and physical risks involve aborting a pregnancy, abortion should be performed by capable hands, under the safest (legal) conditions, and in accordance with existing laws. One exciting development is the release on March 3, 2011 of the Maternal Mortality Watch (MMW), a national intergovernmental initiative led by civil society with the support of the Mexican government (National Institute of Women, Ministry of Health, among others), academic sector and the United Nations. The MMW aims to reduce maternal mortality in the country based on undertaking three actions: analyzing public policies; monitoring maternal mortality programs; and increasing accountability.

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Notes

[1] For more information visit www.oportunidades.gob.mx

[2] For more information visit www.seguro-popular.salud.gob.mx

[3] These organizational websites provide more information: www.fundar.org.mx; www.maternidadsinriesgos.org.mx

[4] This section was written in collaboration with Raffaela Schiavon, Ipas México .

[5] Statistics in this section are primarily taken from the Instituto Nacional de Estadística y Geografía. See www.censo2010.org.mx

[6] SSA: Ministry of Health

[7] This section was written with the support of Espacio Espiral. See: www.espacioespiral.org

[8] To access a comprehensive list of legal indications, see www.gire.org.mx

[9] Ectopic pregnancy and molas have different sign and symptoms but miscarriage can be confused with the bleeding of an induced abortion.

[10] One exception is Chiapas where, since 2009, they have been carrying out a MDG adoption strategy in the State Development Plan. This case was not analyzed because it occurred extemporaneously at the time of this project.

CHAPTER 3: INDIA CASE STUDIES

Coherence or Disjunction? MDGs, SRHR, Gender Equity and Poverty in Gujarat and Tamil Nadu

Renu Khanna with Anagha Pradhan and Lakshmi Priya

Introduction

India had robust annual growth of its Gross Domestic Product (GDP) in the 2000s, although it dipped slightly in 2008[1]. Given the extra revenues available, the national government increased public sector spending over the period of the Tenth Five Year Plan (2002-7) and in particular, the Eleventh Five Year Plan (2007-12)[2], in comparison to earlier plan periods. During the past ten years, the government introduced the flagship National Rural Health Mission, the National Rural Employment Guarantee Scheme (backed by a legislation guaranteeing 100 days of employment with equal wages) and has sought to universalize the Integrated Child Development Schemes in all parts of India, benefitting all children aged 0-3 years and adolescent girls. In these years, Phase Two of the Reproductive and Child Health program was integrated into the National Rural Health Mission, including several other SRH services. A National Policy on Empowerment of Women was formulated in 2001, so were the Protection of Women from Domestic Violence Act enacted in 2005, and homosexuality decriminalized in 2009.

In the context of this growth and the mushrooming of various flagship programs and rights-based legislation, this paper seeks to elucidate whether the abysmal performance of India in the 1990s on poverty, gender equality and SRHR has now been reversed, and whether the inter-linkage between these three issues is now being addressed by current legislation, programs and schemes. In spite of the observed loopholes that dilute commitments to gender equity and SRHR under the Beijing Platform for Action and the ICPD Program of Action (ICPD PoA), the MDG agenda provides a good foundation in

examining the coherence or disjunction between legislations, policies and schemes on poverty, gender equality and SRHR, as well as, highlighting progress made on each of the three fronts.

This paper will therefore seek to underscore:

- The coherence or disjunction between global discourses on MDGs, poverty, gender equity and SRHR, as well as the policy frameworks and programs adopted by the Indian government and donors;
- The coherence or disjunction between national policy frames and state level policy frames and programs on MDGs, poverty, gender equity and SRHR;
- Utilization of national or state level policy frames by women, adolescents and people of diverse sexual or gender orientation and identities; and
- The attention paid by social movement groups and media to issues related to the MDGs, SRHR, gender equity and poverty, and the coherence or disjunction between policies, as well as progress made on each.

The study is based on a review of secondary literature; interviews with government officials at national and state levels; and the monitor of newspaper clippings and data for the country and two states. A review of initiatives by social movement groups was also carried out at national and state levels. From India's 28 states and six union territories, Gujarat and Tamil Nadu were selected for the state level study, with interviews and discussions with intended target groups of government programs restricted to low-income neighborhoods (popularly termed 'slums') in the two cities of Baroda in Gujarat, and Chennai in Tamil Nadu.

In keeping with discussions in Rio in March 2009, the indicators listed in table 1 and programs, which have a bearing on them, are monitored in this report.

Table 1 Indicators for monitoring

Macro-economic environment	Poverty	SRHR	Gender equality
-Economic growth variations -Indebtedness -Donor dependency -National accounts and terms of trade -Levels of corruption	-Per capita income (adjusted)/ -Inequality in income -Consumption by quintiles -Proportion of people in poverty -Human poverty index -Life expectancy -Human development index	-Health systems -Proportion of women in reproductive age -Contraceptive prevalence -Maternal mortality ratios -Unmet needs of family planning -Prevalence of HIV/AIDS -Adolescent birth rate -Cervical cancer	-Sex ratio -Sex differences in life expectancy -Sex differences in anemia -Sex differences in proportion of underweight -Sex differences in infant and child mortality -Female/male education -Female/male employment

	-Anemia -Proportion of underweight children -Infant and child mortality rates	-Access to pap smear and mammography -Abortion related mortality -Abortion rate, abortion ratio, the total number of pregnancies that end in abortion -Condom use levels -Age at first pregnancy -Skilled attendance at births -Access to full ANC -Female/male age at marriage -Marriage laws -Data on polygamy and FGM if available	-Female/male Unemployment -Female/ male Wages and income -Female/ male poverty levels

Source: Own elaboration, 2012.

A major constraint in extending the study to other more 'backward' states or rural areas within Tamil Nadu and Gujarat is linked to budget and time availability. Also, owing to a delay in fund disbursement, some of the national and state level interviews could not take place. With regards to the quality of data used for the purpose of this study, national data was not consistently available for all indicators for the years that the paper sought to track – 1990, 1995, 2000 and 2005 – while international data was not always disaggregated by sex (e.g. the proportion of underweight children) and never by caste, nor religion. Furthermore, at times data from different national sources reflected different directions in trends[3]. Even more daunting was difference in the criteria used for measuring the same indicators, at different times[4]. For some of the indicators agreed upon during the March 2009 meeting, data was either unavailable for India (e.g. access to ARV) or were only available at national level and not for the two states. In spite of these constraints, it is hoped that this paper will still provide valuable conclusions.

The first section of this paper examines the coherence or disjunction between national policies on MDGs, poverty reduction, gender equality and SRHR, and the progress that the country has made in these areas. It also provides data explaining the macro-economic environment of India. This section is largely based on a secondary literature review. The second and third sections examine the same issues with a focus on the states of Tamil Nadu and Gujarat. These sections summarize discussions with policy makers, program

implementers, women, adolescents and people of diverse gender or sexual identities. The fourth section highlights the strengths and weaknesses of interventions made by various social movement groups, and the media coverage of the MDGs, poverty, gender equity and SRHR at national and state levels. The final section offers concluding comments and considers ways on how to bring greater coherence between the MDGs and the Indian situation on poverty, gender equity and SRHR; between legislations, policies, budgets and implementation; and between the efforts of social movements and media interventions in India.

National policies and progress on the MDGs, SRHR, gender equity, and poverty: coherence or disjunction?

Macro-economic profile of India and its poverty, gender equity and SRH access outcomes

***Macro economy*:** Based on the World Bank's (2009) Development Economics database, India had an estimated population of 1.140 million in 2008, with 29% of the population living in urban areas. Over the past two decades, the country saw an annual increase in its average GDP. India's GDP grew at 5% annually for the periods of 1988 to 1998, and at 7.2% between 1998 and 2008, while per capita GDP grew at a rate of 3.5% and 5.6% respectively. After witnessing an economic slowdown in 2008, the economy is now reviving. From 2008 to 2012, India's GDP is expected to grow at an annual average rate of 7.3% with a per capita GDP of 5.3% (World Bank, 2009).

From 1998 to 2008, the same World Bank database recorded the ratio of capital formation to GDP to have increased from 23.6 to 39.7; the ratio of exports of goods and services to GDP from 6.1 to 22.7; and the ratio of gross national savings to GDP from 22.2 to 37.6. The ratio of Current Account Deficit to GDP was also reported to have declined from 2.9 to 2.6, and the ratio of total debt to GDP decreasing from 21 to 19.9. However, the total debt outstanding and disbursed grew from US$ 61.659 million in 1988 to US$ 230.611 million in 2008, and total debt service from US$ 6.055 million to US$ 31.076 million. Fourteen per cent of India's outstanding debt in 2008 represented loans acquired

from the International Bank for Reconstruction and Development (IBRD) and the International Development Assistance (IDA) (World Bank, 2009).

While overall trends in macro-economic indicators in this period showed positive improvement, it is of concern that the terms of trade deteriorated from 100 in 2000 to 93 in 2007, and 89 in 2008. Inflation rose from around 4% in 2000 to 8% in 2008 (although not as high as 11.2% in 1988). As a result, the implicit GDP deflator increased from around 4% in 2000 to 6.2% 2008 (again, not as high as the 8.2% in 1988) (World Bank, 2009).

Another concern reported is the high levels of corruption in the country, with India ranking 84 out of 180 countries in 2008, based on Transparency International's Corruption Perceptions Index (Transparency International, 2009). Transparency International's index measures the extent to which business people and country analysts perceive the existence of corruption amongst public officials and politicians.

***Poverty*:** The Human Development Index (HDI) improved from 0.489 in 1990 to 0.612 in 2007 (UNDP, 2008). Disaggregated data reveals that life expectancy at birth increased from 58 years in 1990 to 64 years in 2005 (World Bank, n.d), and GDP per person employed (PPP) increased from USS 3,531 in 1990 to US$ 7,455 in 2008 (World Bank, n.d). In 2006, India ranked 134 out of 182 countries on the Human Development Report (HDR). Data from the World Development Indicators suggests that the poverty headcount ratio (per cent of population at US$ 1.25 a day) declined from 54% in 1990 to 42% in 2005 – a rate of decline inadequate to achieve the target of halving the population in poverty (World Bank, n.d.). The Human Poverty Index declined over roughly the same period from 37% to 28%, with India's income poverty reduction indicator outranking its human poverty reduction (UNDP, 1997; UNDP, 2009).

The World Development Indicator database shows that the poverty gap ratio declined from 16% in 1990 to 11% in 2005. Should this trend continue, the poverty gap is estimated to further reduce by mid-2015. The Gini-coefficient – a measure of inequality – showed decreased inequality in rural consumption from 1993-4 (0.281) to 1999-2000

(0.260). Between 2004-05, an increase in the Gini-coefficient standing of 0.297 was reported. No comparable data was available for urban areas. It appears that the reduction in income inequality does not lead to a reduction in consumption inequalities in rural areas. According to the NFHS, the proportion of rural households with access to land decreased from 36% in 1992-3 to 41.5% in 2004-5.

National data on the proportion of population below the national poverty line suggests that there is little possibility of achieving the MDG target of halving the proportion of people in poverty by 2015, although Planning Commission figures show a decrease from 36% in 1993-4 to 27.5% in 2003-4 (Planning Commission, 2008b). The monitoring period also saw a slight decline in the ratio of employment to population for adult women and men, with a marked decline for the 15-24 age group[5]. The unemployment rate for adults increased from 1993-4 to 2004-5 on both daily status, principal and subsidiary status[6].

On the whole, as observed by the UNDP (n.d.), India can achieve MDG 1: Eradicate Extreme Poverty and Hunger only if dramatic changes in policy and implementation take place. The proportion of children who are underweight (46%in 2005-6) or anemic (56% in 2005-6) is unlikely to be halved by 2015. The huge difference between the proportion of children under three years who are underweight and the national headcount ratio may be due to the fact that the consumption basket by which the national poverty line is currently defined reflects what is required for minimum calorific requirements[7], not nutrition; and the fact that estimates of the amount of income required to meet calorific consumption do not take into account the high rate of inflation[8].

***Caste, religion and poverty*:** Poverty is also caste and ethnicity specific in India. Schedule Castes (SCs), Schedule Tribes (STs), and backward castes accounted for 80% of the rural poor in 2004–5 (Planning Commission, 2008b). Gaps between the poverty levels of the total population and of dalits and tribals are greater than gender gaps, and so are the gaps higher in the extent of underweight children, infant mortality, child mortality and access to education. However, there are also significant gender gaps in these

communities. Available data on education suggests that gender gaps in education from Class 1 to 8 are greater among SCs in the total population. The picture is more complex with regard to STs — pointing to the interlocking of caste and gender disadvantage[9].

While a greater proportion of Hindu than Muslim households live in the lowest wealth quintile group, gender gaps in primary and secondary enrollment are higher among Muslims than Hindus, pointing to non-income barriers to education (IIPS and Macro International, 2008). In regard to nutrition, however, anaemia in infant girls was slightly lower among Muslims than Hindus, as well as the proportion of women with a body mass index (BMI) below 18 kg/m2 (The proportion of underweight infants is more or less the same for Hindus and Muslims). Available data and the Dalit MDG Shadow Report suggest that SC and STs (and women in particular) lag behind the general population in the achievement of MDG 1, while the trend varies by goal with regard to Muslim women and men. Despite more than two decades of the enactment of the 1989 SC/ST (prevention of atrocities) Act, discrimination remains.

***Gender and poverty/ gender equality*:** Women constituted 48% of India's population in 2005, as they did in 1990. Poverty is indeed feminized in the country, not so much in terms of number of females in poor households — which is marginally higher than males in rural but not urban areas[10]— but in terms of the intensity of poverty felt and faced by females. According to the National Family Health Survey 3 (NFHS 3) (IIPS and Macro International, 2008) infant girls (6-35 months) and even married women are much more often anemic when compared to boys and men. The NFHS 2 and 3 found that between 1998-9 and 2005-6, the proportion of adult women — that is, women aged 15-45 years — who were anemic increased. The surveys also found that women in the 20-39 years age group had a lower BMI than men, and there was little decline in women's BMI between 1998-9 and 2005-6. Micro level studies suggest that intra-household food and nutrition distribution is skewed in favor of males throughout India. The feminization of poverty is also reflected in higher infant mortality rates for females than males, despite the greater resilience of females at birth. This points not only to poorer nutrition amongst females,

but also smaller investment in their health care. Though the life expectancy of women in 2007 was 2.9 years more than for men, there was only a year difference in their life expectancy in 2003 (UNDP, 2009; World Health Organization, 2008).

The greater poverty faced by females is also reflected in girls' poorer access to middle, secondary education and tertiary education compared to boys. There is a slight gender inequality in the primary completion rate, even though this was remarkably reduced between 2000 and 2008, according to the World Bank (World Bank, n.d.).

Moving on to whether women have access to the means to overcome poverty, there is no national level data on women's ownership of assets. India scores 0.5 on a scale of 0 (full inequality) to 1 on inheritance and access to land and institutional credit, as per the Gender Institutions and Development Database (OECD, n.d.). World Bank (n.d.) statistics and the NFHS data indicate that the percentage of adult women in the labor force declined slightly from 2000 to 2007 (World Bank, n.d.). National Sample Survey Office (NSSO) data however suggests an increase in work force participation rates of women, especially in urban areas. In relative terms there has been a feminization of the Indian labor force as the percentage of adult men in the labor force declined at a faster rate[11]. Unemployment rates as per the World Development Indicators were slightly higher for females (5.3%) than males (4.9%) in 2004 (World Bank, n.d.). The ratio of female to male earned income declined from an estimated 0.34 in 1995 to 0.32 in 2004, as per the Human Development Reports of 2009 and 1997, probably due to the greater proportion of women than men in vulnerable employment; the lower wages earned by women; and the fact that fewer women work outside agriculture. The share of women employed in the non-agriculture sector grew from 12.7% in 1990 to 18.1% in 2005. Further, according to the NFHS 3, approximately 20% of women do not have a say on their own or will need to consult with their husbands on how their earnings should be used. Women also lag behind in the political sphere. They constituted only 9.24% of all parliamentarians in 2005 (Planning Commission, 2008e), although in 2006 elected women constituted 42.8% of all public officials in local government.

Gender-related development index (GDI) combines indicators on dimensions and causes of women's poverty. The gap between HDI and GDI persisted from 1990 to 2005, with GDI being 97.1% of HDI, as per the UNDP HDR in 2009. India ranks the same in GDI as in HDI. Given past trends, it is highly unlikely that India will achieve MDG 3 – promoting gender equality and empowering women – apart from possibly meeting the target of gender equality in primary school completion. The UNDP is more optimistic and observes that India can achieve MDG 3 with policy changes put in place.

The Protection of Women from Domestic Violence Act was passed in 2005, but violence against women persists in families. Spousal violence often takes the form of physical or sexual violence. NFHS 3 reports that in 2005-6, 34% of adult women reported having had experienced violence in marriage. It is not possible to comment on the trends of violence, as NHFS 3 data collection was limited to documenting incidence of spousal violence.

***Health/ SRHR*:** Based on UNDP's observations, India is 'off track' in achieving MDG 4, to reduce child mortality. According to the UNDP (n.d.), malnutrition, along with poor access to health care, contributes to this situation. The three NFHS' suggest however that the country is on track towards achieving this goal, but the criteria used to measure IMR varied between the surveys, making them difficult to compare.

As of 2005-6, all NFHS show that the gender gap in age at marriage has persisted over the last fifteen years, with men typically being three years older than their wives assigning the former greater power in the marital relationship. Arranged marriage within the same caste and religion continues to be the norm, but is slowly being challenged. However, honour killings are on the rise (in particular, in North West India). Honour killings take place when couples break social norms and marry outside their caste and religion. Despite the Prevention of Child Marriage Restraint Act, 1929, 43.4% of married women aged 20-24 years reported having married below 18 years, as per the District Level Household Survey-3 (DLHS-3). Laws on polygamy vary between religions and are governed by personal laws, but it is illegal for Hindus, who constitute the majority of the

population. Nevertheless, the practice of having more than one partner is not uncommon even among Hindus.

Women continue to face the burden of insufficient contraception, and the use of contraception by unmarried women is still taboo. Infertility is looked down upon; women are often blamed and infertility is used as grounds for divorce. Abortion is legal up to 20 weeks on four conditions: a) continuation of pregnancy constitutes a risk to the life or grave injury to the physical or mental health of the woman; b) substantial risk of physical or mental abnormalities in the fetus as to render it seriously handicapped; c) pregnancy caused by rape (presumed grave injury to mental health); and d) contraceptive failure in married couple (presumed grave injury to mental health). Therefore abortion is not available on demand. Nearly 38% of women did not have a say over decisions on their health care either by themselves or with their husbands in 2005-6, as per the NFHS 3 (no comparable data for earlier periods).

Moving on to sexual and reproductive health, international and national data suggests that India is unlikely to achieve MDG 5 – improving maternal health by reducing maternal mortality by three quarters, and promoting universal access to reproductive health. The maternal mortality rate (MMR), as per the Sample Registration System, barely declined from 398 in 1997 to 254 in 2004-6 (Registrar General India, n.d). The World Development database records an MMR for India of 450 in 2005 (data not provided for 1990). Access to ante-natal care, skilled birth attendance, and post-natal care is far from universal, though access to the first two has improved over the years. Adolescent birth rate declined from 76 in 1991 to 45.9 in 2005. The abortion ratio and abortion percentage stood at 29% and 2.8% respectively in 2003, with no clear trend since 1991 (a slight decrease until 1996 followed by an increase) (Johnston, 2010). According to the 1997-2003 Sample Registeration System (SRS), unsafe abortion was the third leading cause of maternal death and accounted for 8% of all maternal deaths (Registrar General India, n.d.).

India is not likely either to achieve the MDG target on ensuring universal access to other reproductive health services, such as eliminating unmet needs for contraception, reducing the adolescent birth rate, or increasing male responsibility for contraception (NFHS 1,2,3). In 2008, only three per cent of women had access to pap smear and two per cent had access to mammogram (World Health Organization, 2008), showing India is still distant from achieving universal access to preventive cancer screening services. National data on access to preventive cancer screening is not available.

By contrast, India is on the way to achieving the target on reversing the spread of HIV/ AIDS. Positive developments have been made on the decriminalization of same sex relations in 2009 and sex work. A strong debate continues in the country about the merits of decriminalization vs. the legalization of sex work. Condom use among young people aged 15-24 years did not increase between 2005 and 2008, and remains lower for females (18%) than males (37%). Sterilization is the dominant method of contraception; condom use by all people aged 15-49 years is low, placing people at risk if their partner is HIV positive. Condoms were used as contraception only by 5.3%of currently married adult women surveyed in the 2005-6 NFHS, a slight increase from the figure of 2.4% in 1992-3.

Summing up: progress on MDGs, gender, poverty and SRHR: A key paradox is that in spite of GDP growth, India is unlikely to achieve the MDG targets for nutrition, infant and child mortality, gender equality (other than in primary education and possibly secondary education) nor maternal and reproductive health. Although progress has been made on reversing the spread of HIV/ AIDS, achievements on targets for poverty reduction remain a contested issue. The reason for this may lie in the direction of growth — being less in agriculture and more in industries and services — as well as weak accountability in regard to poverty, gender equity and the SRHR of women.

Central government policies on MDGs, poverty, gender and SRHR

National targets: A review of five chapters of the national Five Year Plan — Inclusive Growth: Vision and Strategy, Rapid Poverty Reduction, Nutrition and Social Safety Net, Health and Family Welfare and Towards Women's Agency and Child Rights — makes reference to the MDGs only in the chapters on Women's Agency and Children's Rights (limited to child development) and on Health and Family Welfare (mentions that the NRHM is set to achieve the targets under the MDG). References made to the MDGs are only in passing; leaving the impression that the national government's planning process is not significantly influenced by the MDGs[12]. .

The 2007-12 Five Year Plan contains 27 National Targets, elaborated in the chapter on Inclusive Growth: Vision and Strategy (Planning Commission, 2008a). A comparison of these targets with the MDG targets reveals some coherence between the national poverty targets vis-à-vis MDG targets, but not those for gender equality and reproductive health. To illustrate, the 27 National Targets include reducing the poverty gap ratio, the proportion of population living below minimum dietary requirements, infant and maternal mortality rates, and increasing the proportion of the population with access to improved drinking water. In addition, there contains India specific National Targets of reducing anemia among women and girls, reducing gender gaps in literacy, and ensuring that 33% of all beneficiaries of government programs are women. However, targets on bridging disparities across castes are missing. There are no National Targets on the share of women in non-agriculture work or in parliament, neither on reducing gender gaps in education, nor ensuring universal access to reproductive health – all major MDG concerns[1314]. The national target of improving the juvenile sex ratio through the narrow implementation of restricting abortion services (rather than addressing son preference) may go against women's access to abortion, as can be seen from micro-level studies in Rajasthan. To achieve these targets, a total of Rs 3,644,718 crores has been budgeted, which at comparable prices is around 120% higher than the outlay for the Tenth Plan period (2002-7). In relation to the GDP, public sector spending will be increased from

9.5% during the tenth plan period to 13.5% during the Plan period (Planning Commission, 2008a). Details on external assistance across all sectors could not be obtained.

***Nutrition*:** India framed a National Nutrition Policy in 1993, and is in the process of tabling the Right to Food bill. The nutrition interventions outlined in the chapter Nutrition and Social Safety Net include extending the Integrated Child Development Scheme[15] (ICDS) throughout India, and providing nutrition support to all children aged 0-3 years, in addition to the present coverage of the 3-6 years age group and pregnant and lactating women. The chapter also extends mid-day meal scheme throughout India and makes a provision for mid-day meals in public schools until Class 8, and revamps and reduces leakages through the targeted public distribution system (through computerization and the introduction of smart cards) [16]. Related to nutrition, the chapter Strengthening Women's Agency and Child Rights introduces the implementation of the *Kishore Shakti Yojana* (adolescent girls' empowerment scheme) through the ICDS, which includes a nutrition component, namely the provision of iron, folic acid and de-worming tablets, as well as supplementary nutrition for adolescent girls. Girls aged 10-19 years are to be weighed four times a year, and those weighing less than 35 kg will be given 6 kg of food grains/ monthly for three months.

A study of the financial statement of *Kishore Shakti Yojana* reveals that in the year 2005-6, only 36% of the funds released were spent nationally. The figures were even more abysmal for Tamil Nadu (8.3%) and Gujarat (10.3%) (Ministry of Women and Child Development, n.d.). While the utilization rate of ICDS scheme was better and *Anganwadi* centers are being operationalized as planned (except in Jammu and Kashmir), the Right to Food Campaign notes that only 46% of children aged 0-6 years, 38% of pregnant and lactating women and roughly 3.8% of adolescent girls were covered in 2007-8 under the ICDS (Right to Food Campaign, n.d.). Corruption and non-implementation of guidelines on nutritional supplementation have been noted in several states ('Food forum punches holes in child scheme – Joint body of social activists & NGO decides to keep tab on

anganwadi centres...', 2010). It is therefore not surprising that micro-studies do not show the positive impact of attendance in ICDS on levels of child malnutrition (Sood and Sood, 1987) (when compared to non-attendees) nor levels of malnutrition when they are 7-13 years (Bhasin et al, 2001) where the program has been poorly implemented.

The exploitation of *Anganwadi* workers and helpers (females) by paying them a low honorarium is another issue. The targeted public distribution system (PDS) have come under criticism for errors of inclusion of non-poor and exclusion of a section of the poor (Khera, 2008), as well as not procuring and supplying wheat in adequate quantity, which led to rising prices. Single women, migrant people and transgender people find it difficult to get ration cards. The implementation of the Mid-Day Meal scheme was varied across and within states, with good implementation contributing to increase in enrollment (including girls) and nutrition of children (e.g. in Gumla Block of Jharkhand) and weak implementation (e.g. in parts of Uttar Pradesh) not having any positive impact (Upadhyay, 2010). It is hoped that the Right to Food Bill, when enacted, will strengthen the program's implementation.

***Poverty reduction*:** Four poverty reduction programs are referred to in the 2007-12 Plan, in the chapter entitled Rapid Poverty Reduction: namely, rural wage employment, rural self-employment, rural housing and social security interventions[17]. The total budget for poverty reduction has been increased from Rs 79,291 crores (2002-7) to Rs 190,330 crores (2007-12), representing a 140% increase. The wage employment program – the National Rural Employment Guarantee Scheme – is backed by legislation guaranteeing 100 days of employment at equal wages, failing which unemployment allowance would be provided. While there is no reservation for women within the Act, the guideline under the National Target is that 33% of all beneficiaries should be women. Childcare is to be provided where six women or more come with children under six years. Drinking water and a place to rest are also to be provided. Under the NREGS, the budget allocated is Rs 100,000 crores (at current prices) for the period 2007-12.

As per the NREGS web page, 113 million households received job cards (cumulative), 47% of who demanded jobs in 2009-2010. Of the households who demanded jobs, 99% secured them. There is no data with regards to the proportion of household job cards that were issued in women's names. Altogether 2.833 million job days have been created, although it is not clear whether this figure is cumulative or only reflective of trends for 2009-10. If it is only for the year, this comes to roughly 53.9 days per recipient household. In 2009-10, 49% of all employment created went to women, 30% to SCs and 21% to STs (Department of Rural Development, n.d.) revealing a pro-dalit and Adivasi orientation.

Independent reviews suggest that where NREGS has been implemented effectively, it has reduced caste barriers (Sainath, 2009a) and migration (Sainath, 2009b), and improved women's access to employment at equal wages. However, implementation has been slow with only 26% of the allocated amount released (Department of Rural Development, n.d), and is beset with corruption (Singh, 2009). With regard to gender issues, women's participation in NREGS was less than 50% in some states in 2007, including Jharkhand, Uttar Pradesh and Bihar, where poverty is concentrated, and above 50% in Tamil Nadu, Kerala, Andhra Pradesh, Rajasthan and Tripura (in Karnataka and Gujarat around 50%) (Sudarshan, n.d.).

There was less participation of younger women with children. Gender norms in society and conditions of workplace (the absence of good child care facilities, allocation of work like digging wells and sexual harassment by illegal contractors) were some of the barriers to women's participation. In parts of Bihar, Jharkhand, Madhya Pradesh and UP, one bank account was opened per job card (one per household) and found to be in the names of men. That is, even if women work, the payments go to men (Khera and Nayak, 2009). This situation was not visible during the visits made by the authors to sites in Rajasthan, Karnataka and Tamil Nadu where half or more of workers are women. However even there, there no provisions were made for temporary toilets. Cloths were also not available for menstrual hygiene in workplaces. There now is a new provision that

NREGS can be used for building toilets, houses, paying mid-day meal providers and crèches (Centre accepts suggestions of States under NREGS, 2009), however, there is little evidence that this provision had been utilized for these purposes. Given the high level of anemia among women of reproductive age, it is a great concern as there is no nutritional component within NREGS. In one village of Rajasthan, it was observed that the NREGS participants could be easily identified as "they have become thinner, since NREGS's inception, having to travel four to five kilometers to work for the full day, in addition to their reproductive work".

The self-employment program — SGSY— is based on collective micro-finance with a target that 50% of the groups should be exclusive for women. In 2009-10, there were 3.7 million SHGs in India, of which 72% were exclusively women (Department of Rural Development, n.d.). Each group had roughly 15-20 members. Approximately 8% of groups have now become defunct; while 28% have received their first installment of revolving fund of Rs 25,000; and 29% having had received their second and larger installment of Rs 2,500,000. The government estimates that almost 93 million households have crossed the national poverty line though this program, which accounts for 63% of BPL in 2002[18]. Micro studies on SGSY, however, place the estimate much lower. While the SGSY scheme did improve women's access to micro-credit and income (provided that they manage the activity), the program did not have a major impact on women's ownership of assets and rarely had it managed to break the gender division of labor (productive and reproductive work). Consumption loans had at times gone towards 'dowry' and education loans were primarily invested on males rather than females (Murthy and Ranadive, 2005). The SGSY scheme is therefore de-linked from SRHR schemes, other than the fact that some of the SGSY group members are in the village health or sanitation committees or primary health care (PHC) patient welfare committees whose role is to spread 'health messages' and mobilize people for health camps. Opportunities for raising awareness on SRHR issues among SGSY groups have been missed.

Moving on to the housing program, under the *Indira Awaz Yojana*, houses are allotted in the names of female members of selected households or in the joint names of husband

and wife. At least 60% of funds are to be used to construct houses for SC/ ST people. Further, 60% of the IAY allocation is earmarked to benefit SC/ ST families, and 15% for other minorities. However, the distribution of funds for housing in phases is a problem for the poor, with delays and corruption occurring at every stage. Furthermore, there are operational problems in giving house titles to women under the *Indira Awaz Yojana* when land is owned by men — as is the case in most households in India. Though the Plan aims to search for strategies to address this problem, it does not mention how this problem would be resolved. Housing and domestic violence are inter-linked, and studies from Kerala suggest that having assets in women's names lowers their vulnerability to domestic violence (Panda and Agarwal, 2005).

An important concern is that the government has mooted several poverty reduction programs on the one hand, yet on the other is permitting the conversion of agriculture land for industrial purposes, allowing special economic zones in rural areas and permitting infrastructure projects that appropriate agriculture land with poor compensation. There is little, if any, insurance cover to deal with market fluctuations and poor agricultural yields. Droughts and floods are becoming common with climate change, as well as the over-exploitation of ground-water resources.

***Gender*:** No legislation guarantees women gender equality, although the constitution does prohibit discrimination on the grounds of sex. However, there are several types of legislation to protect rights of women, namely the Widow Remarriage Act, 1856; Child Marriage Restraint Act, 1929; Immoral Traffic (Prevention) Act, 1956; Dowry Prohibition Act, 1961; Maternity Benefit Act, 1961; Equal Remuneration Act, 1976; Indecent Representation of women (Prohibition) Act, 1987; and the Protection of Women from Domestic Violence Act, 2005. A bill is being tabled in the Lower House of Parliament to reserve and guarantee 33% of all parliamentary seats for women, while there already exists a 50% reservation for women in local governments. Rights of women related to divorce, custody of children and inheritance vary by religion, with Hindu women having equal rights to inheritance after amendments made in Hindu laws in 2005. India ratified

the Convention for the Elimination of Discrimination against Women (CEDAW) in 1993, but has yet to ratify the Optional Protocol, which empowers NGOs to make appeals to International Courts of Justice should the government fail to comply with the articles of CEDAW. However, there is a huge gap between rights as per legislation and CEDAW, and the realities of women on the ground as monitoring mechanisms remain weak. The Indian government has also placed declarations on Article 5 (a) and 16 (1) of CEDAW, saying it will be able to abide with these articles only to the extent that Personal Laws of communities permit, as well as on Article 16 (2) on compulsory registration of marriages.

The 2000 National Policy on Empowerment of Women of India makes no reference to the MDGs. The section on women's agency in the 2007-12 Plan, in its chapter on Advancing Women's Agency and Child Rights does not refer to the MDGs, although the section on child rights does (Planning Commission, 2008f). The chapter mentions several actions which if implemented would further some of the targets of the MDG 3, Gender Equality and Women's Empowerment by eliminating gender disparity in education and increasing the proportion of women in parliament. However, there are no targets for the MDG 3 indicator of increasing ratio of women's earnings to that of men's, or in increasing the share of women in non-agriculture work. On the issue of gender and poverty, the chapter on Advancing Women's Agency and Child Rights refers to strengthening women's rights to land and housing, preventing discrimination against women living with HIV/ AIDS, and improving access of women to micro-credit. Despite these, no references are made towards increasing the proportion of women in paid work, implementing equal wages, or eliminating the practice of dowry, which is one cause behind households slipping into poverty. Preventing violence against women is evidently not seen as important in the reduction of poverty among women.

On the issue of gender and SRHR, the chapter makes both progressive and regressive comments. On the one hand, it seeks to enact legislation on the compulsory registration of marriage, sexual harassment at the work place and the protection of women with HIV/ AIDS against discrimination. It also seeks to promote the reproductive rights of

women with disabilities; train health personnel to treat survivors of violence; and empower adolescent girls through awareness raising on nutrition, health, sexuality education and negotiation strategies (including through the national scheme discussed earlier, the *Kishore Shakti Yojana*) – measures that are all rights-based. On the other hand, while the chapter refers to the rehabilitation of survivors of rape, it makes no mention of bringing perpetrators to book. The chapter while referring to the strict implementation of the Pre-Conception and Pre-Natal Diagnostic Techniques Act (PCPNDT Act), does not tackle the broader social issue of son preference, nor does it explain that its faulty implementation can seriously jeopardize women's access to safe abortion.

***Health/ SRHR*:** In the health sector, important government policy frameworks include the National Health Policy, 2002 and the National Population Policy, 2000. A draft National Health Bill and HIV/ AIDS Bill are still in the pipeline. To implement these policies, the National Rural Health Mission (into which the RCH II is integrated, and is funded by donor partners including the World Bank) was launched in 2007. A proposed National Urban Health Mission has been postponed to the Twelfth Five Year Plan period. While Health and Family Welfare departments or programs have been merged under the NRHM, the National Aid Control Organization continues to function independently through the National AIDS Control Program 3, pointing to the artificial separation of health and reproductive health from HIV/ AIDS.

The health chapter in the 2007-12 plan elaborates the different health policy frameworks and the services provided to translate these policy frameworks on the ground. No references are made to ICPD+15 in this chapter, nor the MDGs. None of these national level policy documents clearly recognize the concepts of reproductive rights, sexual rights or sexual health, nor discuss these concepts. The National AIDS Control Program covers sexual health. While the NRHM and RCH mention a range of services such as infant health, antenatal care, emergency obstetric care, abortion services (manual vacuum aspiration), contraceptive services, infertility services, STI/ RTI services, and adolescent reproductive education, many of the monitoring indicators are focused on family

planning targets and infant, child and maternal mortality. Such monitoring indicators suggest that the government is not serious about other SRH services, and refers to these services only because they are part of the donor-funded Reproductive and Child Health Phase II Program Implementation Plan (RCH II PIP). The National Aids Control Program (NACP) lays emphasis on prevention, care and support, and addressing human rights issues of People Living with HIV/ AIDS (PLWHA). But the reproductive health needs of women living with HIV/ AIDS are not mentioned in these paragraphs. Further, the National AIDS Control Program includes compulsory screening of ANC (ante-natal care) mothers, with no screening of their partners. Treatment for SRH complications due to violence, adolescent reproductive health services, and SRH services for people of diverse sexual or gender identities are also not mentioned, other than HIV prevention.

The analysis by Jan Swaasthya Abhiyan — People's Mid Term Review of the Eleventh Five Year Plan (Abhiyan, n.d.) — shows that the projected 30% increase in allocation in each of the first three years of the 2007-12 Plan is exaggerated. The real increase was 12.6% in 2007-8 and 11.2% in 2008-9, barely above the annual growth of GDP. As a consequence, total public expenditure on health has remained around 1% of GDP, despite the government's stated target of 2% of GDP by the end of the Plan period. This is much below the WHO target of 5% of GDP. Various reports show that national government spending in 2004-5 for clinical services, medical education, research and HIV/ AIDS increased three to four times, while spending on immunization, family welfare and contraception increased less than 1.5 times, barely keeping pace with inflation (Duggal, 2009). Another concern is that in India public spending on health accounts for less than 20% of total health spending. A low allocation to health is one part of the problem; another is the under-utilization of allocated funds, which is indicative of a low absorption capacity and failure to mobilize decentralized spending (Abhiyan, n.d.). In 2006, expenditure on health in India was only US$ 21 per capita, well below the US$ 34 per person recommended in the report of the Commission on Macro-Economics and Health for basic health care services in low-income countries[19] (World Health Organization, 2001).

The 2007-12 Plan signifies a marked shift in the division of responsibility between state and market in meeting SRHR needs and other health interests of the poor, with greater emphasis made on public-private partnerships than ever before (Planning Commission, 2008g). User fees have entered through the back door. Patient Welfare Societies at the primary health care, block (taluk) and district hospital level are allowed to charge user fees at their discretion and use this revenue to improve services (Ministry of Health and Family Welfare, n.d.). The extent of privatization of health services for the poor varies between states.

The Health and Family Welfare chapter of the 2007-12 Plan acknowledges poverty as a social determinant of access to SRH, as well as economic inequalities. It emphasizes greater investment in strengthening health infrastructure in remote areas; addressing human resource shortages; increasing access to health care of vulnerable groups; and so on. However, the solutions proposed appear to tilt heavily towards Public Private Partnerships (PPPs) and health insurance models rather than making any substantial increase in public direct investment in the health sector or strengthening its capacity to enable the provisioning of services. The link between SRH morbidity and the poverty of women, as well as their access to poverty reduction programs is inadequately analyzed, other than in regard to people living with HIV/ AIDS. Gender inequalities as a determinant of health or SRHR are also not well recognized, other than in the area of maternal health services.

The 2002 National Health Policy promotes medical tourism. However, its emergence and rapid expansion in India has impacted adversely on the public health system. The assumption on which this policy was based – that services for the haves and haves-nots are totally independent of each other – is flawed. Reddy and Qadeer (2010) argue that:

> *"In its efforts to fill its coffers through Medical Tourism, the government has underplayed the obvious contradiction between the vast uncared-for majority and an unethical focus on profits through Medical Tourism. It has ignored many of the*

underlying negative implications of Medical Tourism such as shifts in subsidies to the private sector and extremely low inputs in the public health sector."

A recent report of the UN Rapporteur on Health portrays the current health workforce as presenting a major bottleneck in India in achieving the MDG 5 on maternal health (United Nations, 2010). There are too few skilled birth attendants. Auxiliary nurse midwives who are supposed to reside at village sub-centers and assist in childbirths are often absent from the very communities they are supposed to serve. They also do not have the competencies of a skilled birth attendant as the midwifery part of their basic training was reduced along with the reduction of their pre-service training from 24 to 18 months. The same report by the UN (2010) also states that:

> *"India has extremely weak technical capacity for managing maternal health programs at the national and state levels. This presents a major constraint on the country's attempts to reduce maternal mortality and achieve MDG 5. Unless this constraint is removed, even increased investment in maternal health may be ineffective. The cost of increasing senior management is only a small fraction of the total resources devoted to maternal health in India."*

According to Mavalankar et al., cited in the UN report (2010), India needs around 110 maternal health technical officers with authority to plan, implement and monitor maternal health programs without having to go back to non-technical officers for approval. Technical advisory committees on maternal health should also be formed at national and state levels to provide expert advice to technical staff.

The *Janani Suraksha Yojana* (JSY) is the centerpiece of India's maternal health strategy. It aims to increase the number of institutional deliveries by providing cash incentives to pregnant women, thereby increasing the access to health services of women living in poverty and marginalized social groups such as the dalits and tribals. There is overwhelming evidence that the JSY successfully increased antenatal care and the number of institutional deliveries, and probably helped reduce neonatal deaths (Lim et al., 2010). But there are also problems with the JSY. The program needs to be better

targeted as oftentimes, the poorest and the least educated women do not have the highest chance of being JSY recipients. The shortage of competent staff also translates into qualitatively poor maternal and neonatal care in the facilities (Vinod, 2010). The scheme is constrained by a conditionality that excludes the most vulnerable women: those below 19 years or with more than two children. The need for recipients to possess Below Poverty Line identity cards excludes some genuinely needy families yet provide services to people who have cards despite not meeting eligibility criteria. Corruption and bribery exist, and the poorest are the most affected. Finally, although the JSY has increased the demand for services, the health system has not been able to supply good quality services uniformly or consistently. As the UN Rapporteur's report points out: "The focus in India is on increasing institutional delivery, but institutional delivery is not a proxy for access to skilled birth attendance or lifesaving care" (United Nations, 2010).

***National Policies on poverty, gender and SRHR: Coherence or Disjunction*:** On the whole, government policies on poverty, gender and SRHR show some coherence but also several disjunctions. The main area of cohesion is found in government attempts — due to pressure from social movements — to further rights-based approaches, such as the right to work; prevention of domestic violence; prevention of atrocities against SCs/ STs; women's participation in local government; and recognition of rights to food, health and non-discrimination for people with HIV. Such legislation enables addressing the intersections between gender, poverty and health.

Meanwhile, government support for the privatization of agricultural land; the creation of special economic zones; the privatization of health; and the promotion of medical tourism along with the institutionalization of user fees and public private partnerships, all have an adverse impact on poverty-reduction strategies and SRH. Disjunctions within programs or between schemes in a sector thus result in a failure to address the root causes of poverty, gender inequality or SRHR violations.

Donor policies, gender, poverty and SRHR

A summary of donor policies (UNDP, 2007; UNIFEM, 2007; UNFPA, 2007; DFID, 2008; UNICEF, 2008) and lenders (World Bank, 2004; ADB, 2007) in India on MDGs, gender, poverty, and SRHR found that many donors emphasize MDGs much more than the government does. While all major donors directly focus their efforts on poverty reduction, the UNFPA, UNICEF and DFID additionally seek to address the gender-specific causes of poverty. Even then, the issue of gender is not comprehensively understood, nor addressed. On nutrition programs for example, the UNICEF focuses on nutrition of pregnant and lactating women; the UNFPA on nutrition of adolescents; and DFID and UNICEF on the nutrition of children, but none focuses on the nutrition of women who are not pregnant or lactating. DFID refers to strengthening women's access to markets, while UNIFEM refers to strengthening women's economic rights and participation and their ability to negotiate in new trade agreements (DFID, 2008; UNIFEM, 2007), but neither has a strong strategy on strengthening women's ownership of land and assets, or expanding women's engagement in paid work. While the UNDP seeks to strengthen implementation of NREGS (UNDP, 2007), it makes no recognition of the possible consequences of anemia or SRH morbidity on women's participation in the program. Hence, strategies of donors on addressing gender-specific causes of poverty are only slightly better than those of the government.

All seven donors focus on some or other SRH issue, with HIV/ AIDS being a concern of all donors. Four focus on maternal health (World Bank, UNICEF, UNFPA and DFID), two on reproductive health (UNFPA and DFID), two on combating violence against women (UNIFEM and UNFPA), and one on adolescents' reproductive health (UNFPA). Amidst all these, no reference is made towards the SRHR of people of diverse sexual or gender identities other than those directly related to HIV/ AIDS. There is also a stronger focus amongst donors on reducing HIV prevalence than improving maternal health or promoting comprehensive SRH services for all. This may in part explain why India is on target on HIV indicators, but behind targets for maternal health and other RH indicators.

While the links between poverty and SRHR are recognized by World Bank and ADB contradictory solutions are being proposed. The World Bank calls for greater public health expenditure and regulation of the private sector, but in the same breath demands for public-private (for profit) partnerships in health and levying user fees in urban areas for water and sanitation (World Bank, 2004). The ADB on the other hand calls for greater public investment on health in Mizoram, but at the same time calls for tertiary hospitals to promote public-private partnerships in health (Asian Development Bank, 2007).

In regard to donor policies on gender equity, a positive trend is observed in DFID's call for strengthening the demand for health through the *Mahila Samakhya Program*; in the World Bank's advocacy for gender mainstreaming in the health department; in the UNFPA's call for gender mainstreaming in RCH; and UNICEF's emphasis on women's needs in humanitarian responses. On the other hand, three out of the seven donors seek to address the issue of declining sex ratio by combating 'female feticide' rather than addressing son preference. The use of the term 'feticide' denotes the strong pro-life stance of donors. In this sense, UNIFEM's stance is stronger in that it focuses on gender equity and emphasizes women's economic and political empowerment.

Overall, it is obvious that the UN actors, compared to the World Bank and the Asian Development Bank, have been more progressive in tackling the issues of SRHR, gender and poverty reduction. However, almost all donor agencies are tilting towards promoting public-private partnerships in social sectors and tend to assume, like pro-lifers, that fetuses have human rights.

Tamil Nadu policies and progress on the MDGs, poverty, gender equity, and SRHR: coherence and disjunctions

Profile of poverty, gender inequity and SRHR

In 2004-5, Tamil Nadu had a per capita GSDP of RS 31,603, higher than the per capita GSDP of India (Planning Commission, 2008h). Because of its higher levels of development to begin with, its growth rate during 2002-7 (6.6%) was slower than in India as a whole (7.0%) (Planning Commission, 2008h). In 2004-5, the percentage of people below the national poverty line was slightly lower in Tamil Nadu (22.2%) than in India (27.5%) (Planning Commission, 2008a) and in 2005-6, the proportion of underweight children was substantially lower (25.9% compared to 45.9% for India). However, in 2000, the percentage of households without agriculture land[20] and the Gini Ratio of per capita consumption were higher than the Indian average for both rural and urban areas (Planning Commission, 2002).

Annex 4 shows important statistics from national and state level sources on Tamil Nadu on gender, poverty and SRHR from 1990 to 2005. Again, data is inconsistently available across all indicators for the years this paper seeks to track. Unlike India, where several donors have analyzed progress on the MDGs, such analysis was not available for Tamil Nadu. The unavailability of data compelled the authors to use their own computation, based on targets set in MDG, for different indicators.

Similar to the case of India, in Tamil Nadu there is no clarity as to the possibility of achieving the MDG target 1 on reducing poverty. According to the State Planning Commission, the proportion of population below the national poverty line decreased from 35% in 1993-4 to 22.5% in 2003-4. NFHS 2 and 3 suggest that progress on halving the proportion of the anemic population or adults with BMI below 18 kg/m2 is much less likely. Based on the NFHS 2 and NFHS 3, the state may, however, achieve the target of halving the proportion of underweight children, and possibly the required two-thirds reduction in the IMR and child mortality rate. This may be explained by a decreased

incidence of poverty, or the better functioning of Integrated Child Development Services ICDS in the state (Rajivan, 2006) combined with higher literacy levels of parents, greater participation in the SHGs in disseminating information on nutrition, and a better functioning public health system especially for infant, child and maternal health services, including abortion and other SRH services (Ravindran and Murthy, 2009; Balsubramaniam and Bhavani, 2009).

As in India, poverty in Tamil Nadu is feminized in general, but the forms of feminization vary and the extent of experience of poverty is lower. Gender gaps are also prevalent in Tamil Nadu such as evidenced by its child mortality rate and the proportion of adults with a BMI below 18 kg/m2 or who are anemic(IIPS and Macro international, 2008). In 2005-6, anemia levels among Tamil Nadu women were slighter higher (0.3 percentage points higher) than for all Indian women. The proportion of Tamil Nadu women with low BMI was only slightly lower than the national population average of women (IIPS and Macro international, 2008). However, anemia levels are lower among female infants, hence the existence of gender disparity in the IMR[21] cannot be ascertained. Further, the enrolment of boys is lower than girls in classes 10 to 12.

There is an absence of state-level data on women's ownership of assets, but multiple micro-level studies note that women (apart from single women) rarely own land (Murthy et al., 2008). The percentage of adult women employed in the labor force increased from 46.7% in 1992-3 to 53.8% in 1998-9, but decreased to 46.2% by 2005-6[22]. While the proportion of Tamil Nadu women in current employment is higher than for India as a whole, as in India, women in Tamil Nadu generally earn 0.32% of what men earn. Women earn PPP US$ 1,643 per annum in comparison to men who earn PPP US$ 5,063 per annum — reflecting the fact that most women are in vulnerable employment (State Planning Commission, 2008b). A larger proportion of women than men work in agriculture – a sector that is retracting as industries and services grow. Similar to national-level data, around 20% of all in women Tamil Nadu do not have a say on how to use their earnings (IIPS and Macro international, 2008). The double burden of work for

women and the absence of any nutrition component for non-pregnant or lactating women within ICDS make it not surprising that Tamil Nadu is also behind in regard to the MDG Goal of halving the proportion of underweight women.

Poverty is class, caste and ethnic specific in Tamil Nadu, with landless households and SCs accounting for the majority of the poor (State Planning Commission, 2008b). The proportion of landless is highest among dalits. While the State Planning Commission, in its chapter on poverty, has not commented on the poverty of STs and Muslims, data from the 2005-6 NFHS suggests that the proportion of people living in the lowest wealth quintile is highest amongst STs, followed by SCs, and then others. A smaller proportion of the Muslim population than the Hindu population is in the lowest wealth quintile. The proportion of children aged 6-59 months who are anemic and underweight is highest among SCs (with no data on STs), and higher among Hindus than Muslims or Christians. The proportion of adult women who are anemic is higher among SCs than STs and other castes, and lower among Muslims than Hindus and Christians. The proportion of women with a low BMI is highest among STs, followed by SCs and then others, and higher among Hindus than Christians or Muslims. However, the proportion of women with low BMI was observed to increase amongst Muslims and decrease substantially for other groups.

Although the average age at marriage is around three years older for Tamil Nadu women and men than it is in India generally, the gender gap in age at marriage has persisted over the past fifteen years. Arranged marriage within the same caste continues to be the norm. While breaking caste and religious norms in marriage is looked down upon, honour killings are less common here than in north-west India. The prevalence of HIV/ AIDS is slightly higher in Tamil Nadu than India as a whole, though the prevalence rate is reversing among ANC mothers and high risk groups (IIPS and Macro international, 2008). According to the NFHS 3, more Tamil Nadu married women reported spousal violence at least once, than did Indian women as a whole (39% vs. 34%), reflecting either higher incidences of violence or more willingness to report by the former. The sex ratio of

population improved between 1991 and 2001, and after dipping in the 1990s, the sex ratio at birth improved between 1999-2000 and 2004-6 (Sharma and Haub, 2008).

Unlike the whole of India, Tamil Nadu is likely to achieve MDG 5, reducing the maternal mortality ratio and improving access to skilled birth attendance. By 2005-6, there was almost universal access to ANC, and the proportion of women with access to PNC within two weeks had doubled, as per DLHS 2-3. Yet, like the rest of India, the target of eliminating unmet needs for spacing and limiting is unlikely to be achieved. In absolute terms, Tamil Nadu has less unmet need for child spacing and limiting compared to India as a whole, with unmet needs being higher for limiting than spacing in 2005-6, in contrast to 1992-3. There is no data that maps out the trends in adolescent fertility rate in Tamil Nadu making it difficult for the researchers to provide comments on the possible achievement of the MDG. However, the percentage of live births to women 15-19 years stood at 3.2% in Tamil Nadu in 2005-6, lower than for India. By 2005, Tamil Nadu had achieved the target of reversing the spread of HIV/ AIDs, as per the Sentinel Survey (2007). Moving beyond MDG indicators on SRHR, NFHS 2 and 3 report that access to post natal care within a day also improved by three fourths between 1998-99 and 2005-6. Contraception continues to be a female responsibility, with little improvement from 1992 to 2005. There was a three-fourth decline in women reporting RTI/ STI symptoms, abnormal vaginal discharge, and menstrual problems between 1992-3 and 2005-6 (NFHS 2,3), although the percentage of women reporting RTI/ STI symptoms was higher among Tamil Nadu women than men (other than HIV), and almost similar to the Indian average. The percentage of women reporting primary or secondary infertility and obstetric fistula placed the incidence at 6.7 and 0.3 respectively for 2007-8 (compared with 1.5 and 8.4 respectively for India). There is no reliable data on women's access to pap smears or breast examination. The 2005-6 NFHS found that disconcertingly, over one fourth of all Tamil Nadu women do not take decisions (alone or jointly) on their own health care, despite their space for decision making on health care being better when compared to all Indian women. Access of pregnant women to full ANC and post natal care was lower among Hindus than Muslims and Christians in Tamil Nadu. SCs/ STs had less access to

maternal health services in comparison to other caste groups (with SCs faring the worst on access to ANC and STs on PNC). Where Muslim and Christian women fared worse was in their low contraceptive prevalence rate and access to JSY benefits. Unmet needs for contraception are highest among Muslim women (IIPS and Macro International, 2008).

On the whole, Tamil Nadu seems on track with regard to reducing the proportion of underweight children 0-3 years; ensuring gender equality in education; reducing infant, child and maternal mortality; and reducing the incidence of HIV/ AIDS. The degree of success is mixed in regard to other reproductive health needs of women, and bleak with regard to achieving gender equality in economic and political participation, anaemia and malnutrition, and BMI among adults. SCs/ STs lag behind on most indicators, as do Muslims on access to JSY, and unmet needs for contraception and education remain high. The increased prevalence of poverty between 2001 and 2003-4 is a cause of concern. Where data is available, rural areas fare worse on most indicators, but if it were possible to disaggregate data – further classifying urban areas into slums and non-slums – the picture may have been different.

Attention to MDGs, gender equity, poverty and SRHR in Tamil Nadu plans and sectoral policies

***State targets, outlay and borrowings*:** A review of the Tamil Nadu Five Year Plan reveals that the plan (outlined in Chapter 1) does not use the term MDGs, although its 20 monitoring targets cover seven MDG targets and indicators. This includes reducing the proportion of households below the poverty line, the proportion of underweight children, infant mortality rate, maternal mortality rate; and promoting universal completion of elementary access to drinking water (State Planning Commission, 2008b). The chapter also mentions that priority would be given to meeting unmet needs in family planning, though it reports no monitoring target. The earlier critique of the national targets through the lens of the MDGs, poverty, gender and SRHR also applies at state level. However, as opposed to the National Target of 33% women beneficiaries in all

government programs, such a quota is missing at state level. This highlights the evaporation of some well-intentioned policies as they trickle down to the state.

The state outlay for the 2007-12 State Plan, of Rs 85,344 crores, is twice as large as in the Tenth plan period (2002-2007)[23]. Of this amount, 21% will be drawn from the state's own funds, 19% from central assistance, and a heavy 60% will be financed through loans — of which 19% will come from external aided projects. Only 3.2% of state government outlay is allocated to health (State Planning Commission, 2008b), with a 9.18% investment in education and agriculture being greater (State Planning Commission, 2008a).

***Poverty reduction policies*:** Unlike the national Five Year Plan, there is no separate chapter assigned to poverty reduction. The Tamil Nadu Eleventh Five Year Plan chapter on Rural Development (which covers poverty reduction) does not use the term MDGs. Similar to the national level, wage employment, self-employment and housing are all seen as rural poverty reduction strategies. Social security programs do not seem to be regarded as part of rural poverty reduction strategies, but a separate chapter reports on social welfare. Apart from provisions under the national poverty reduction programs, community infrastructure development through decentralized government is seen as central to poverty reduction and rural development. Fifty per cent of women's SHGs in the state will be given revolving funds and other financial assistance, and identity cards that will allow SHG women members to access government programs. The flow of funds (tied and untied) to decentralized bodies will increase, and a women's quota of one third participation in Gram Sabhas (village assemblies) will be enforced.

While some of these initiatives are impressive, the target of employment coverage for 30% of all registered households under TNREGS remains problematic [24]. Further, in contrast to the national chapter on Rapid Poverty Reduction, no mention is made in the state chapter on Rural Development that women would be given housing in their own names. Similar to the national level chapter on poverty, strengthening land ownership of rural women or their earnings vis-à-vis men is not emphasized. Of added concern is that

only 15% of the budget of the Department of Rural Development in 2007-12 was allocated to wage employment, 4% to self-employment, and 9% to housing (State Planning Commission, 2008c). If the government fails to provide employment, an unemployment allowance is to be paid by the state.

In terms of implementation of the SGSY, government data shows that in 2009-2010 323,218 SHGs had been formed in Tamil Nadu, of which less than 5% have become defunct (better than the national figure); 79% had been assessed for the first round of loan of Rs 25000 (but only 9% secured funding), and 18% had been assessed for the second round of loans. Roughly, 21% of members are believed to have crossed the poverty line (Department of Rural Development, n.d.). The performance of SGSY in Tamil Nadu is generally worse in comparison to all-India performance. It is therefore not surprising that the program was recently shifted from the Department of Rural Development to the Tamil Nadu Women's Development Corporation. The performance of NREGS, on the other hand, is better than the national average, with 6,535,710 households now with access to job cards, and 67% of them demanding employment from the government. All of the households that demanded for employment were successful, with an average of 54 person days of work per household in 2009-10, approximately the same as the average for the country. Women constituted 82% of workers in 2009-10; dalits constituted 59% of the employed (higher than in population); and tribals constituted only 2.5% (lower than in population) (Department of Rural Development, n.d.).

***Health*:** In the Tamil Nadu State Plan, the term 'MDG' is nowhere to be found in the chapter on Health and Family Welfare but there are some new health policies introduced. These include comprehensive health checks at village or PHC level; under the *Muthulakshmi Reddy scheme*, an additional maternity cover of Rs 6000 (roughly US$ 140) for pregnant women; strengthening of the 66 World Bank-supported Comprehensive Emergency Obstetrics (CeMOC) centers in the state: provision of cervical cancer diagnosis and treatment in two districts (also World Bank supported); new emphasis on meeting

unmet family planning needs; treatment of infertility through Indian systems of medicine; setting up state illness societies to meet catastrophic health costs for the poor; strengthening insurance for elderly; strengthening tertiary care in hospitals, including accident, trauma and cardiac; improve urban health services; and implement the strict monitoring of the PCPNDT Act (State Planning Commission, 2008b). However, a number of important issues for women – such as increasing access to abortion services, reducing malnutrition among women who are not pregnant, reducing gender based violence, expanding access of adolescents and single women to contraception and SRH services – were left off. The term 'sexual and reproductive rights' is not used and neither is the term 'sexual health'. Currently, the state government has gone ahead in exploring public private partnerships to strengthen the capacity of secondary hospitals to reduce maternal and infant mortality, provide universal cervical cancer screening in two districts, and prevent and treat cardio-vascular diseases in four districts (Ravindran, 2009).

Beyond what is mentioned in the chapter, the introduction of *Kalaignar Kappedu Thittam* (Chief Minister's health insurance scheme) is of interest. Under this, people below the poverty line can access treatment for life threatening illness from the private health sector for up to Rs 100,000 per household per year. This includes reproductive cancer treatment, but excludes emergency caesarian section or infertility treatment. The card is issued in the name of the head of household (usually a man) and not the joint names of husband and wife. The scheme also excludes provisioning for the identification of transgender people (classification system is limited to the binary male or female).

The percentage of State GSDP allocated to health increased from 1.25% in1995-6 to 1.53% in 2004-5, going beyond the Indian average. Per capita public health expenditure rose from Rs 166 to Rs 448 during the same period–(Rao and Chowdhury, 2008). However, according to one estimate, a further 0.6% of GSDP was required in 2009-10 to fulfill the health commitments of the state government (Rao and Chowdhury, 2008). The World Bank funded Health Systems Development Project constitutes 31% of the health budget outlay for the 2007-12 Plan (State Planning Commission, 2008b). Overall, half the

budget goes to primary health care, of which one third provides maternity assistance of Rs 6000 per head. Other health issues receive less financial support. A proposal to allow Patient Welfare societies to levy user fees at tertiary level was defeated by the government and unions of workers and left political parties.

***Gender*:** The section on Women's Welfare in the chapter on Social Justice, Empowerment and Welfare Services of the 2007-12 Plan mentions neither the MDGs nor the 1994 ICPD Program of Action (POA) (State Planning Commission, 2008d). It is rather interesting that the terms 'empowerment' and 'justice' have been dropped from the women's section of this chapter, although the title has a more progressive element. The Women's Welfare section purports the objective of promoting socio-economic empowerment of women through the formation of self-help groups; making women aware of their rights and protecting them from any form of exploitation; and strengthening social security for elderly women. Unfortunately, these objectives are not translated into progressive programs. Schemes like marriage assistance programs; the cradle baby scheme to prevent the murder of female infants; a free supply of sewing machines for the deserted, destitute and physically 'handicapped' women; assistance for children of poor widows; the formation and strengthening of SHGs; and the provisioning of widow pensions, all reek of welfarism. New proposed programs include extending family counseling centers (from dowry to domestic violence) from six districts to all districts; the strengthening of *panchayat* level federations of SHGs with the provisioning of Rs 10,000 each; the provisioning of identity cards to SHG women to improve their access to services, including health services; implementing programs that improve the literacy of SHG members; organizing entrepreneurship training programs for women; and extending the pension scheme for widows to also include deserted women. The new World Bank project *Vazhndu Kattuvom* (We will live and show) will continue to promote women's 'empowerment' in 15 districts, focusing on micro-finance to improve the livelihoods of women. Despite this, there is no mention of the rights of women to land, housing, full employment, equal access to income and markets, or sexual and reproductive rights that are all found in the national 2007-12 Five Year Plan. There too is a clear exclusion of the

33% national target for women in all government programs (State Planning Commission, 2009a). On the positive side, there are more funds allocated for women's development, an increase to Rs 784 crores in this Plan period, from Rs 381 crores in the previous Plan. Of this amount, the World Bank provided 86% through a soft loan.

On the whole, the Tamil Nadu government's reproductive health policies are more progressive than the national policies, particularly with regard to maternal health (other than the provisioning of legal abortion services), and the provisioning for the needs of transgender people. How far the latter agenda of the state is linked to bringing down the prevalence of HIV is a matter of debate. There is little difference in poverty reduction schemes between national and state levels. Shortcomings are manifested in the absence of a 33 % quota under all government poverty reduction schemes, and where no reference is made towards issuing housing title deeds on the names of women. Another serious limitation is in the dilution of national level women's rights and advancement schemes into welfare schemes at the state level. This leaves to debate whether furthering reproductive health without women's empowerment will work. Equally problematic is Tamil Nadu's great dependency on external loans to fund women's development program schemes (86%) as well as its dependency on health for secondary or tertiary care (33 per cent). Sustainability is an issue.

Perceptions of Tamil Nadu officials on MDGs, gender, poverty and SRHR

Interviews were held with policy makers from the State Planning Commission, State Commission for Women, Reproductive and Child Health Program, Tamil Nadu State Aids Control Society (TANSCAS), the Social Welfare and Nutritious Meal Program Department, the Labor and Employment Department, and a middle level staff member of the *Panchayati Raj* and Rural Development Department. These interviews aimed to gauge awareness about the MDGs and the 1994 ICPD POA; and the extent to which these commitments have influenced their department's planning processes, specific issues in the state that are related to their sector, specific programs and targets in Tamil Nadu

state, progress and constraints in achieving national and state targets, budgets and expenditures, and the linkages they perceive between SRHR, gender and poverty.

Discussions with policy makers and middle level managers confirmed observations made from the review of policy documents as to the coherence and disjunction between national and state policies, and within state policies. Touching upon areas of coherence first, the interviews highlighted the existence of a state-specific scheme, *Samathuvapuram*, which seeks to bring different castes groups to live together. Such schemes seek to reduce barriers to physical access of poverty reduction, health/ SRH and nutrition services amongst dalits who normally live on the periphery of the main villages. Another area of coherence is in awareness raising schemes on the prevention of HIV/ AIDS for youth groups and through women's self-help groups in the state. The interviewers illuminated health schemes that were left off in the 2007-12 Plan document, such as the provision of master health checks in public hospitals for sex workers, men who have sex with men, and transgendered persons; and the provision of free sex-reassignment surgery for males who wish to change their sex in selected government hospitals in Chennai (Right to Choose, 2010). A separate board for transgender people (men to women) was set up in 2008 to ensure their welfare (Govindan, 2009).

In regard to disjunctions, the interviews confirmed our findings from the desk review that the MDGs do not have a major influence on state government policies nor monitoring mechanisms, even though all the policy makers interviewed were aware of the MDGs, (apart from the lone middle level rank official who was not aware of the MDGs). There was much less awareness about the ICPD POA. Only the member of the State Planning Commission (who also happened to be the gender expert) and the RCH Commissioner were aware of the ICPD POA. Surprisingly, the Chairperson of the State Commission of Women was not aware of these commitments, although she seemed to be familiar with the Beijing PFA.

Discussion with policy makers highlighted another disjuncture linked to rapid urbanization in Tamil Nadu on the one hand, and the lack of any employment guarantee scheme or RCH–II program in urban areas on the other. Two out of the seven officials interviewed highlighted this. Amongst policy makers, the interviews found varied sensitivities on gender, poverty and SRHR issues, their inter-linkages, and how these impacted upon their department's responsibilities. For example, while Tamil Nadu provisioned for added special nutrition supplements in its budgeting (three eggs per week for 3-5 year-olds and primary school children, instead of two), no added provisions were made for non-pregnant and lactating women with low BMI. Further, while compulsory ANC screening was being implemented for people living with HIV by the Tamil Nadu State Aids Control Society (TANSACS), a policy that protected the identities of women (to ensure that she would face no discrimination if tested positive) was sorely missing.

Fragmented responsibilities over implementing poverty reduction, gender equality or SRHR programs also posed serious challenges. Interviews with officials revealed that two different departments were in charge of implementing poverty reduction schemes even when in the national policy document, NREGS, SGSY, housing, and social security, came under the chapter on Rapid Rural Poverty Reduction. TANSACS and the Health and Family Welfare Department also functioned separately.

The interviews also revealed that sound policies were not always implemented. For example, while the RCH II component within NRHM was comprehensive, its implementation was reported to be best for maternal health, infant health and HIV/ AIDS. Issues such as legal abortion; reproductive cancer screening and treatment; adolescent reproductive health; male contraception; and contraceptive choice were not prioritized within RCH II. Other barriers to implementing sound policies included: high concern amongst politicians over vote banks (glorified in Tamil Nadu, motherhood is a vote puller); the un-/ availability of funding (plentiful for HIV/ AIDS, but not for universal reproductive cancer screening); the attitudes and skills of service providers (especially for

abortion and vasectomy); inadequate health facilities and service quality at different levels; and the attitudes of men and women at the community level. Serious gaps between budget allocation and spending in NRHM were also causes of concern for some policy makers.

Community reach of poverty, gender equity and SRHR policies and programs

Interviews with nine lactating women found discontinuity of care between ANC, delivery, and PNC (post-natal care). All women had access to three or more ANCs where their blood pressure and weight could be measured and tetanus injections given. Four of the women interviewed went to government facilities for ANC services, while four women went to private clinics, and one went to a NGO health post. Only three women who had attended school beyond Grade 10 showed clear understanding of the importance of and results derived from the tests. Seven of the women had taken blood and urine tests; six of them were advised to have scans and all but one paid for them[25]. Half of all women interviewed were accompanied to the clinics by their husbands. The average cost of ANC services for their last delivery had been Rs 1700; the cost was higher in private facilities. Those who went to government ANC clinic reported a long waiting period and little individual attention[26]. Those who went to private clinics complained about costs. None received benefits from the ICDS.

Eight of the nine women[27] had gone to a government facility for their previous delivery. Cost was a major driver for this choice, especially as five of the nine working women were compelled to quit their jobs, with no maternity assistance from their employer. Between the first and last child delivery, four of the eight women interviewed (the other four were primis) went to a nearby government health post than the government hospital[28]. Four out of nine women had a normal delivery, while five had to undergo caesarian section. Reasons cited for caesarian delivery were mostly linked to the drying up of amniotic fluid, high blood pressure or the baby was too large. The cost of normal delivery in government facilities averaged Rs 2360. The costs for going to a government

health post (not factoring in "under the table" payments) were lower than in government hospitals. The cost of a caesarian delivery ranged from Rs 500 at a government health post with a blood bank and operational theater costs to Rs 30,000 in a private clinic. The quality of delivery care and hygiene was reportedly better in government health posts and private hospitals than in government hospitals[29]. Except for the women who had caesarian operation, none received PNC. Of the nine women, only one (from an upper caste) could access maternity benefits under the *Muthulakshmi Reddy* scheme. Of the others, seven were aware of the scheme and had applied. Two cases were pending with the health departments, and five had been rejected on various grounds[30]. The rates of accessing Medical Registry System (MRS) were lower than in rural areas (32%)[31].

Interviews with five women who faced problems in conceiving found that only one had access to effective treatment[32]. Majority of these women shifted between five to six providers in search of quality treatment (two government hospitals, and the rest private) spending between Rs 10000 to Rs 40000 on treatment and travel, apart from loss of income. They all reported that government hospitals had not provided them with the adequate information on causes of infertility, and the options available to them. The private health clinics, meanwhile, had provided high hopes but did not deliver after extracting their fees. All five women were threatened by their in-laws that their husbands would remarry but, apart from one case where the man did remarry, the husbands were supportive.

Interviews with four contraceptive users found that two used Copper T and two had been sterilized. The users of Copper T each had one child; the women who were sterilized each had two children: a son and a daughter. One of the Copper T users had gone to a private provider and paid Rs 1000 to ensure her confidentiality as her mother-in-law disapproved of contraception use[33]. The sterilized women had gone to the public hospital where they had delivered and received Rs 450-750 from the government as a bonus. None of the women had been informed about possible side effects, nor were

there offered other options. They all considered male sterilization unthinkable as they believed the myth that their husbands would become weak. All of the women experienced some complication, but no follow-up visits were made to the respective service providers.

Discussions with three married women in their mid-20s who had used abortion services found they had done so to prevent an unwanted pregnancy. Each had two children and thought that temporary contraceptive methods had many side effects[34]. Their husbands did not use condoms. Due to their fear of surgery or belief in a myth that one of their children might later die, or that they would no longer be able to fulfill the sexual desires of their husbands, the women interviewed avoided sterilization. For similar reasons, they also did not want their husbands to be sterilized. Two of the women had gone to a government hospital for abortion but the other went to a private facility to ensure confidentiality from her in-laws. All of them had been around three months pregnant at the time of the abortion. The abortions cost them Rs 3000-7000, in addition to opportunity costs of roughly Rs 3000. The women who went to the government hospital reported to have been reprimanded for not using contraception; one was forced to have an IUD inserted. At the time of writing, rumors where going around of pregnant adolescent girls being charged exorbitant fees for abortion services, ranging between Rs 14,000-20,000.

Interviews with six survivors of domestic violence (three adult women and three adolescents), found that none had gone through formal mechanisms of legal redress. Domestic violence against the three adult women took different forms: a) abandonment; b) remarriage or extra martial relations; and c) physical violence. Two of the women were aware of the PWDV Act, but did not want to access these services due to long procedures or their husband's inability to pay for maintenance. Two of the women were poverty-ridden after their husbands left them. The three adolescent girls had been sexually abused by their brother, maternal uncle, and paternal uncle respectively. They

registered fear in sharing this with their parents because they felt they would not believe them (two), or their parents would not be able to withstand the shock (one).

Interviews with two cancer survivors and the daughter-in-law of a woman who died of uterus cum intestinal cancer found they had lacked preventive screening, prompt diagnosis, or follow-up care, following an earlier occurrence of cancer. Most of the women had gone to three to four hospitals (government, private and NGO- operated), and paid between Rs 12,500 and Rs 37,000 for treatment for the last stages of cancer, in addition to loss of income of their relatives, and the eventual death of one woman. One of the two survivors was not out of danger. Neither received reimbursement from the Chief Minister's Health Insurance Scheme. Their families mortgaged assets to pay for their treatment.

Interviews with two transgender persons (male to female — often referred to as *Aravanis*) and one men who have sex with men(MSM) from low-income groups revealed that most *Aravanis* and MSMs engaged in sex work to survive. They reported facing discrimination in all walks of life, although after the repeal of section 377 of the Indian Penal Code, they faced less harassment from the police. *Aravanis* and MSMs who were HIV positive could readily access free ARV from designated ART centers. The people interviewed were aware of the availability of sex-reassignment surgery in one government hospital, but felt that the service being offered was inadequate[35]. All appreciated the master health checks provided by the government and had used them, but felt such a service should benefit all poor persons or they would otherwise be stigmatized. The inclusion of mental health services was also recommended. They also had found that promises of housing, separate public toilets and quota in colleges and employment have yet to materialize.

Discussions with members of the Tamil Nadu Sex Workers Association found that for 80% of all women enter into sex work due to poverty. Of those who were poor, only 10% had been trafficked into doing sex work. Fifty per cent of Association members were HIV positive, and encountered similar experiences with ARV, male condom availability,

master health checkups and housing schemes, similar to those available for the *Aravanis* and MSMs. The Association reported that sex workers could normally negotiate for condom use, unless their clients resisted or were drunk. Members of the Association recommended for the supply of female condoms, as well as the implementation of economic programs for middle-aged sex workers that were not 'supplementary' in nature. At present, the Association favored decriminalization of sex work over legalization as they felt that trafficking of women and girls would increase with the latter.

An interview with a lesbian from a low-income group who ran a lesbian hotline in an NGO founded by lesbians also faced special discrimination. She reported that there was less social acceptance of lesbians than gays and no government awareness programs about them, as they were not considered a high-risk group for HIV. Lesbians had no access to rations, housing, work and education if their sexual orientation is known in public. They cannot legally marry or adopt, unless they remain silent about their identity, and often, are unable to share their sexual orientation with gynecologists or doctors in government hospitals or sexual health programs[36]. Access to artificial insemination was felt to be another need.

Two focus group discussions with 32 adolescent girls found that compared to their male siblings, 67% had less access to mobility, 53% less access to play time, 50% less access to health care, 46% less access to food[37], and 26% less access to education. Seventy six per cent reported painful periods, 61% reported heavy white discharge, 60% with irregular periods and 25% reported heavy bleeding during the menstrual cycle. Less than 5% with RH problems had been taken to the doctor by their parents. Majority believed that privacy was better in private clinics. Fees ranged between Rs 300-500 per visit, but most often than not, their problem was not solved. Eleven per cent reported sexual harassment within the family, 48% in public spaces, and 25% in schools. Several knew how to cope with the first two situations, but did not know how to deal with harassment in the family [38]. Of those going to middle school, 40% reported that their schools provided eggs or bananas on an average of twice a week. Most did not eat the mid-day

meals because of their poor quality. RH education was available only to girls in Classes Six and Seven (15% of the participants). Contrary to the ICDS visit, 25% reported being weighed at the ICDS center.

Interviews with six women living in houses allotted to them by the Tamil Nadu Slum Clearance Board found two were original allottees, two had rented houses, and the husbands of the other two had purchased their own houses. Interestingly, the original owners of the houses rented or purchased, were all women, in keeping with the government policy. Of the two women who resided in their own house, one intended to bequeath it to her son and the other, to the child who looked after her in her old age. Both felt empowered as homeowners. Among the reasons behind women selling their houses include dowry payments, illness in the family, and debts incurred by alcoholic husbands.

A visit to an ICDS center in *Thorapakkam* found that the nutrition supplementation program for children under the age of five and pregnant and lactating women were being implemented to some extent. However, the adolescent girls' weighing and nutritional supplementation program was not being implemented at all. The number of children aged 3-5 years officially enrolled in day care tripled in attendance number on the day of the visit. All the children were from SC/ ST communities, and 23% were under-weight, many of them girls[39]. There were discrepancies between the nutritional supplementation, which the *Anganwadi* worker said was provided and what the helper and mothers said the children received[40]. According to an *Anganwadi* worker, pregnant and lactating women (all SC/ ST) enrolled in ICDS received nutritional supplementation, yet over 60% of pregnant and lactating women from poor households were not covered. The ICDS monitoring committee was not active. The ICDS center had once conducted a meeting on menstrual hygiene, with the attached middle secondary school.

In total, the interviews found that pregnant women have significant access to institutional delivery in public facilities (with the proportion at primary level increasing); and *Aravanis* or MSMs to condoms and ARV. Some progress has been made in improving

pregnant women's access to ANC; of *Aravanis* seeking sex reassignment surgery in tertiary hospitals; and of women obtaining title deeds to houses. But, there has been little progress in improving the access of adolescents to nutrition, SRH education or services; of pregnant and lactating women to nutrition supplementation from ICDS centers; to contraceptive choice at primary level; to PNC services in government facilities by women who have recently delivered; to safe abortion services at primary level by women and girls; to infertility treatment from public facilities by couples with difficulty conceiving; and to reproductive cancer screening facilities by women. Services to prevent violence also appear to be weak. Facilities like the Chief Minister's Health Insurance Scheme and the *Muthulahsmi Reddy Scheme* (MRS) have bypassed people who need them. Barriers to access include availability and quality of services in nearby public facilities as well as patriarchal norms within the family. The unavailability of services has caused poverty, desertion by spouse, and mental anguish.

Gujarat policies and progress on MDGs, poverty, gender equity, and SRHR: coherence and disjunctions

Profile of poverty, gender equity and SRH access outcomes: Gujarat

***Poverty*:** Gujarat is the fourth most economically developed state in India (Government of Gudjarat, 2004) with a per capita income and per capita monthly consumption higher than the national average by 27% and 25% respectively (Government of Gujarat, 2008). Over the years, Gujarat has had mixed success in reducing poverty. It is one of seven states that reduced the absolute number of poor between 1973 and 2004, but at the same time recorded an increase in the proportion of its population below the poverty line. In 1999-2000, the state ranked fifth lowest in the incidence of poverty with 13.2% in rural areas and 15.6% in urban areas, less than the 27.1% for all rural areas and 23.6% for all urban areas in India (Government of Gujarat, 2008). But by 2004, Gujarat had dropped to rank seventh in India, with 16.8% of its population now below the poverty line. There may, however, have been an easing of rural income poverty, which explains this decline (Government of India, n.d.).

As it is with India, poverty in Gujarat is a result of an uneven pattern of development. There are disparities between sectors, locations and sections of the population regarding economic development. Despite recording an impressive growth rate for secondary and tertiary sectors, Gujarat is the only state that recorded negative growth in its primary sector in the 1990s. Per capita income from the primary sector in Gujarat decreased from Rs 792 in 1980-1 to Rs 491 in 2000-1 while that from secondary and tertiary sectors increased from Rs 528 to Rs 1222; and Rs 620 to Rs 1320 for secondary and tertiary sectors respectively (Government of Gujarat, 2008).

Over the past decades, with favorable post-reform government policies, the industrial sector has spread to new districts such as the coastal region. In 2009, Gujarat had eight operational Special Economic Zones (SEZs)[41]; in 2010, India had 111 operational SEZs[42]. But industrial growth has not been reflected in the generation of adequate employment and skill development. There is also evidence that local people have been exploited in the process of industrial growth, which has been concentrated in larger capital-intensive industries. Small-scale industries, including cottage industries, registered negative growth rate over the 1990s (Government of Gujarat, 2008).

From 1993 to 2000, Gujarat was only one of three states to record a decline in the overall unemployment rate (from 5.7% in 1993-4 to 4.5% in 1999-2000) while unemployment increased throughout the rest of the country, from 6 to 7.32%. Overall, the growth of employment generation decreased in Gujarat over the 1990s. The proportion of casual laborers to the total workforce was marginally reduced in rural areas from 34.8% in 1983-4 to 34.5% in 1999-2000, while it increased from 18.3% to 24.9% in urban areas. In 2006, more than three fourths of total placements through employment exchanges in India (1.77 lakh[43]) took place in Gujarat (0.99 lakh). In the same year, however, 2.84 lakh persons were registered with employment exchanges in the state (Rajivan, 2006).

Despite patchy development, Gujarat remains one of India's economically better-off states. The relatively high rate of economic growth, relatively good employment, and the

extent of seasonal or temporary migration that allows people to survive (but negatively affects their health, nutrition and education) are some of the factors responsible for its lower than average incidence of income poverty. The poverty alleviation schemes appear to have played a limited role, with evidence that they have benefited only the poor from more prosperous areas in the state, or relatively better-off people from the poor areas (Gujarat HDR, 2004).

The reduction in income poverty in Gujarat has occurred without a corresponding reduction in human poverty (Government of Gujarat, 2003). This is the opposite situation to some other states, such as Kerala, Tamil Nadu, and Maharashtra. In Gujarat, a reduction in income poverty by one per cent point corresponds with a reduction in human poverty by 0.8% points. In other states such as Tamil Nadu, this would correspond to a reduction in human poverty by 1.25% points.

According to the DLHS 3, Gujarat fares better than India in terms of living conditions – an indicator of human poverty that indicates deprivation — with 44.5% across India reporting low standards of living as compared to 37% in Gujarat. However, living conditions deteriorated in Gujarat between 2002-4 (34.6%) and 2007-8 (37.8%). The proportion of households with electricity, access to toilet facility, and piped drinking water decreased while the proportion of households staying in kacha houses increased[44].

The literacy rate, another indicator of poverty, is higher for Gujarat (69.7%) than the national average (65.4%), but lower than that of Kerala (90%) and shows disparities between sections of the society (UNDP, 2004). Illiteracy is higher among minority groups — SC, ST and Other backward classes (OBC) — and even here, higher for women. Among adult women, 58.2% of SC, 65.5% of ST, and 51.3% of OBC women were found to be illiterate, compared to 21.9% of 'other' women (Dainanthi, 2009).

Gujarat will not achieve its poverty reduction MDGs by 2015. There is no clear trend in the reduction of the population below poverty line. The percentage of rural households

without agricultural land has increased. In fact, many types of inequality are observed to have increased in Gujarat.

***Gender*:** On the empowerment of women, Gujarat lags behind the national average and appears to be showing negative trends. The sex ratio decreased from 934 in 1981-91 to 920 in 1991-2001, and the child sex ratio from 928 to 833. Some proxy indicators for men's responsibility in RH, such as age at marriage and the proportion marrying before legal age, are lower than the national average and have remained unchanged over the past five years. In 2007, the average age at marriage for men (22.4 years) in Gujarat was lower than the national average (24.5 years). The average age of women at marriage has remained closer to the national average (Sainath, 2009a).

Quantitative data on women's workforce participation masks the qualitative realities of their employment conditions. In 2001, the female work participation rate for rural Gujarat (39%) was higher than that for rural India (29.9%) but overall, was marginally lower than the all India rate (at 13.5% compared to 13.9%). While the proportion of employed women in Gujarat rose slightly from 50.4% in 1998-9 (IIPS and ORC Macro, 2001) to 51.9% in 2004-5; 61.1% of the employed women in 2004-5 were employed in agriculture related activities; 35% were engaged in unpaid work and only 54.6% worked in cash employment. The proportion of marginal workers was much higher among women (13.3% and 14.6% of main workers) than men (3.8% and 51.1% of main workers). The engagement of women in the informal sector and unpaid work is associated with lower wages and lack of social protection for women. This is unlikely to change unless policies that help reduce women's disproportionate burden of domestic unpaid work are implemented, for this affects their ability to compete in the labor market (UNDP, 2004).

The National Family Health Survey - 3 (NFHS 3) found that 81% of women who earned cash through employment decide on how to use earnings, either alone or in discussion with their husbands. However, given the low work participation rate, and the fact that

only 61% women earned cash compared to 81% of men, this is a poor indicator to measure the empowerment of women. The proportion of women reporting that they participated in decision making – including regarding their own health treatment — was comparable to the low national average of 36.7% in 2004-5. Just over half of all women were "allowed" to go by themselves to a place outside the community (52%), to a health care facility (54%) or to a market (66%), indicating their restricted mobility. More than ten years of education and paid employment were associated with increased participation in decision making and less on restricted mobility, as also were old age; widowhood; being divorced, separated, or deserted; or residing in a nuclear family with increased participation in decision making (IIPS and Macro International, 2008).

Gender rigidity or insensitivity is very high in Gujarat. More than half of all women (57%) and almost three quarters of men (74%) believed that husbands were justified in beating their wife if she disrespected her in-laws, neglected her children or argued with her husband. Eleven per cent of men aged 15–49 years believed that a wife did not have a right to refuse sex; almost 40% believed that husbands had a right to punish wives or reprimand them if sex is refused (27.5%) through the use of force (6%) or by having sex with other women (5%).

The proportion of Gujarat women who reported physical and/ or sexual spousal abuse (rural 30.2%; urban 24.1%; and in total, 27.6%) was lower than the national averages. These figures are reduced with an increase in the educational level of women, being 14.9% among women with ten or more years of education. Another 19% of all women reported emotional abuse from their spouse. Only 30% sought help to end the abuse, and58% remained silent.

To conclude, poverty reduction efforts in Gujarat present a paradoxical picture. Despite the higher than national rate of economic development over the last three decades, the state experienced a dip and then a rise in the proportion of persons living below the poverty line. Although unemployment has decreased, there is an increase in the

proportion of casual laborers in the total workforce. The most vulnerable sections of the population, such as the STs, remain disadvantaged. Economic growth has not done much for women either. Although there is increase in the proportion of employed women, most remain engaged in unorganized sectors including agriculture, with minimal economic and social benefits. Of greater concern is the disparity between economic and human development, which again means that the SCs, STs, women and rural populations lag behind in access to health, education, and skill development. A drop in the use of male contraceptives and an increase in reported violence indicate the poor status of women in an economically developed state. As is well- known, economic and human development are interlinked and complementary to each other. With lagging human development, Gujarat's economic development may not be sustainable over a longer period.

The goals on gender indicators also seem difficult to achieve by 2015. The goal of closing the gender gap in primary and secondary school completion by girls will probably not be reached. The percentage of adult women in paid employment is increasing very slowly even though the work participation rate grew from 1998 to 2005, implying that many women remain in marginal work. Gujarat is also not likely to see any significant increase in the average age at marriage. Although this is a state with high economic growth rates, its achievements in human development and social sectors leave much to be desired. Increasing economic and social inequality and poor health, nutrition and education indicators call for greater investment in the social sector and more effective implementation of development programs.

***Health*:** Despite good economic growth, Gujarat lags behind in terms of health indicators. Health sub-centers and PHCs remain inaccessible for 36.7% and 29.2% of villagers respectively. Health infrastructure remains weak at the PHC level, with only 46.9% providing 24 hours service and 77.1% with more than four beds. At the CHC level, only 11.3% of facilities are staffed by an obstetrician-gynecologist and only 65.6% have a functioning operation theatre (Government of Gujarat, n.d.).

Gujarat fares better — if only marginally in some cases — than the country on most common health indicators, such as women receiving full ANC; institutional deliveries; safe deliveries; full immunization of children; and acceptance of modern contraception. However, disadvantaged groups such as illiterate women, minority group women, and those living in backward districts all report poorer rates. As well, the state's performance has deteriorated since DLHS 2 on most of these indicators. The proportion of women who received full ANC was marginally higher than the national average in 2007-8 (19.9%, compared to 19.1%) but had decreased from 25.2% in 2002-4 in both in rural and urban areas. The DLHS 2 (IIPS and Macro International, 2001) reported that illiteracy, a shortage of village health facilities, minority status, and residing in backward districts are generally associated with poor access to ANC. Similarly, the proportion of fully immunized children, which was higher in Gujarat than in India in 2002-4, had increased only marginally over the previous five years (Dainanthi, 2009). A child from ST, with birth order of 4+ and from a household with low living standards was less likely to receive full immunization, but there was no difference noted in regard to the sex of the child (Sainath, 2009a).

According to the DLHS 3, a higher proportion of couples use modern methods of contraception than the national average (54.3%, compared to 47.3%). A decrease in male contraceptive use, especially in urban areas, however needs exploration (National Rural Health Mission, 2009). More men than women (34.8%, compared with 18.8%) were aware of ways to prevent HIV/ AIDS transmission (IIPS and Macro International, 2008). The proportion of married women who reported STI/ RTI symptoms was similar to the national average (17.2%, compared with 18.3%) (Sainath, 2009a).

More than two thirds of women would like for school education to include information on body changes during puberty including menstruation, sex and sexual behavior, and contraception. A third of women (32.3%) and 28.1% men have a lower BMI than normal, rates comparable to national averages and higher than those for Tamil Nadu. More

women (32.3%) than men (28.1%) were malnourished except in ages 15– 29 where more men were malnourished. Malnourishment is most evident among ST with 94% of women and 83% of children being underweight. Anemia is highly prevalent, with 79.8% of young children and 55.5% of adult women, as well as 60.8% of pregnant women and 22.2% of men. In each category, the figures are higher for residents in rural than urban areas. The prevalence of anemia is highest for ST (74% women, 45% men and 82.9% children years), and among SCs and Muslims.

The report of the Common Review Mission 3 notes that the state has gone the way of PPPs to the detriment of improving the public health services (National Rural Health Mission, 2009). Frontline health workers refer women who need delivery services to the private sector or *Chiranjeevi* providers even when deliveries can be conducted at well-equipped health sub-centers. This promotion of private sector by public health personnel themselves is further weakening public health services. Quality of care is a big issue in the *Chiranjeevi* Scheme, for physical standards of care, upkeep of facilities and the follow-up of women after delivery.

The goal of universal access to reproductive health services in terms of ANC and skilled birth attendants is not achievable in Gujarat. Because indicators for post-natal care changed between NFHS 2 and 3, as well as the DLHS — data cannot be compared over time. Compared to the percentage of population living below the poverty line — an official estimate of 16.8% — the uptake of the *Janani Suraksha Yojana* is not commensurate. DLHS 3 reports that only 10% of women received financial assistance under the JSY (IIPS and Macro International, 2008). Nutrition indicators for underweight and/ or anemic children and anemic married women are quite unlikely to improve to the desired levels, and have in fact worsened. Anemia in the schedule tribe populations is at shockingly high levels in the state. The only good news is that the MMR goal appears to be achievable.

Attention to MDGs, poverty, gender equity, and SRHR in Gujarat policies and plans

Three Gujarat Government documents read for this purpose (Gujarat Population Policy, Gujarat Gender Equity Policy and the State Health Plan 2009-10) (Government of Gujarat, 2005; n.d.; 2009) as well as the experience of doing the Mid-Term Review of the RCH II Program in October 2009, indicate that the Gujarat Government's planning documents tend to be progressive and politically correct. All documents recognize that Gujarat is a better state with good economic indicators, but with marked socio-economic disparities and poor human development indicators. While there is no mention of the MDGs in the Gujarat Population Policy or the Gender Equity Policy, the State Plan for 2009-10 refers to the MDGs, and specifically mentions MDG target 2, indicator 4 – to halve the prevalence of underweight children. In the Gujarat State Policy for Gender Equity, the multiple layers of oppression experienced by the working class and unorganized women are however not adequately focused. Gujarat as an economically better-off state, is a destination for women from weaker regions in the country. Their vulnerabilities in terms of SRHR are not explicated. Abortion is not recognized as an important issue; neither are new reproductive technologies, surrogacy, or reproductive health tourism. The only SRHR concerns reflected in the Gujarat Population Policy are those of the ICPD POA: doing away with targets; promoting male participation (but without a comprehensive understanding of gender power relations); and shifting focus to reproductive health understood in the limited way of RTIs, vasectomies and adolescent health needs. The Gender Equity Policy addresses sexual rights of women and proposes new formats for getting detailed reports of women subjected to sexual violence. The State Health Plan (2009-10) shows increasing commitment to Adolescent Reproductive and Sexual Health (ARSH), to address unsafe abortions through manual vacuum aspiration (MVA).

The document Development Program 2009-10 (Government of Gujarat, 2009), which is also a type of budget and financial plan for Gujarat, refers to MDG 6 — to reduce MMR by three-quarters, from 389 to 100 by 2015; and to reduce IMR from 53 to 30 — in the

section on the *Chiranjeevi* Scheme. The government of Gujarat has identified 30 *taluks* (blocks) with very low socio-economic status as target beneficiaries for the human development program. There is a mention of a "gender framework" for implementing the ten priority programs, such as the *Nirogi Bal* (Healthy Child), *Beti Bachao* (Save the Girl Child), *Chiranjeevi* (Long Life for the Mother), and the *Vanbandhu* scheme (a scheme announced by the Chief Minister to invest an additional Rs 15,000 crores in the tribal blocks to help improve the HDIs). The Health Section of the document once again refers to the MDGs and the SAARC Social Charter and lists out a twenty-point program to improve the health of the people of Gujarat, including addressing 'female feticide' and the 'two-child norm' both which have the potential of violating reproductive rights.

While proclaiming its high levels of economic growth, infrastructure development and administration in a spirit of self-congratulation, Gujarat has been publically shamed by the Planning Commission of India because of its abysmal Human Development and social indicators. As a consequence, the Government of Gujarat has resorted to some populist schemes, programs and campaigns for the rights of the girl child – the *kanya kelavni abhiyan* to increase girls' enrolment in schools; the *beti bachao abhiyan* to prevent sex selective abortions; as well as for poverty alleviation amongst the tribals, the coastal populations and the desert-dwellers. But these are mere tokenisms. Important positions in the State related to women's programs are headed by political appointees who do not necessarily have a vision or an appreciation of women's rights and issues. The equity programs for the tribals, coastal and desert populations have not really achieved the desired results. Muslims and Christians, and minority populations continue to live in fear. Muslims especially face an economic embargo. SRHR has never really featured in the government's or society's agenda. In fact, with a right wing conservative government in power, the youth wings of the party have actually tried to impose dress codes in the universities.

Gujarat's economic and other policies are heavily tilted towards private investment, with slogans of 'Vibrant Gujarat' to attract foreign investments. In the same vein, the state

believes in medical tourism: Gujarat is the centre of global Reproductive Tourism, offering surrogacy services and Assisted Reproductive Technologies to non-resident couples who want babies. The Health Department's *Chiranjeevi* Scheme, a PPP offering institutional deliveries to Below Poverty Line (BPL) families in the private sector has set the trend and the *Nirogi Bal Program* is based on the PPP model. Strengthening of the public health sector is not a priority for the state.

Health expenditures in the state have been fluctuating and do not keep pace with the economic growth rate. Per capita expenditure on health increased from Rs 135.24 in 1995-6 to Rs 397.88 in 2000-1 and decreased to Rs 345.69 in 2004-5. Health expenditure as a percentage of the GSDP increased from 0.85 in 1995-6 to 1.84 in 2000-1 and decreased to 1.04 in 2004-5 (Rao and Choudhury, 2008). Allocations for women and children have been increased from Rs 380 crores in 2008-9 to Rs 730 crores for 2009-10, an increase of Rs 350 crores for nutrition in accordance with the Supreme Court order to universalize the ICDS. Allocations to health have increased by Rs 227.50 crores — from Rs 844.75 crores in 2008-9 to Rs 1072.25 crores in 2009-10 — but, most of this is for the development of a new medical college at Patan, a new civil hospital in Ahmedabad, and improving quality standards through NABH and NABL (in line with the state's policy to promote medical tourism), as well as achieving 100% health coverage for the urban poor, probably addressing the fact that urbanization rate in Gujarat is very high (Government of Gujarat, 2009).

Perceptions of Gujarat officials on MDGs, poverty, gender equity, and SRHR

One state level Officer from the State AIDS Control Society (SACS) and six health personnel from *Vadodara Municipal Corporation* were interviewed. Their understanding about relationships between the MDGs, national and state level policies, and ground level activities was varied. The most aware among those interviewed was the senior officer from Gujarat State Aids Control Society (GSACS) who said the MDGs 2 and 6 were most relevant for the GSACS (or all SACS), and were used as the guiding principles for

developing national policy. Yet, he believed, that the MDG guided national and state policies were very limited in scope in relation to SRH needs and rights of the groups it seeks to serve. This is perhaps explained by the constricting legal framework within which the health programs are needed to function. Psychological health needs of persons with alternate sexualities or PLWHA are not adequately addressed through the AIDS control program, a program that lacks perspective on equity and gender to a large extent.

For an officer responsible for implementing ICDS in the city, the State-set goals for her department were more relevant than the international MDGs. She had heard about the MDGs but failed to comment on the connection between the MDGs related to reduction in maternal and neonatal mortality, and malnutrition as part of the MDG on reduction in hunger and poverty, and the State-set Golden Goals of 'zero PEM', 'zero maternal and neonatal mortality', and 'ensuring marriage of girls after 18 years'.

A senior gynecologist from the state-run tertiary hospital had not heard about the MDGs. This doctor's views present the irony in public health services. Awareness of issues such as women opting for hysterectomies as a 'one time solution' co-existed with a firm belief (or apathy) that the focus of medical education was 'clinical' and there was little scope for introducing social aspects such as 'gender' into the curricula. The respondent believed that the decline in utilization of the hospital services was a result of declining quality of services, but also because of 'increased paying capacity of people'.

As with health, various poverty reduction schemes or activities were also reported to have limited impact on the lives of the poor. Despite an increase in the absolute amount of funds available through the schemes, the access of poor people (who often have low levels of literacy) to these has remained limited due to their inability to furbish a number of official documents and applications to avail of the schemes. Poor coordination between various departments or stakeholders in the scheme also contributes to the problem.

Community reach of SRHR policies and programs

Although all sections of the community — women from reproductive age group, adolescent girls, adolescent boys, men who have sex with men and transgenders — reported physical access to reproductive and sexual health services, access in terms of 'quality' varied for the groups.

Physical access to ANC and delivery related services were good. Most women access private health care. All women from BPL families knew about the *Janani Suraksha Yojana* and the *Chiranjeevi Yojana,* and all except one of the eligible women had availed of these schemes, which significantly reduced the cost of health care for these women. None of the women who availed of these schemes reported any problems, for instance, the private clinics accessed by these women were near enough for most of them to walk to or, spending was limited to about Rs 20 for an autorickshaw. However, access in terms of quality of ANC and PNC is not as good as the physical access. Though all women were in regular contact with the *anganwadi* worker from their area and were aware of services provided through the *anganwadi* to pregnant women, not all availed of these. A seventeen year old woman who was repeatedly told by all doctors she consulted that she was too thin and had too little blood in her body while she was pregnant, did not eat the nutritious snacks provided though the ICDS, as they 'did not taste good'. She was unable to attend the health information and check-up sessions in the *anganwadi* as she was fully occupied with her chores and caring for her three-month infant, who frequently was unwell. All respondents except one who delivered in the government hospital were discharged within 24 hours of the delivery. They preferred to stay longer in government hospitals but they were not given any information or counseling at the time of discharge. Additionally, post-natal check-ups were cursory. Women were asked whether they had a problem, and those who registered as having no problems, were not checked. Some women, especially those for whom it was not the first delivery, chose not to return for a PNC visit.

With the availability of pills for inducing abortion, women find services more accessible. All four women interviewed in the age group of 24–30 years, had sought to terminate pregnancies using 'pills'; they did not know the name of the tablet, but described the dosage as 'two tablets to be taken in two consecutive days, under a doctor's observation, costing around Rs 500'. Women reported looking for a doctor who would prescribe 'pills for abortion'. All women interviewed for the study had opted for private practitioners. Before one respondent decided on a private provider for the abortion service, two more doctors were first consulted – one general practitioner and one gynecologist. Both had refused to give her the pills and said that since she was already two months pregnant she would require curetting. The same respondent did not go to the hospital for curetting because of fear that the procedure would be performed without anesthesia, and delivery of the service would be as painful. Adolescent girls and boys also reported awareness about such means of terminating unwanted pregnancies.

Adolescent boys talked about condoms as another way of avoiding pregnancy, but had limited awareness about their importance in preventing STIs or about conception itself. Adolescent girls, including the one who was married, had little, if any, awareness about contraceptives. They believed that oral contraceptive pills were helpful in advancing or postponing periods, to accommodate social and religious occasions.

Women seeking treatment for infertility reported an acute need for information and counseling centers. The role of husband's counseling in ensuring their support to women was highlighted by a woman, whose husband became supportive after being counseled by a doctor.

Men having sex with men (MSM) and transgenders (TG) fared worst in access to health care. Most preferred a clinic that was managed by a community-based organization (CBO) working with MSM and TG communities. Though their experiences were mixed, in general, persons declaring their alternate sexuality were treated with disrespect at public facilities. Whereas in the private sector, where it was 'service for a price', treatment was

reported to be equal for all patients. MSM and TGs who experience immense emotional stress as a result of their sexuality, reported an acute need for counseling services. Lack of counseling centers was compounded by negative social attitudes towards counseling. Those seeking counseling were considered 'weak', even by other members of the MSM and TG community. The legal framework, which criminalizes same-sex relations (according to an interview done before the repeal of section 377) was believed to be a huge contributing factor to psychological stress, often leading to addictions, multi-partner sexual behavior and suicides among MSM and TGs.

All respondents reported a need for patient-sensitive medical services and medical professionals. Women and adolescent girls preferred woman doctors who could empathize with them; boys wanted male doctors who would address their sexual problems without being judgmental and where confidentiality is maintained. MSM and TGs preferred a member from the MSM or TG community, a doctor sensitive to their physical and emotional needs and who would treat them with respect and kindness.

Women had little control over the choice of health care provider, even for their own health conditions. Women from APL families reported that their husbands choose the doctor for ANC and delivery. Women opting for hysterectomies as a 'one time solution' for their physical as well as social problems such as menstrual seclusion, reflected on the poor status of women in society as well as the health professionals' insensitivity towards gender aspects of the health conditions. Instead of offering alternatives, the doctors were reported to counsel the husband to go ahead with hysterectomy. All except one woman had opted for a private hospital where the surgery cost was around Rs 10,000.

Chiranjeevi Yojana — a public private partnership initiated by the Government of Gujarat — has been praised for its contribution to improved ANC; increased proportion of institutional deliveries; and lowered infant and maternal mortality among the poor. All of the people interviewed were aware of this. Access by the most eligible women showed success in terms of reach. Free or subsidized services at private clinics served as an

incentive for most women. In a society where most women are not free to decide on their own care provider, and where affordability of services is the main criteria for selection, the scheme is well-supported by the beneficiary households. Most women reported receiving full ANC with more than three ANCs, two TTs, and iron-calcium supplements for three months. However, the hospital stay of less than 24 hours, lack of post-natal information and counseling, and poor PNC needs more attention. The absence of dedicated sexual health services for adolescents greatly contrasts with the government's stated commitment towards healthy adolescents as a part of its *Nirogi Bal Varsh* program. The limitations of NACO's interventions targeted at MSM and TGs were apparent throughout the interviews. There is an urgent need to address the physical, mental and social health needs of members of these communities to facilitate improvements in sexual health and reduce the risk of contracting STIs, including HIV.

Civil Society Action on MDGs, gender equity, poverty and SRHRs

National movements

There are several civil society actions and movements around the issues and concerns of the MDGs. We describe the most relevant and significant pan-Indian struggles in this section.

***Wada Na Todo Abhiyan (Abhiyan)*:** is a national campaign that holds the government accountable to its promise to end poverty, social exclusion and discrimination. *Wada Na Todo Abhiyan* (Do not break the promise campaign) emerged from consensus among social action groups who were part of the World Social Forum held in Mumbai in 2004 where the need for a forceful and concerted effort to make a difference was agreed upon, based on the fact that one-fourth of the world's poor live in India. The *Abhiyan* monitors the promises made by the government to meet the objectives set in the 2000 UN Millennium Declaration, the National Development Goals and the National Common Minimum Program (2004-9), with a special focus on the right to livelihood, health and education. The *Abhiyan* works to ensure that the concerns and aspirations of Dalits,

Adivasis, nomadic tribes, women, children, youth and the differently abled are mainstreamed across programs, policies and development goals of the central and state governments[45].

In 2005 and 2007, the *Abhiyan* brought out two citizens' reports on the MDGs: the first, a citizens' report on the achievements of the MDGs and the second, a thirteen state and thematic Mid Term Review report on the Achievement of MDGs. The reports were disseminated with wide media coverage of the different issues[46].

Wada Na Todo Abhiyan conducted fifteen state and regional consultations for the mid-term review of the Eleventh Five Year Plan, to consolidate people's voices for effective implementation of the remaining portion of the plan. The state consultations provided space for policy makers, academics, civil society and the larger public to deliberate on the gaps in the Eleventh Five Year Plan, and collectively come up with corrective mechanisms.

***Jan Swasthya Abhiyan*:** The *Jan Swaasthya Abhiyan* came out with a People's Mid Term Review of the Health and Health-related chapters of the Eleventh Five Year Plan. Its report highlighted important points about the state of health and human resources in the country, the implementation of the NRHM, and the absence of the NUHM, among other things. The woefully low levels of public expenditure on health were also pointed out. The report analyzed the National Health Accounts and showed that expenditure on health has not increased beyond 1% of GDP in real terms (Abhiyan, n.d.).

UNFPA and UNIFEM, in association with National Alliance of Women and Voluntary Health Association of India, organized state and regional consultations to collect feedback from the poor and marginalized social groups about the delivery of schemes, which are specifically intended to improve the quality of services. While the VHAI steered health-related programs of the Central Government, the, National Alliance of Women led the discussion on women, child and minority issues. From these consultations, valuable feedback from community groups about the problems they faced in accessing

services were obtained. Feedback and recommendations made were fed into the Eleventh Five Year Plan Mid-Term Review process.

The Right to Food campaign[47]**:** The right to food campaign is an informal network of organizations and individuals committed to the realization of the right to food in India. They believe that everyone has a fundamental right to be free from hunger and under-nutrition. Realizing this right requires not only equitable and sustainable food systems, but also entitlements relating to livelihood security such as the right to work, land reform and social security. The campaign considers that primary responsibility for guaranteeing these entitlements rests with the state. Lack of financial resources cannot be accepted as an excuse for abdicating this responsibility. In the present context, where people's basic needs are not a political priority, state intervention itself depends on effective popular organization.

The campaign began with a written petition to the Supreme Court in April 2001 by the People's Union for Civil Liberties (PUCL) Rajasthan. The petition demanded that the country's gigantic food stocks should be used without delay to protect people from hunger and starvation. This petition led to a prolonged, public interest litigation (PUCL vs. Union of India and Others, Writ Petition [Civil] 196 of 2001). Supreme Court hearings have been held at regular intervals, and significant 'interim orders' have been issued from time to time. However, it soon became clear that the legal process would not go very far on its own. This motivated the effort to build a larger public campaign for the right to food.

The campaign has taken up a wide range of aspects linked to the right to food. Sustained demands include: a) a National Employment Guarantee Act; b) universal mid-day meals in primary schools; c) universalization of the Integrated Child Development Services (ICDS) for children under the age of six; d) effective implementation of all nutrition-related schemes; e) revival and universalization of the public distribution system; f) social security arrangements for those who are not able to work; and g) equitable land rights

and forest rights. Some of these demands have already been met to some extent. For instance, the Indian Parliament unanimously enacted a National Rural Employment Guarantee Act in August 2005, and cooked mid-day meals were introduced in all primary schools following a Supreme Court order of April 2004. Further issues are likely to be taken up as the campaign grows.

Campaign members undertake social audits of the NREGS, ICDS, and MDM schemes. They have been intervening in the United Progressive Alliance government's Right to Food Act, which the campaign rejects as an incomplete piece of legislation, having only to do with the right to food entitlements through the public distribution system, not freedom from hunger and deprivation.

The ICPD +15 Review Process[48]**:** The year 2009 marked an important milestone in the journey of actualizing reproductive health and rights. It was fifteen years since the ICPD; six years from the realization of the MDGs and ICPD goals, which are envisioned to be met by 2015; and mid-way in the NRHM, which culminates in 2012.

In November 2008, a preliminary consultation on the ICP PoA was organized. The consultation brought together diverse organizations and networks working on women's health, nutrition, maternal health, primary health, women's rights, human rights, dalit rights, young people's health and development, issues of sexuality, transgender and sexual minorities, as well as population issues. This meeting underscored the need to revisit the ICPD PoA to take stock of the gains and gaps, as well as identify emerging challenges in the fields of population and reproductive and sexual health and rights. During the consultation, it was felt that there is a need to push the boundaries of conceptual thinking around reproductive health, to have a dialogue on various health issues, and establish linkages with different groups and movements within civil society in order to create synergy. This culminated in the establishment of Gains & Gaps: ICPD+15 Civil Society Review in India. This review aimed to facilitate a constructive engagement

with government and called for additional measures to address prevailing concerns to fulfill various health-related promises.

The concerns of the ICPD+15 process were that despite the unprecedented economic growth of the last fifteen years in India, the health status of the poor, and women in general, continues to be a matter of serious concern. Economic growth is coupled with hunger, deaths, and increasing malnutrition among women and children. In the domain of reproductive health, India continues to have the largest proportion of maternal mortality incidences worldwide. Access to safe abortion services, an area in which India was once a pioneer, has been compromised. Issues of access, supplies, quality and informed choice continue to be inadequately addressed in the family planning program. There is continued discomfort about addressing sexual rights and sexual health, with a lack of clarity over the need and form of adolescent sexuality education. While HIV and AIDS have rightfully been accepted as areas of concern, the program is vertically driven with little acknowledgement of the extent to which violence against women severely affects their health status. Despite the Delhi High Court's judgment, same-sex relations continue to be criminalized.

This period has also seen the emergence of new concerns, such as artificial reproductive technologies, the growing needs of the adolescent population, and needs of the elderly. While there has been some mention of women's exclusion from policy processes, many other socially vulnerable groups such as dalits, adivasis, religious minorities, transgendered people and other sexual minorities, also remain invisible in the policy domain. Policy-making continues to be influenced by international concerns and agencies, and also by corporate sector and commercial interests.

The 'for-profit' private sector continues to grow without any regulation, and health costs remain an important cause of impoverishment for people. While new schemes to bring women within the ambit of health systems have been floated, there are hardly any measures in place that make systems accountable to the citizens of the country, which is

an essential component of a rights-based approach. Against this background, the overarching objectives of the ICPD+15 review process are to:

- Conduct an overview of key gains and challenges that have emerged in the last fifteen years since ICPD in the context of health related policy and programming in India;
- Initiate advocacy efforts with policy makers, parliamentarians and international organizations;
- Raise awareness among multiple stakeholders about the significance of reproductive and sexual rights in the context of the existing health condition of specific vulnerable groups; and
- Identify areas for action for different stakeholders across sectors and regions, to realize reproductive and sexual rights of various groups.

Around twenty consultations, roundtable discussions and meetings have been held in different parts of the country over the last eighteen months, on diverse topics such as population policies; coercion versus rights; sexuality and sex work; conflict and violence against women; engaging men; controversies around contraception; safe abortion; and sex selection. Parliamentarians have been approached; the media have been made into partners. The review process has been a means of keeping alive the struggle and commitment to sexual and reproductive rights.

Legal Action for Maternal Health Rights[49]**:** Several lawyers and health and reproductive rights groups are using the strategy of litigation to promote maternal health rights. The Human Rights Law Network has been very active in liaising with women's health, organizations and other networks in filing public interest litigations on various reproductive rights issues. Most of the cases are related to the denial of services by the health system. The *Ramakant Rai Sterilization public interest litigation (PIL)* against coercive sterilizations done in conditions that compromised the quality of care, was successful. In March 2005, the Supreme Court ordered state governments to take immediate steps to regulate healthcare providers that performed sterilization

procedures, and to compensate women who suffered complications due to sub-standard practices, as well as the relatives of victims who died from botched operations. In February 2010, an historic decision was made in the Delhi High Court where compensation for the violation of the constitutional and reproductive rights of two impoverished women, Shanta Devi and Fatima (Laxmi Mandal vs. Deen Dayal Hari Nager Hospital and Jaitun vs. Maternity Home, MCD, Jangpura) was ordered. The Court also ordered a maternal death audit be carried out on Shanta Devi, who died giving birth to a premature baby. The judgment is expected to have immense health policy implications in India – a country where maternal death occurs every five minutes. Salenta, a woman who suffered a pregnancy related injury — a vagina fistula — and whose surgery was delayed on at least four different occasions, twice due to her inability to first pay for the procedure, was awarded reimbursement for her expenses, and compensation for her physical suffering.

Voices against 377[50]**:** 'Voices Against 377' is a coalition of non-governmental organizations (NGOs) and progressive groups based in Delhi. It is a point of intersection and dialogue between various social movement groups where a united voice is being articulated against Section 377 of the Indian Penal Code, which criminalizes adult and consensual sexual acts deemed to be against the 'order of nature'.

Through the Million Voices Campaign launched last December 9, 2004, diverse opinions and experiences of sexuality were put forth as a response to Section 377. These were also used to counter myths and taboos about issues of sexuality in society. In addition, there have been a series of Open Letters written to the Law Minister, Prime Minister, Government of India, citizens of India by eminent personalities, intellectuals and citizens, demanding the repeal of Section 377. The Writ Petition of 2001 in the Delhi High Court, filed by Naz Foundation (India) Trust, challenged the constitutional validity of Section 377. On November 22, 2006, Voices Against 377 filed an intervention in the court in support of the Naz Foundation's stand to decriminalize consensual same-sex sexual acts.

The campaign has been successful. In July 2009, the Delhi High Court passed a judgment, which stated that:

> *'Section 377 IPC, in so far it criminalises consensual sexual acts of adults in private, is violative of Articles 21, 14 and 15 of the Constitution. The provisions of Section 377 IPC will continue to govern non-consensual penile non-vaginal sex and penile non-vaginal sex involving minors. By 'adult' we mean everyone who is 18 years of age and above. A person below 18 would be presumed not to be able to consent to a sexual act. This clarification will hold till, of course, Parliament chooses to amend the law to effectuate the recommendation of the Law Commission of India in its 172nd Report which we believe removes a great deal of confusion. Secondly, we clarify that our judgment will not result in the re-opening of criminal cases involving Section 377 IPC that have already attained finality.'*

To conclude, India has some vibrant social movements that have been successful on several fronts, for example, in getting the attention of the World Commission on Dams, getting the Right to Information Act enacted and so on. While equity has been a central feature of all these movements, gender and SRHR have not received much attention. While the Right to Food campaign examines implementation of NREGS, ICDS, PDS and mid-day meal schemes, gender disparities and interconnections between SRH of women or adolescent girls have rarely been the focus. The mainstream women's movement has focused strongly on reservations for women in Parliament and violence against women, but has given little attention to SRHR or the economic rights of women. The health or SRHR movement has placed maternal health, coercive population policies, adolescent RH and access to safe abortion on their agenda, but has not examined these issues in the context of poverty reduction programs. At times there have even been disjunctions between various movements, which points to the need for sitting together and dialoguing, for example, around how to address issues of declining sex ratio or disclosure before marriage.

Civil society action on MDGs, poverty, gender equity and SRHR in Tamil Nadu

***Movements*:** Movements of landless laborers, fish workers and informal sector workers, women, children, dalits, *Aravanis* and HIV positive people are strong in Tamil Nadu. These groups have worked on many issues, including rights to work and livelihood, food and nutrition, public health, education, political participation, housing, sex-selective abortion and non-discrimination. A campaign against dowry is at a nascent stage. The National Alliance of Women's Organizations has a nodal representative organization in Tamil Nadu which has contributed to producing national shadow reports on CEDAW and the Beijing Platform for Action with the NGOs Ekta and Initiatives: Women in Development taking the lead. A monitoring initiative by the Forum for Livelihoods of NREGS commenced in 2009, spanning 15 districts (Forum for Livelihoods Rights, 2010). Their report highlighted issues of corruption and the weak implementation of NREGS in the state. However, it gave less attention to the impact of NREGS on SRHRs of women, or how SRHRs could mediate access to employment. In urban areas, the women's construction workers union, domestic workers union (*Manushi*) and adolescent girls associations are strong, with the last focusing on adolescent SRH education.

The NRHM community audit initiative, led by the Community Health Cell in Tamil Nadu, has monitored facilities and services at different levels, as well as state commitments on maternal and child health services. The Tamil Nadu Association of Positive People and Tamil Nadu Positive Women's Network are vibrant organizations that have come together to demand government action for their members' rights, health and well-being. However, compared to states like Gujarat, Uttar Pradesh and Rajasthan, movements in Tamil Nadu have not come together in a concerted way to advocate for women's right to legal abortion (other than for sex selection), infertility treatment, adolescent reproductive health services, reproductive cancer screening services or addressing violence against women. As a result the state of Tamil Nadu did not produce a shadow report on ICPD+15; neither did it make any state contribution to the national report.

A campaign to realize the right to safe and legal abortion was initiated in 2010 by RUWSEC, an NGO, in two districts of Tamil Nadu, and is at a nascent stage. In comparison, the Campaign Against Sex Selective Abortion is strong in Tamil Nadu, and played an important role in improving the sex ratio at birth in Tamil Nadu since 1999-2000 (Sharma and Haub, 2008). However, such campaigns have been accused of aligning themselves with the pro-life lobby, including doctors opposed to abortion, in order to achieve their agenda. On the whole, while there are several social movements in Tamil Nadu monitoring and furthering causes on poverty, gender or SRHR, they need to work together more effectively to examine and address cross-sectoral issues. The Tamil Nadu People's Forum for Social Development is an attempt to do so, and produces alternative reports on social development.

***Research studies*:** The Population Council has supported two recent studies in Tamil Nadu, one on Third Trimester Labor Management in Tamil Nadu and the other, on young people's SRHR issues (International Institute of Population Studies, 2009). Health policy makers, NGOs and medical professionals were involved in the discussion on these topics. The Rights and Reforms Initiative, School of Public Health, and the University of Witwatersrand also supported the two studies, one on health sector reforms in Tamil Nadu (Ravindran, 2009) and the other on the functioning of patient welfare societies and village water, health and sanitation committees in the state (Murthy, Balasubramanian and Bhavani, 2009) – both published by RUWSEC. The latter study was followed by efforts to strengthen village, health and water sanitation committees.

***Media monitoring*:** Gains and losses made at national level public interest litigation on SRHR apply to Tamil Nadu as well (Sood, 2006). A review of newspaper articles in the left-leaning national daily newspaper *The Hindu* and the ruling party-supporting Tamil newspaper *Dinathanthi* from August to December 2009, found 428 news reports in English on issues related to the MDGs, SRHR, gender and poverty. Of these reports, 62% were published in *The Hindu*, with less coverage in the *Dinathanthi*. Of all reports

published in *The* Hindu, only five specifically mentioned the MDGs, covering progress on child nutrition, child health, education and maternal health[51]. Gender equity and reproductive health received less attention. None of the reports mentioned progress in regard to the ICPD PoA. The newspapers ignored the NGO Forum on SRH, which was held during this period, as well as the MDG Summit.

Substantial coverage was made on health issues in both dailies, most reports covering general health issues like heart diseases, kidney problems, arthritis, mental health, eyesight, the HINI flu and the *Kalaignar Kappedu Thittam*. The reporting on the *Kalaignar Kappedu Thittam*, which constituted half of the news reports on health in *Dinathanthi*, highlighted the fact that most of the benefits had gone to heart diseases, especially amongst children. Little attention was given to sexual and reproductive health issues other than HIV/ AIDS. There was no discussion on issues such as women's access to legal abortion, infertility treatment, STI/ RTI treatment (other than HIV), or prevention of violence against women. The term sexual and/ or reproductive rights were only used once in a report in *The Hindu* and, interestingly, referred to the need for the government to uphold the reproductive rights of single women, adolescents and transgendered people[52]. Reporting in the *Dinathanthi* lauded the *Muthulakhshmi Reddy Scheme* and feeding of pregnant women scheme[53].

Of the selected news reports, 27% covered issues of poverty, malnutrition, NREGS and SGSY schemes. Reporting on poverty concentrated on issues of malnutrition (underweight children, low BMI amongst women, and anemia). The Tamil daily newspaper gave less attention to news on national poverty reduction programs such as the NREGS, IAY and SGSY, pointing to the lack of percolation of information on these programs to most of the non-English speaking population. Reporting in *Dinathanthi* was more inclined towards reporting state government initiatives, particularly the SHGs under *Mahalir Thittam*, and the achievements of the ruling party, such as progress in implementing state government welfare programs such as marriage assistance schemes (which promote dowry), and girl child protection schemes (Dainanthi, 2009). *The Hindu*

provided more coverage about NREGS and highlighted issues of corruption, exclusion and weak program implementation as well as moves to reduce caste barriers (Sainath, 2009a). Neither news item gave much attention to the lack of a nutrition component in NREGS, nor gender issues such as the variable participation of women in the scheme in different states; the fact that bank accounts were only opened in men's names; the economic exploitation of women, gender-based violence or problems faced by *Aravanis*. Discrimination faced by *Aravanis* in terms of employment, education, media portrayal and access to public facilities is amply highlighted in both newspapers, but less sensitivity is shown in reporting about discrimination faced by transgender people and lesbians.

The overall quality of reporting is better in *The Hindu* than the *Dinathanthi*, the former having lesser tendency to sensationalize or lure vote banks. Altogether, the coherence and disjunction on policies, strategies, outcomes, and the implementation of the MDGs, poverty reduction, gender equity and SRHR are inadequately reported. This could be partly explained by the shortcoming of social movement groups and policy makers who issue sound bytes and press releases.

Given that adult female literacy is low in Tamil Nadu (Planning Commission, 2002), non-print media has an important role to play. An FM radio program *'Petral than Pillaya*? (Is he or she a child only if born to you?) promotes the adoption of HIV orphans and the non-discrimination of people living with HIV. It also presents short films on these issues, supported by the Population Services International in collaboration with a film star[54]. A television program, *Ippadikku Rose* (Yours Truly, Rose), is anchored by an *Aravani* and focuses on issues of concern to this community[55]. *Aravanis* also benefit from a 'blog' on transgender issues in Tamil and a matrimonial website that promotes marriages of *Aravanis*. There are also debates in Tamil on gender, caste, and parenting issues organized by various private television channels, popularly called *Patti Mandrams* (debate forums). Advertisements in Tamil on NRHM are broadcast on state and central government television channels and radio, highlighting breastfeeding, maternal health and mental health services. Most television and radio programs, however, continue to highlight patriarchal and caste- or class-based values.

Civil society action on MDGs, poverty, gender equity and SRHR in Gujarat[56]

***Movements*:** Gujarat is the birthplace of the Narmada Bachao Andolan or the Narmada Dam campaign. Many national leaders of the Dalit Rights movement, the Occupational Health movement, and Women's Studies have emerged from Gujarat. The Gujarat-based IIM Ahmedabad's Centre for Health Studies has delivered internationally cited heath systems research on maternal health.

Gujarat is also home to some reputed women's organizations: SEWA, Sahrwaru, Anandi, SWATI and many others. *Godhra violence* and minority women's issues – economic and livelihood issues, security and justice — have been in the forefront of their activities. Most of these organizations come together as a women's movement; a few big ones hold themselves apart. The *Mahila Swaraj Abhiyaan* formed in the 1990s to empower women elected representatives. The Women's Land Rights movement organized a mega gathering recently to discuss resource and budgetary strategies for the twelfth Five Year Plan. The *Jan Swaasthya Abhiyaan Gujarat* has been active on maternal health rights' issues, opposing the pilot project on HPV vaccine in three tribal blocks in the Vadodara District. A *Dai Sangathan* received government recognition, but in the land of public-private partnerships (PPPs), Dais have been reduced to agents for institutional delivery.

While equity is a common concern of all these groups in a state marked by high economic and infrastructural growth, high disparities and shockingly low human development indicators, it has been difficult to bring sexual and reproductive rights to the center stage in all struggles. Sexual minority groups have been able to find voice and gain visibility only in the last five to seven years, in the post HIV/ AIDS era. The current issue troubling the human rights groups in Gujarat is the illegal detention of social development and civil rights activists, as alleged naxalites[57].

***Media Monitoring*:** A review of English and Gujarati daily newspapers, the *Indian Express* and *Gujarat Samachar* in March 2010 found overall that the reportage in the *Indian Express* focused more on the issues of concern for the present study than did reportage in the *Gujarat Samachaar* (based on 281 news items in IE and 186 in GS) (SAHAJ, 2010). Since March 9, 2010 fell during this review period – at a time when the Women's Reservation Bill (assuring 33%reserved seats for women) was tabled in the Parliament – the coverage for Women's Rights as a category was at its highest where 20% of the selected news items were devoted to the Women's Reservation Bill. In the English daily, the Bill averaged 1.5 items per day. Violence against women – including rape, child sexual abuse, molestation, honor killings, and child marriage – was reported quite extensively, but more so in the Gujarati newspaper. Health issues were also covered widely, but women's health and maternal health accounted for only around 4% of the total coverage on health. Both papers carried several reports on medical and health research. Quality of care was another category of news items in both the language editions. HIV/ AIDS was a significant topic, including reports about discrimination, stigma and the redress of grievances. There was one report on transgenders. The *Indian Express* carried 16 items on development programs and provided examples of women's empowerment. In short, the coverage of women's issues was substantial in the *Indian Express*, although not always from the perspective of promoting gender equity.

The *Indian Express* also carried 25 news items about poverty, the NREGS (4), BPL/ APL (3) and the MDM scheme (2), as well as reports about sanitation and construction workers and silicosis. The *Gujarat Samachaar* carried more reports on poverty related issues – almost 10% of the selected news items related to issues of poverty.

The review found no mention about achievement of the MDGs or progress on the ICPD agenda in these newspapers. The review noted that follow up of certain reports – for example, silicosis being due to stone quarrying, and the redress of grievances related to HIV/ AIDS – led to positive outcomes. In the first instance, the Community Health Center near the stone quarrying area was directed to reserve a certain number of beds for

silicosis-affected workers. In the second instance, the GSACS decided to improve the quality of counseling offered. The monitoring role of media is evident from these examples.

The *Indian Express* carried 23 news items dealing with legal issues, of which 16 reflected gender issues (*Khap panchayats*, right to choice, honor killings, Hindu Marriage Act, female infanticide, surrogacy, rights to live in partners and so on). Some of this reporting was unexpectedly sympathetic to women. For example, an Indian Express news item on the 22nd of March 2010 featured a story about female infanticide stating that "The bench noted crime against the female child is a product of perverse social norms". Another news item on section 377 of the IPC described how the Home Ministry was "now quietly moving to amend the IPC to decriminalize homosexuality; this then will change the government's default setting to one that defends sexual freedom".

In summary, the review found that the *Indian Express* covers women's issues and gender issues quite substantively, poverty issues to some extent, and human rights issues also to a large extent. The language and terminology of MDGs, ICPD, reproductive and sexual rights is not explicitly used nor are the MDGs explicitly tracked, whether for Gujarat or for India. The Gujarati paper was more sensational, reporting on suicides and rapes.

Conclusion and Ways Forward: addressing disjunctions and strengthening coherence: MDGs, gender equity, poverty and SRHR

Conclusions

Despite high levels of economic growth in the 2000s, and the presence of a stable government at the center, international and national data suggest that India is unlikely to achieve the MDG goals (Goal 1, 3, 4 and 5) of halving the proportion of underweight children; reducing infant and child mortality by two thirds; eliminating gender disparity in education (other than primary level); facilitating work and the political participation of women; and reducing maternal mortality ratios by three quarters. The ICPD PoA set an

even greater challenge –universal access to the broader range of SRH services. This too has not been met. While reports indicate that India may achieve MDG targets on halving income poverty, this is highly uncertain and open for contestation. Where national figures show that the prevalence of HIV/ AIDS has been reduced therefore implying that India may meet the MDG target in halting the spread of HIV, the inaccessibility of data that measures ARV access does not allow a more thorough assessment of progress .

Gujarat is further from success in meeting the MDG targets for poverty, gender and SRHR than is Tamil Nadu, even though the latter's performance is quite uneven. Gender equality, the halving of adult malnutrition and ensuring universal access to reproductive health are challenges even in Tamil Nadu. SCs/ STs fall way behind other groups in the population in regard to achieving the MDG ICPD PoA target. Progress achieved amongst Muslims in the population varies across indicators. While urban areas fare better than rural areas on most indicators, available data is not disaggregated across slums and other urban habitats.

The slow progress on several MDGs, as well as in meeting the ICPD PoA targets may be explained by the disjuncture between international agendas and the 27 National Monitoring Targets. To illustrate, the MDGs require to be adapted to the Indian context, due to several disparities that need to be taken into account in policy design and implementation: caste, ethnicity, and minority status, all of which had not been adequately factored into the MDG framework. There are also other important concerns within India itself such as anemia and the skewed sex ratio, which go beyond the present MDG targets and indicators.

The fragmented approach towards addressing poverty, gender equality and SRHR in legislation also slows down the pace to achieving progress. Despite legislation that guarantees the right to work for instance, legislation in other inter-linked areas, such as preventing domestic violence and/ or atrocities against SC/ STs remains weak. This is evident in the design and implementation of flagship programs like NRHM, NREGS, SGSY

and ICDS. Other factors that impact upon India's pace and success in achieving targets include: broader neo-liberal macro-economic policies, poor accountability of power holders, the varying strength of social movements, and the persistence of patriarchal or caste norms at community level. The right wing has mobilized against adolescent sexuality education. The poor accountability of the state is reflected in a lower percentage of GDP being allocated to social sectors, with corruption still at high levels; the non-utilization of allocated resources for various reasons; inadequate coverage of target groups; non-deployment of human resources; and the selective implementation of schemes. In particular, legislation and programs on gender equality and SRHR beyond maternal health have been poorly implemented. Another concern is the lack of convergence and effort to address the underlying causes of poverty, gender and SRHR issues within sectoral programs, as well as across sectors. HIV and RCH programs within NRHM, for example, do not address the RH needs of people living with HIV/ AIDS. ICDS and health programs do not collectively address malnutrition amongst adolescent girls. NREGS does not have a nutrition and health component for women who are employed. The reason behind the government's success in halting the spread of HIV could be due to the strong channeling of resources to this sector by donors.

Gujarat may have fared worse than Tamil Nadu due to the state's lower per capita public expenditure on health; the lack of comprehensive maternity assistance; low ICDS coverage of children, adolescent girls and pregnant and lactating women: weaker implementation of NREGS and SGSY; and a smaller proportion of women working in NREGS sites. There are also more gender, poverty and health schemes for transgender people in Tamil Nadu, although implementation of these programs varies in its success. A larger issue is that the government in Tamil Nadu is left of center, while the government in Gujarat is right wing, both in its *Hindutva* ideology and its enthusiasm for privatization.

Based on our study, policies and schemes reach the urban slums of Baroda and Chennai in varying degrees. The community interviews found fairly good levels of coherence in the implementation of maternal health services, although there are areas for

improvement, as well as moderate levels of implementation of programs to prevent HIV amongst high-risk groups, and provide access to ARV. There is, however, poor implementation of the larger package of sexual and reproductive health services for women, adolescents, and people of diverse sexual and gender identities. Nutrition programs for infants and adolescent girls were ineffectively implemented, with slight improvements for children aged 3-5 years, and pregnant and lactating women. The presence of gender-focused NGOs working in a particular sector is found to make a difference as to the extent that women benefitted from development programs in any sector.

The space for social movements to operate and to use public interest litigation and the Right to Information Act to demand accountability is fairly good. It is due to their activism that most of the rights-based legislation has been tabled or passed. Their strength varies across sectors and/ or issues, across time, and between states. NREGS social audits have been sustained and spread over several states, as reflected for example in reports in national media. The women's movement is divided between various castes and issues. The movement of people of diverse sexual or gender identities is stronger in Tamil Nadu, while the women's health movement is stronger in Gujarat. The strength of attention to SRHRs in the women's movement in India has varied across time and space, starting from pre-ICPD era; the monitoring of ICPD promises in the immediate post-Cairo period where maternal health was reported to have been reduced, only to once again increase under the ICPD+15 monitoring. An area for strengthening is discussions across movement, such as between right to food (which focuses on NREGS, ICDS, mid-day meals, and PDS) and women's movement and people of diverse sexual identities. There has been a shadow MDG and Eleventh Five Year Plan monitoring report produced by '*WADA Na Thodo'*, which was also responsible for the production of a Dalit MDG monitoring report for South India. The quality of monitoring, however, could be further strengthened.

Monitoring of print media reveals that there has been good coverage of national flagship poverty reduction and health programs as well as issues of poverty, health and gender, especially in *the Hindu* and *Indian Express* – both written in the English language and considered left-leaning daily newspapers. The local language dailies were seen to have been more often used as vote banks that publicize the achievements of the ruling political parties. Violence against women was well reported in the *Indian Express*. Coverage of health, flagship poverty reduction and nutrition schemes and gender issues was good in the national daily *The Hindu*. However, issues of reproductive health beyond maternal health as well as gender issues in poverty reduction and health were not adequately addressed. The *Indian Express* sustained their reporting on important issues in health services and legal cases, leading to improved outcomes; this points to the potential role of media in promoting social accountability. A major concern is reflected in the weak coverage of the MDGs as well as ICPD PoA in English dailies, over the monitoring period of this study. The visual and audio media in Tamil Nadu was strong on transgender issues, and issues of HIV /AIDS, with sporadic episodes of violence against women.

Ways forward

There is an urgent need to redefine MDGs to suit poverty, gender, caste or other disparities and SRHR issues in the context of India, and to improve alignment of SRHR issues in the ICPD PoA and the MDGs.

Advocacy is required to bring coherence between the commitment of the government to the ICPD POA and the MDGs as well as other human rights instruments, and the National Targets. Legislation and policies need to be reviewed and developed in keeping with the commitments in the international fora and national priorities. Budgets need to be allocated by the central government and states, keeping in view what is required to achieve both national/ state targets and international commitments.

The trend towards privatization in various sectors needs to be examined in the context of the persistence of high levels of poverty, and the apparent increase in poverty since 2000. Although not comprehensive in terms of SRHR, the Tamil Nadu experience shows that greater investment in public health and nutrition can bring down levels of child undernutrition, as well as maternal and infant mortality. Implementation of well-designed programs like NRHM and NREGS has to be strengthened through social accountability measures, including gender, poverty and SRHR indicators. With RCH Phase II coming to an end, it is paramount that government earmarks 50% of all NRHM funds for reproductive health services.

The linkages between programs across all sectors need to be strengthened, as between HIV and RH. For example, addressing male sexual health needs through the cadre of male health workers could also work if the capacity of ANMs to promote the reproductive health of HIV-positive women is strengthened. Better linkages between promoting property rights of women and the SGSY scheme and initiatives to regularize land records must also be sought.

In the context of increasing urbanization, there is an urgent need for a well-designed urban health program with a strong sexual and reproductive health component. There is a need to improve the access of both women and men to decent work conditions, and to markets in urban areas, by, for example, raising economic returns to occupations in which women dominate, such as domestic work, care work and nursing. Programs on women's empowerment need to be extended to low-income urban areas.

A worldview of economic and social equity — including gender, caste and other aspects of diversity — has to be promoted in society, cutting across the economic strata. A good starting point is to work with adolescents. The *Kishore Shakti Yojana* needs to be revamped and its implementation improved. In parallel, male health workers should mentor and work with men and boys in order to change the dominant construction of masculinities.

While there is a need to strengthen reporting on issues of equity, gender, poverty and SRHR in local media, this review suggests that the media can play an effective role in changing social attitudes. The media can also play a role in amplifying citizen's voices and promoting accountability.

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Notes

[1] GDP average annual growth rate increased from 5.5% in 1988-1998 to 7.2% in 1998-2008 as per the World Bank's Development Economics LDB database in 2009.

[2] The public sector outlay for the Eleventh Five Year Plan(2007-12) is estimated by the Planning Commission at Rs 3644718 crores (1 crores=10 million). In comparison, the Eleventh Plan outlay will be 120% higher than the Tenth Plan (Planning Commission, 2008a).

[3] For example, while the NFHS shows a substantial decline in proportion of households ranked low by standard of living index between the years 1998-9 and 2005-6, the DLHS shows no such decrease between the periods 2002-4 and 2007-8.

[4] To cite an example, criterion adopted by different NFHS surveys for calculating infant mortality rate varies.

[5] The MDG data for India drawn from World Development Indicators shows that employment to population ratio 15+ had declined from 58% in 1990 to 56% in 2008, and for ages 15-24 from 46% to 40% during the same period (World Bank, n.d)

[6] From 6.38% in 1993-4 to 8.54% in 2004-5 as per current daily status basis, and from 1.99% to 2.45% as per Usual Principle and subsidiary basis. See: Planning Commission (2008c).

[7]The minimum calorific requirement is estimated at 2400 K cal per day for rural areas and 2100 k cal for urban areas. The Planning Commission (2008b) estimates that Rs 356 monthly per capita consumption expenditure is needed for rural areas and Rs 539 for urban areas in 2004-5 to meet the calorific requirements.

[8] As admitted by the Planning Commission (2008b) in its chapter on Rapid Poverty Reduction within the Eleventh Five Year Plan.

[9] Gender disparities in dropout rates are slightly higher amongst ST girls primary level, while the reverse is true at elementary level. See SES, 2004-5, cited in Planning Commission (2008d).
[10] The Planning Commission notes that the incidence of income poverty amongst females tended to be marginally higher in both urban and rural areas. It also notes that the percentage of females in poor households in 2004-5 is 29% and 23% in rural and urban areas, when compared to 27% and 26% in rural and urban areas in 1993-4. See: Planning Commission (2008b).
[11]The male labor force participation declined between 2000 and 2007 from 85.2% to 84.5%.
[12] Discussions with the Member Secretary of the State Planning Commission, Tamil Nadu also supports in this view.
[13] E.g. contraception, adolescent birth rate, and adolescent reproductive health
[14] Beyond the MDGs, there are no targets on improving access to services for safe abortion, (treatment of) violence against women, infertility, reproductive cancers, SRH needs of adolescents and SRH needs of people of diverse sexual and gender identities.
[15] ICDS is a community based early child care program which seeks to address nutrition, education and health (through referral) needs of children, expectant, nursing mothers and adolescent girls (Planning Commission, 2008f).
[16] The targeted public distribution system provides subsidized food grains, pulses, oil, sugar and kerosene for cooking for those below the poverty line.
[17] The eleventh plan chapter draws attention to the newly introduced Unorganized Sector Workers Social Security Bill 2007 and includes provisions for health, maternity, life, accident, disability cover, old age protection, and support for education of children for those registered under this Act. However, registration procedures are cumbersome, few workers in the informal sector are registered, and the health cover provided is limited. The *Aam Admi Biama Yojana* provides social security for rural landless households (18-59 years), with the premium of Rs 200 being borne by the state and central government. The scheme provides a cover of Rs 30,000 for natural death, Rs 75,000 for accidental death, Rs 75,000 for total disability and Rs 37,500 partial disability. However, it is not clear whether if the man dies the premium would go to his wife or parents. Scholarship of Rs 300 per quarter per child covers two children studying between the 9th to 12th, victimizing the poor who tend to have more children. The government provides old age pension and widow pension, but the Eleventh plan document itself admits that the coverage under these pensions is weak, the amount limited to Rs 400 per month, and it is mainly those without sons who benefit from this scheme (Government of India, 2008b).
[18] As per BPL census, 2002 there are 147,963,607 rural households below the poverty line. See: http://bpl.nic.in/Total_Bpl_Rural.htm
[19] According to the World Health Organization (2001), basic health services include major communicable diseases and maternal and peri-natal conditions that account for large proportion of avoidable deaths in these low-income countries.
[20] 64.3% of all rural households in Tamil Nadu do not own agriculture land.
[21] The NFHS 3 reported no gender disparity in the IMR but the 2008 SRS reported that this existed.
[22] Figures are based on a comparison of National Family Health Surveys (NFHS) 1, 2 and 3.
[23] According to the state's Planning Commission (2008a), state outlay for the Eleventh plan has been fixed at Rs 85,344 crore as against the outlay of Rs 40,000 crore for the Tenth Plan (2007-12).
[24] The national 2005 NREGA Act states that all registered households have to be provided with employment.
[25] Government health posts at PHC level do not have scanning facilities.
[26] One out of the four women who went to a government facility for ANC visited her provider in the evening requesting for more information on the process. For this visit, she was charged a fee of Rs 50.
[27] Of all those interviewed, one woman opted to not go to a government facility after losing her first child in a government hospital due to a delay in treatment, which resulted in the drying up of her amniotic fluid.
[28] Of the eight who delivered in a government facility during the last delivery, three or 37% went to a health post nearby, and 67% went to the *Government Kasturba Gandhi Medical* (Gosha) hospital.
[29] An exception was the case of the lone woman who availed special ward in Gosha hospital paying Rs 3300 for caesarian. She reported good quality care, access to clean linens and toilets, and good food.
[30]One woman's application was rejected on the grounds that the family had a mobile phone, one because she avoided sterilization, one for lack of a ration card in the urban area (migrant), one a for lack of income certificate, and one woman because she accessed ANC in her village. Apart from a lack of income certificate, none of the rationales used were valid.
[31] Of the 25 women met from the area of two PHCs, six were not eligible as it was their third children. Of the other eighteen, nine got some/all benefits under the *Muthulakshmi Reddy Scheme* ranging from Rs 1000 (5) to 4000 (4) (Ravindran, 2009).
[32] This in part is due to the type of care required by the informant who had frequent miscarriages due to a weak uterus. Owing to her condition, she decided to seek treatment from a private care provider because she felt the doctors there spent more time for her. However, for the actual delivery, she went to the government hospital. In the case of the other four women interviewed, they shifted.
[33] However, they were informed that they had to change the copper-t after three years.
[34] Such as heavy bleeding (IUDs) and putting on weight (pills)

[35] Inadequate in meeting quantity of demand, as well as demand for 'penis tucks' and silicon implants which were not available in the lone hospital providing sex-reassignment surgery.
[36] Breast, ovarian and endometrial cancer is higher amongst lesbians than heterosexual women.
[37] Some girls were asked to eat later, which often means lesser access to food.
[38] Sexual harassment is often dealt with by throwing chilly powder to the offender, the victim hitting back with slippers, or the victim lodging a complaint to adults.
[39] Of the 129 children in 0-5 years, 125 were weighed in the last quarter, of whom 77% fell in the normal range and 23% were underweight. A higher percentage of females (26%) in 0-5 years were found to be underweight than boys (20%).
[40] While the *Anganwadi* worker reported giving 3 eggs per week to children in 3-5 age group, the mothers of children and helper reported a lower figure of 1-2 eggs per week.
[41] For more information, visit http://www.gnr.stpi.in/SEZ_pdf/OperationalSEZs_function.pdf
[42] http://sezindia.nic.in/writereaddata/updates/FACT%20sheet.pdf
[43] One lakh is equivalent to 100,000.
[44] Government of India, Ministry of Health and Family Welfare, District-level Household Survey 2007-8: Fact sheet Gujarat (DLHS – 3).
[45] For more information, visit: http://www.wadanatodo.net/aboutus/default.asp
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[47] For more information, visit: http://www.righttofoodindia.org
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[50] For more information, visit: http://www.voicesagainst377.org
[51] *The Hindu:* Monday, Oct 12, 2009, 2010, RTI a 'tool of governance' in the hands of common man**;** September 30, 2009, UN starts campaign to eradicate poverty in India; September, 2009, Spend more on education, health: NGOs; December, 10, 2009, Child under-nutrition in India is a human rights issue; December 7, 2009, Food for thought at Copenhagen.
[52] See: *The Hindu*, December 14, 2009 2009, Reproductive health should be part of education curriculum.
[53] See: *Dinanthanthi*, October 11, 2009, 150 Karpini Pengalukku Udavi Thogai (Assistance to 150 pregnant women); and October 25, 2009, Garbinipengalukku Unavu Vazhangum Viyha (Food festival for pregnant women)
[54] See: *Life… Love… and Hope….*2009. [video] Mysskin and Kumar, S., 2009. India.
[55] Wikipedia, n.d, Ippadikku Rose, http://en.wikipedia.org/wiki/Ippadikku_Rose
[56] This section is based on one of the authors' work experience in Gujarat.
[57] Naxalite is the general designation given to several Maoist-oriented and militant insurgent and separatist groups that have operated intermittently in India since the mid-1960s.

CHAPTER 4: NIGERIA CASE STUDY

Sexual and Reproductive Health and Rights, Poverty and the Millennium Development Agenda in Kaduna State

Ngukwase Surma and Mary Okpe

Introduction

This research examines how policy on Sexual Reproductive Health and Rights (SRHR), the Millennium Development Goals (MDGs) and poverty alleviation are framed and integrated into Nigeria's national policy. This research paper examines policy implementation linked to the above, and establishes the gaps and contradictions between discourse and practice in Nigeria.

This research hypothesizes that structural mismatches or disjunctions exist between:

- Global discourses and agendas (SRHR, MDGs and poverty), and the nation's policy frames and priorities;
- National policy frames and priorities and state/ local level policy frames and processes;
- SRHR policies and priorities, as they had been framed and eventually implemented since ICPD, Beijing and the MDGs or the poverty alleviation architecture; and
- That these disjunctions and mismatches have detrimental effects in achieving gender equality and ensuring/ meeting SRHR needs.

This research focuses on the Kaduna State, as one of the two states that hosted the millennium cities initiatives and millennium villages projects in Nigeria. The millennium cities and villages projects are initiatives of the Earth Institute of the Columbia University in New York, which aims to offer a "proof of concept" that demonstrates that the MDGs are

achievable. This, in addition to the technical support received from the United Nations Development Programme (UNDP) is poised to present Nigeria – having a relatively large young and adolescent population – as an ideal model of the MDG concept. It is against this backdrop that this research examines the Nigerian governments' intervention in adolescent sexual and reproductive health to elucidate the scope of on-going interventions, and whether or not policy design and implementation align with the broad agenda of the ICPD PoA.

The African framework for sexual and reproductive health and rights

It is important to acknowledge that the existence of a sexual and reproductive framework in Nigeria is informed by the ICPD PoA, as a result of the advocacy work of SRHR activists in the African continent. In this regard, the Maputo plan of action on SRH is used as the continental framework, and as such, will be used as this study's framework to assess SRH in Nigeria.

The Conference of African Ministers of Health in October 2005 held in Gaborone, Botswana, adopted the Continental Policy Framework on Sexual and Reproductive Health and Rights, endorsed by the African Union (AU) Heads of State in January 2006[1]. The Continental Policy Framework on Sexual and Reproductive Health and Rights addresses the reproductive health and rights challenges faced by Africa. It calls for strengthening the health sector by increasing resource allocation towards health to improve access to services. Mainstreaming gender issues into socio-economic development programs and SRH commodity security are also addressed. Moreover, the AU Ministers of Health recommended for SRH to be among the top six priorities of the health sector. In harmony with this ministerial recommendation, the outcome of the World Summit held in New York in September 2005 reiterated the need to attain universal access to services, including access to reproductive health care services.

The Maputo Plan of Action operationalizes the Sexual and Reproductive Health and Rights Continental Policy Framework and seeks to take the continent forward towards the goal of

universal access to comprehensive sexual and reproductive health services in Africa by 2015. The short term plan for the period up to 2010 is built on nine action areas: integration of sexual and reproductive health (SRH) services into primary health care; repositioning family planning; developing and promoting youth-friendly services; safe abortion; quality safe motherhood; resource mobilization; commodity security; monitoring; and evaluation. The Plan is premised on SRH in its fullest context as defined in the ICPD PoA 1994, which also takes into account a life cycle approach. The elements of SRHR include Adolescent Sexual and Reproductive Health (ASRH); Safe Motherhood and Newborn Care; Abortion Care; Family Planning; Prevention and Management of Sexually Transmitted Infections, including HIV/ AIDS; Prevention and Management of Infertility; Prevention and Management of Cancers of the Reproductive System; Addressing Mid-life Concerns of Men and Women; Health and Development; the Reduction of Gender-based Violence; Interpersonal Communication and Counseling; and Health Education.

The Program of Action (PoA) for Implementing the Continental Sexual and Reproductive Health and Rights Policy Framework 2007–2010 comprises nine broad areas. Eight of these areas are reflected in the Nigeria PoA, with the exception of strengthened community-based STI/ HIV/ AIDS and SRHR services.

The Nigeria plan of action covers the following areas:

1. Increase access to quality safe motherhood and child survival services
2. Integrate HIV, STI, Malaria, SRH Services with PHC
3. Position youth-friendly SRHR as a key strategy for youth empowerment, development and wellbeing
4. Re-position family planning as a key strategy for the attainment of the MDGs
5. Reduce incidence of unsafe abortion
6. Increase resources for SRH
7. Implement SRH commodity security strategies for all SRH components
8. Implement monitoring, evaluation and coordination mechanisms for the Maputo plan of action

NIGERIA: Political, Economic and Social

With a population of 140 million, between 1960 and 1999, Nigeria was under 15 years of military rule, only gaining independence in 1999 when the military (once again) handed over power to the civilians (National Bureau of Statistics, 2006). Even when Nigeria has always had a multi-party, first past-the-post, winner takes all electoral system – one political party had most often than not, won majority of all seats. Today, the People's Democratic Party (PDP) holds majority seats at all levels, with the opposition becoming extremely weak and almost non-existent.

The country is a federal republic with a presidential system of government. The constitution provides for the separation of powers between the three arms of government – the Executive, the Legislature and the Judiciary (Federal Republic of Nigeria, 1999). The republic has a three-tier structure governed by the Federal (central) Government, State Governments and Local Government Councils. A Minister, appointed by the President, governs the Federal Capital Territory.

Each level of government has its duties stated in the constitution (Federal Republic of Nigeria, 1999). The Federal government creates laws and policies for the federation; the State government makes laws and policies at the state and local level, as well as implements federal policies and laws; whereas Local government implements laws developed at all levels, in addition to making its own policies in compliance with federal and state policy. The federal government sets the tone for the country's development, whereas the state and local government follow suit. Despite ten years of democratic rule since 1999, democratic institutions remain weak with Governors and Chairpersons at local level controlling the legislature. At the national level, the legislature, which is predominantly PDP, is considered unable to properly perform its oversight functions over an executive arm that is also from the same political party.

Nigeria is endowed with oil and has made huge amounts of money from gas and oil reserves, but its economic performance has been unimpressive since 1960. The World Bank puts Nigeria's average annual growth rate of Gross Domestic Product (GDP) at less than 4% for the years between 1960 and 2000. Udeh (2000) estimates that between 1981 and 1999, Nigeria received over US$ 228 billion from oil and gas reserves yet the proportion of the population living on less than US$ 1 between 1999 and 2007 did not decline significantly[2].

Table 1 Economic Indicators

Economic Indicators	1990	2000	2001	2002	2003	2004	2005	2006	2007
GDP Growth (%)	8.2	5.4	4.6	3.5	9.6	6.6	5.8	5.3	5.7
Oil Sector Growt (%)	5.6	11.1	5.2	-5.2	23.9	3.3	-1.7	-3.7	-5.9
Budget Deficit/ GDP	2.9	-2.3	-4.3	-5.5	-2.8	-2.6	-0.2	0.3	0.7
Ext. Reserves (% of GDP)	Na	Na	Na	Na	7.7	11.4	24.4	36.5	42.6
External Debt /GDP	106.5	64.9	57.3	72.1	61.1	84.5	69.2	7.4	4.0
Domestic Debt/ GDP	31.3	32.2	36.6	26.1	28.6	25.3	20.8	18.6	19.2
Incidence of poverty (%)	42.7	65.6	65.6	65.6	65.6	54.4	54.4	54.4	54.4

Source: Federal Republic of Nigeria and UNDP, 2008.

In 1999, immediately following independence, to qualify for debt relief, the nation prepared its first PRSP – the National Economic Empowerment and Development Strategy (NEEDS). NEEDS is replicated at state and local council level (SEEDS and LEEDS). The NEEDS document served as the development road map for the nation. With it came an inflow of international donor funds and technical expertise to help rebuild the nation's economy and systems in support of economic and social development. Since then, there has been several reform and poverty alleviation processes set in motion that coincided with the MDGs. Today, Nigeria has a millennium development model that encompasses the federal, state and local government levels, even when at state and local levels there are just two pilot millennium cities and villages, among them, the Kaduna State. As host of a millennium city and village, this paper will investigate how this model impacts upon policy-making and its implementation. It will also identify gaps and the interconnections between sexual and reproductive health and poverty.

In this light, this report first discusses health sector policies between 1999 and 2008, focusing on sexual and reproductive health of adolescents. It examines Nigeria's poverty alleviation framework and programs between 1999 and 2008, and highlights the interface between

health/ sexual and reproductive health and the MDGs. This paper also seeks to explicate whether poverty programs consciously integrated sexual and reproductive issues in their design, and what type of implications are there for the failure to do so. This is followed by an examination of the nation's millennium agenda and model, and its connections with health reform and poverty alleviation. Finally, the report discusses the connections and or disjuncture between policymaking and implementation between SRHR, poverty and the MDGs, and how the MDG agenda impacts upon Nigerian women's health.

Sexual and reproductive health in Nigeria

National health care system

The national health care system is built on the three-tier responsibility of the federal, state and local governments. Schedules of responsibilities to be assigned to each level are prepared in consultation with all tiers of government and approved by the Federal Ministry of Health. The health system can be divided into orthodox, alternative and traditional systems of health care delivery, all recognized and regulated by government (Labiran et al., 2008).

Nigeria formulated 24 sectoral health policies[3] between 1960 and 1985. The policy on Primary Health Care (PHC) as a key for attaining the goal for health for all was adopted in 1988. This policy provides the platform for several health initiatives such as the national health plan, and presents efforts of government to pursue the MDGs (HERFON, 2006).

In 2004, the government revised the National Health Policy to reflect emerging realities and trends in national health status. The Revised National Health Policy 2004 was developed within the context of the health strategy of the New Partnership for Africa's Development, the United Nations Millennium Development Goals and the National Economic Empowerment and Development Strategy (NEEDS). The development of a comprehensive health sector reform program served as an integral part in this process. The overall objective of the National Health policy was:

"... to strengthen the national health system to be able to provide effective, efficient, quality, accessible and affordable health services that will improve the health status of Nigerians through the achievement of the health-related Millennium Development Goals (MDGs)" (Federal Ministry of Health Abuja, 2004).

The main targets of the national health policy 2004 aligned with the health targets of the Millennium Development Goals, namely:

- Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate;
- Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate;
- To have halted, by 2015, and begun to reverse the spread of HIV/ AIDS; and
- To have halted, by 2015, and begun to reverse the incidence of malaria and other major diseases.

Despite the adoption of the National Health Policy in 2004, Nigerian health indices remained poor. In table 2, the state of health amongst Nigerians between 1999 and 2007 is presented.

Table 2 Health indicators for Nigeria 1999-2008

Indicators	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Prevalence of under-weight children	12	12	29	29	29	*	*	*	*	*
Under 5 mortality rate	151	207	183	*	198	197	194	191	*	*
Infant mortality rate	105	*	110	*	98	103	70.49	99		
Percentage of 1 year old immunized against measles	26	35	35	35	35	35	35	54	50	*
Maternal mortality ratio	700	800	*	*	*	*	1,100	*	*	*
Percentage of births attended by skilled health personnel	*	35	*	*	35.2		35	*	*	*
Contraceptive prevalence rate	8.6	12.6	15	*	12.6	*	13	*	*	*
Antenatal care coverage	63.7	*	64	*	58	*	*	*	*	*
HIV prevalence rate	7.3	6.4	5.8	5.4	5.2	4.0	4.4	3.8	3.1	*
Condom use at last high risk sex	*	12.6	*	*	35	*	*	*	*	*
Life expectancy	50	*	52	*	51.10	50.49	46.74	47.08	47.44	46.53

N.B. *Data not available

Source: National Planning Commission, 2003; The World Bank Group, 2010.

To address the weaknesses in the health system, the Federal Ministry of Health embarked on a Health Sector Reform in 2003. This was part of a wider national economic and social reform initiative under the country's National Economic Empowerment Development Strategy (NEEDS). Health was one of the major sectors envisaged as contributing to achieving NEEDS goals. Public sector reforms were expected to support and sustain sectoral reforms, such as health. Part of the health reform strategy was the expansion of the Health Promotion component of the Revised National Policy, which led to the development and adoption of the National Health Promotion Policy in 2006 (Federal Ministry of Health Nigeria, 2006).

A national health bill was drafted by the Federal Ministry of Health to define a health system for Nigeria as part of the reforms[4]. A redraft of the bill affecting sections relating to state and local government responsibilities resulted in re-stating and strengthening federal roles and responsibilities as these link with state and local governments.

According to the Federal Republic of Nigeria State (2008), the new bill addresses the following:

1. responsibility for health
2. functions of the federal ministry of health
3. establishment of a primary health development fund
4. eligibility for health services and establishment of the national health system
5. health establishments and technologies
6. rights and duties of users and health care personnel
7. national health insurance scheme
8. national health research and information system
9. human resources for health
10. control of use of blood, blood products, tissue and gametes in humans
11. regulations and miscellaneous provisions

After nearly three years of scrutiny, the bill was finally approved by both houses of the national legislature. When the bill finally becomes ratified as a law[5] , it is expected to help facilitate the National Health Policy objective of improving the health status of Nigerians and the achievement of health-related MDGs.

Table 3 Nigeria's health ranking, 2002-2005

S/No.	Health indices	Rate	Ranking among countries
1	Access to sanitation	33%	115th of 129
2	Crude birth rate > per 1,000 persons	40.51 per 1,000 persons	20th of 190
3	Children under weight rate	11%	14th of 95
4	Contraception	15%	77th of 89
5	Drug access	0%	141st of 163
6	HIV/ AIDS > adult prevalence rate	5.4%	19th of 136
7	HIV/ AIDS > deaths	310,000	2nd of 102
8	Hospital beds > per 1,000 persons	1.67 per 1,000 persons	98th of 149
9	Infant mortality rate	70.49	33rd of 179
10	Life expectancy at birth > female	47.32 years	209th of 226
11	Life expectancy at birth > male	45.78 years	208th of 226
12	Malaria cases > per 100,000	30	71st o 94
13	Physicians > per 1,000 persons	0.28 per 1,000 persons	48th of 148
14	Probability of not reaching 40	33.7%	30th of 111
15	Smoking prevalence males > percentage of adults	15.4%	6th of 42
16	Spending > per person	30	95th of 133
17	Water availability	2,514 cubic meter	115th of 169

Source: CIA, 2003; 2005; UNICEF/ UN, 2002; UN Population Division/ WHO, 2002; WHO, 2002; 2005.

A key structural barrier to the provision of adequate health services is the distribution of health care responsibilities among the three tiers of government: federal, state, and local. The Nigerian Constitution does not outline governmental responsibility over health care; instead, the 1988 National Health Policy and Strategy to Achieve Health for All Nigerians (1988 National Health Policy) allocates responsibility over the primary health sector to local government; the secondary health sector to state government; and the tertiary health sector to federal government. The federal government has little control over state and local

governments in the discharge of their duties. In addition, unlike a constitution or other legislation, the 1988 National Health Policy lacks legal force; it cannot impose legal obligations. The challenge is particularly huge for officials at local government level, where poor primary care has serious consequences for women seeking maternal care (Center for Reproductive Rights, 2008).

Sexual and reproductive health

The 2008 National Demographic and Health Survey (NDHS) reported a total fertility rate (TFR) of 5.7% births per woman. This is at par with the 2003 NDHS (5.3%), and consistent with the TFR registered in the 1990 NDHS (6.0%). These fertility rates vary by zone, throughout the country. Yet, contraceptive prevalence rate (CPR) in 2008 is at 15%, an increase from NDH 2003 figures of 13%. While use of contraception by married women has generally increased and stands at 9.7% in 2008, the NHDS in 2008 shows that the use of modern contraception is highest among the age group 35-39 years.

Alongside high fertility rate, maternal and child mortality rates are equally high. The figures, however, excludes women who die from complications of unsafe abortion. It is estimated that nearly 610,000 women resort to induced abortion each year in Nigeria. Of this number, 10,000 die annually from complications of unsafe abortion (SOGON, 2004). Despite this, abortion remains illegal in Nigeria unless it is meant to save the mother's life. The prevalence of HIV/ AIDs also remains a problem.

To address many of these problems the Federal Government, through the Federal Ministry of Health has developed a number of policies and strategies on reproductive health. One such policy is the National Reproductive Health Policy and Strategy 2001, which aims to achieve quality reproductive and sexual health for all Nigerians. Its overall goal is to create an enabling environment for appropriate action, and provide the necessary impetus and guidance to national and local initiatives in all areas of reproductive health.

The Federal Ministry of Health Nigeria (2001) outlines the following objectives of the policy. These are to:

- reduce maternal morbidity and mortality;
- reduce prenatal and neonatal morbidity and mortality;
- reduce the level of unwanted pregnancies;
- reduce incidence and prevalence of sexually transmitted infections, including the transmission of HIV infections; and
- limit all forms of gender-based violence and other practices that are harmful to the health of women and children.

In 2007 the policy on Integrated Maternal, New-born and Child Health Strategy was developed to complement existing policies and address the increasing number of maternal and child deaths. It consists of interventions to address the main contributing factors to maternal, new-born, and child deaths. Other reproductive health related policies include the National Policy on Population for Sustainable Development 2004; National Policy on the Health and Development of Adolescents and Young People in Nigeria 2007; and the National Gender Policy 2006. These policies were developed in line with the ICPD programme and the African Regional Strategy on Reproductive Health.

Nigeria's National Reproductive Health Policy and Strategy of 2001[6]**:** This addressed a series of concerns including high levels of maternal and neonatal morbidity and mortality, fragmentation of reproductive health services and limited impact of programs aimed at improving sexual and reproductive health, and the underuse of family planning services (Federal Ministry of Health Nigeria, 2001).

The policy also laid out government actions necessary to meet its goals of reducing maternal morbidity, maternal mortality and unwanted pregnancies by 50%, as well as raising the contraceptive prevalence rate by almost 12%. These measures include removing barriers to reproductive health care, improving access to emergency obstetric care and post-abortion services, strengthening primary care level reproductive health services, bolstering training

for healthcare personnel in reproductive health, and promoting access to family planning information and services.

***Integrated Maternal, New-born and Child Health Strategy (2007 IMNCH Strategy)*:** This comprises intervention packages that address the main contributing factors to maternal, new-born and child deaths. The packages refocus fragmented methods of implementing maternal and child health services into more integrated methods. Specific goals include ensuring that 70% of deliveries occur in health facilities by 2015, and that at least 70% of emergency obstetric care be provided at primary health care clinics and general hospitals. The Strategy recognizes that poverty is a barrier to health care access, and therefore aims to institute the Basic Health Insurance Scheme that would ensure free services for pregnant women, new-borns and children under the age of five.

***National Policy on Population for Sustainable Development of 2004 (2004 Population Policy)*:** This policy aims to improve "the reproductive health of all Nigerians at every stage of the life cycle" (National Population Commission of Nigeria, 2004). Objectives to reach this goal include "expanding access and coverage and improving the quality of reproductive and sexual health care services" (National Population Commission of Nigeria, 2004)increasing and strengthening comprehensive family planning services and safe motherhood programs and addressing the reproductive health needs of adolescents.

Adolescent reproductive health

Nigeria has a high population of young people. Two in five Nigerians (44% of the population) are less than 15 years of age; the median age in Nigeria is 17 years; median age at first marriage for women is between ages 20-49; median age for first sexual intercourse is 17.9 years varying by region with girls in north west and north east having sex for the first time under 15 years. The median age at first birth for women ages 20-49 is 19.6%. Childbearing therefore begins early with about half of all Nigerian women of reproductive age becoming mothers before the age of twenty[7]. The 2003 HDNS showed that teenage

pregnancy increased from 3.5% 1999 to 4.3% in 2003. The 2008 survey is silent on teenage pregnancy.

This rapidly growing population of young people coupled with the spread of HIV/ AIDS indicates a need for young people to be adequately educated to make informed decisions, form positive attitudes, beliefs and values and develop skills to enable them to cope with the biological, psychological, socio-cultural and spiritual aspects of their sexuality.

While a dedicated budget line for programs targeting adolescents and youth has yet to be developed, some steps have already been taken by government at the national level to respond to young adult and adolescent reproductive health, such as the National Adolescent Health policy revised in 2007, as well as a National Youth Policy also released in 2007. In 2003 the national family life/ HIV/ AIDS education curriculum was adopted and states were expected to adapt the contents of the curriculum to suit their own requirements. Public reaction against the curriculum, lodged especially by faith-based organizations, has led to the reluctance of states to adapt and implement the curriculum.

Donors and NGOs have played the lead role in adolescent sexuality and reproductive health initiatives, particularly in relation to HIV/ AIDS prevention and control, the prevention of teenage pregnancies, sexuality education and abortion.

Kaduna state sexual and reproductive health

Kaduna State has between 1999 and 2008 has spent US$ 158,718,878.49[8] on health.

Table 4 Budget allocation to some ministries in Kaduna State, Nigeria, 1999-2008*

Budget	1999	2000	2002	2004	2006	2008
Total Budget size	$60.9	$108.1	$242.5	$267.6	$420.4	$386.7
Total health Budget	$14.1	$14.5	$29.7	$19.2	$31.7	$49.2
% of health to total budget	23.3	13.5	12.3	7.2	7.5	12.7
Total Budget to ministry of women affairs	$0.279	$0.596	$1.02	$0.791	$1.4	$1.8
% of women affairs to total budget	0.5	0.5	0.4	0.3	0.3	0.5

Ministry for Poverty alleviation	Not yet a ministry	Not yet a ministry	Not yet a ministry	$0.057		$5.06
%of poverty alleviation to total Budget				0.02		1.3

Source: Ministry of economic planning, Kaduna, n.d.
*Figures rounded off to the nearest millions in US$

The presentation of the budget document does not make explicit the specific programs and activities targeted to advance SRH and adolescent RH, except for those such as family planning and HIV/ AIDS. The budget shows only general allocations, making it impossible to work out which focus area receives the highest funding. A major issue discerned is the dwindling health allocation in the years between 1999-2008; from 23.3% in 1999; to 7.2% of the total budget in 2004; 7.5% in 2006; and 12.7% in 2008. This in itself reveals the low level of government commitment in tackling health issues in Kaduna.

Since 2007, maternal/ child healthcare received the highest priority in health programs, with the present administration rolling out a policy of free maternal and child care from ages 0-5 for certain ailments.

Health systems at the local council level: Ikara local government area of Kaduna state

Local councils have the principal responsibility for primary health care delivery, and are expected to implement the policies drawn up by federal and state ministries of health.

Conclusion

A generally rich policy environment exists at national level that takes on board the ICPD agenda. Policy implementation is expected at state and local levels, and states are enabled by the constitution in constructing their own state laws in line with national laws and policies. In the Kaduna State, free maternal and childcare for ages 0-5 years has now received such legal backing. This is no doubt driven further by the MDG agenda, and built on earlier civil society activity on issues of women's empowerment, reproductive health and the sexual and reproductive needs of adolescents.

The current level of access to reproductive health services, however, does not reflect adherence to policy recommendations. There are no laws that back up the principles embedded in the policies, and little or no funds are made available for implementation (Center for Reproductive Rights and Women Advocates Research and Documentation Centre, 2008). Again, at state level, similar state policies or actions are not derived from general policy recommendations. An area that has received attention in some states is the issue of maternal and child mortality. Maternal and child policies are viewed strategic in reducing maternal, infant and under-five mortality. With government funding, various programs to this end have been introduced by several states, such as Kano and Kaduna. In the Kaduna State for example, a free maternal and childcare policy was introduced in September 2007 to benefit pregnant women and children under five for specific ailments. Similarly, HIV/ AIDS agencies have been set up in all states of the federation, and national work on HIV/ AIDS is on-going.

Most of the reproductive health programs in Nigeria are being funded and implemented by international development organizations such as DFID, USAID, WHO, IPAS, and Pathfinder International. A review of national and federal level health budgets in Nigeria reveals that apart from providing lump sums to health-related issues, no specific allocations are made toward sexual and reproductive health issues. Sexual and reproductive health rights activists have argued that there is need for specific allocations to SRH to enable tracking[9].

In line with the MDG agenda and its targets on health goals 4, 5 and 6, Nigeria has placed more emphasis on reducing maternal and child mortality, as well as fighting the spread of HIV/ AIDS. There seems to be little attention to other issues of sexual and reproductive health by state governments, even though some states such as Anambra, Lagos, Ondo, Rivers, Edo and Enugu have passed laws against female genital mutilation (FGM), and some states like Anambra, Edo, Enugu, Ondo and Rivers have also passed laws against harmful traditional and widowhood practices.

Nigeria has several policies on SRH and Adolescent SRH, which take on the ICPD and Beijing agendas, in addition to being a signatory to the Maputo Declaration 2005. Nigeria has a country plan for the actualization of the African continental SR policy, which is also aligned with the ICPD agenda. Unfortunately, there is little political will directed to other aspects of SRH beyond the MDG health goals targets. A large per cent of SRH efforts are donor-driven. PATHS (a DFID-funded project), for instance, is working in about three states on maternal and child health and other issues. Other development (funding) agencies like IPAS, USIAD, UNFPA, UNICEF, JICA also work in Nigeria on SRH issues. Such a heavy reliance on donor funding will not be sustainable for Nigeria in the long run. There is danger of donor withdrawal or fatigue, posing great challenges to the continuity of successful programs.

Poverty alleviation interventions and sexual and reproductive health

About two-thirds of Nigerians are poor despite living in a country with vast potential wealth. While revenues from crude oil have increased in the past decades, Nigerians continue to fall deeper into poverty (National Planning Commission, 2004b). These figures increasingly worsened in the 1990s in spite of several attempts by successive Nigerian governments to fight poverty through the establishment of numerous programs since independence. However, data provided by the Nigeria MDG mid-point assessment in 2008 (Federal Republic of Nigeria and UNDP, 2008) shows that there has been a marked decrease in poverty from 65.6% in 2000 to 54.4% in 2007. Despite this marginal success, more than half of the population remains poor, with the report emphasizing that the poverty goal will most like not be attained (Federal Republic of Nigeria and UNDP, 2008).

Table 5 Social indicators 1990-2007

Social indicators	**1990**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Population (million)	88.5	108	118.8	122.4	125.6	129.2	133.8	140.0	140.0
Population growth rate	2.8	2.8	2.8	2.8	2.8	2.8	2.8	2.8	3.2
Life expectancy (in years)	na	na	54.0	54.0	54.0	54.0	54.0	54.0	54.0
Incidence of poverty (%)	42.7	65.6	65.6	65.6	65.6	54.4	54.4	54.4	54.4

Source: Federal Republic of Nigeria and UNDP, 2008.

Nigeria's poverty framework

The framework currently guiding Nigeria's poverty intervention is the National Economic Empowerment Development Strategy (NEEDS), which is also a strategy paper with an economic reform agenda. The purpose of NEEDS is to raise the country's standard of living through a variety of reforms, including ushering in macro-economic stability, de-regulation, liberalization, privatization, transparency and accountability. NEEDS also seek to address basic deficiencies, such as the lack of fresh water for household use and irrigation, unreliable power supplies, decaying infrastructure, impediments to private enterprise and corruption. Based on government plans, strategies enshrined in NEEDS would reduce poverty, create seven million new jobs, diversify the economy, boost non-energy exports, increase industrial capacity utilization, and improve agricultural productivity (National Planning Commission, 2004a). NEEDS is partly based on the MDGs. Each of the 36 states of the federation produce state level strategy papers modeled on the national framework. State level strategy papers are referred to as the State Economic Empowerment Development Strategy (SEEDS).

NEEDS II was in the process of production when this became integrated in the President Yar'adua 7 point agenda (2007) and Vision 2020(2009) and currently forms the economic and poverty development framework. However NEEDS I is still considered as providing the poverty eradication framework. As a respondent in one of the poverty alleviation programs stated:

> *"We have the NEEDS, the SEEDS and LEEDS at local governments – all these are designed to tackle poverty... In terms of poverty eradication, I know that we have the NEEDS. NEEDS is supposed to be the country's poverty eradication strategy scheme. Well you know the frame work of NEEDS; NEEDS is predicated on one thing... the private sector should run the show, the private sector should expand, the private sector should be the major provider of jobs, it should be the major provider of income, it should be the major engine of growth and development. And through that poverty is supposed to be tackled"*[10].

National Poverty Eradication Programme (NAPEP)

In 2001, government established the National Poverty Eradication Programme (NAPEP) with two main mandates: first, to coordinate poverty alleviation activities of ministries, departments and agencies (MDAs) directly involved in poverty reduction; and second, to periodically extend intervention projects that complement efforts to implement MDAs[11]. Funding for NAPEP is derived from the federal and state governments as well as international donors.

While NAPEP consolidates and monitors all poverty eradicating programs/ projects, ministries with poverty programs at the time of NAPEP's inception were allowed to continue drawing budgetary allocations for their own programs instead of transferring all funding to NAPEP.

In addition to coordinating poverty eradication projects, NAPEP also implements the following projects:

1. Poverty Empowerment Scheme (YES)
2. Rural Infrastructures Development Scheme (RIDS)
3. Social Welfare Services Scheme (SOWES)
4. Natural Resources Development and Conservation Scheme (NRDCS)

With the incoming Office of the Special Assistant to the President on Millennium Development Goals (OSSAP-MDGs) and the virtual poverty funds, NAPEP has added to conditional cash transfers to poor families in its program, with funding from the MDG debt relief fund and matching grants from state governments.

At State level, the Kaduna State office of NAPEP[12] has executed several poverty alleviation projects, some in collaboration with other MDAs[13]. For instance NAPEP has collaborated with the State Ministry of Poverty Alleviation, especially on Conditional Cash Transfers. However it also appears that NAPEP runs most of its programs independent of other line ministries. NAPEP's interpretation of what constitutes gender mainstreaming includes having women as beneficiaries of some its projects, as well as female specific projects. This is captured in an interview with a key informant.

"...I try to see that women are catered for; we are not only working for the 35% but sometimes we give more ...we have come to realize that if you allow the women to compete with the men they do better... when you give them micro-credit they will be able to use it judiciously... we have a program on VVF... we rehabilitate patients by giving them some skills while receiving treatment... we have given them some skill acquisition materials... they range from fashion design, hair dressing, agricultural enhancement or skills...we had up to twenty various skills..."

Gender mainstreaming in poverty programs should go beyond rolling out female-specific initiatives, or the number of women benefiting from it. From the point of a project's initial design (testing phase), its impact on gender should inform the project's final design and implementation. For instance, the tricycle project of NAPEP may not in the long run benefit women because in the local context as there are very few female commercial drivers, especially in the northern part of the country. Hence, even if women are provided with tricycles, the chances of them hiring male drivers are high.

Kaduna State Ministry of Poverty Alleviation

In Kaduna State, like all other Nigerian states, its SEEDS is modelled on the NEEDS document. The SEEDS is considered as serving the state's poverty alleviation framework, as well as its development agenda. To this end, state budgets have been based on what was planned for in SEEDS I, and now SEEDS II.

In 2006, the state upgraded its poverty alleviation agency to a full-fledged Ministry of Poverty Alleviation to tackle extreme poverty and poverty through the provisioning of skills and micro-credit; to coordinate and harmonize poverty programs in the state; and to formulate and review policies and strategies that seek to reduce poverty. While acknowledging that poverty and health are interlinked, the Ministry of Poverty Alleviation does not however appear to be relating with the Ministry of Health in terms of program planning and implementation. Instead, it has worked with the State Agency on HIV/ AIDS, and has engaged in some level of poverty program integration with other agencies such as

NAPEP. With NAPEP, the ministry collaborated in schemes on conditional cash transfer and NAPEP's village solutions scheme, for which the state provides counterpart funding. The ministry is also a member NAPEP's joint implementation committee.

In 2009, the ministry also began collaboration with the State MDG office and drew some of its funds from there. Interestingly, no connections had been made with the agricultural program funded by the World Bank that works specifically with farmers and is, in all intents, a poverty alleviation program. The ministry's only contact with the Ministry of Agriculture is working with the Cooperatives department to verify the identities of cooperative societies eligible for the Ministry of Poverty Alleviation's micro-credit facilities.

FADAMA II Project – Kaduna State

The FADAMA project under the Kaduna Agricultural Development Programme aims at facilitating sustained increase in income for rural dwellers (farmers, pastoralists, fishermen, hunters and gatherers). The project was established in 2003 at national and state levels. A poverty alleviation program funded by the World Bank, the FADAMA project operates independent of other poverty alleviation programs and does not engage with the health and women's affairs ministries or the Kaduna MDG office in its planning and implementation. The FADAMA project could also be considered a project aimed at meeting MDG 1 and promoting rural development, yet it has no connection with any other poverty programs. Its health component involves capacity building and awareness raising activities on HIV/ AIDS for members of farmers associations. While officers acknowledge the interface between poverty and health, they do not explore this connection in depth, nor from the perspective of sexual and reproductive health. Quoting a respondent who expressed a concern about the disconnect:

> *"... to sit down with ministry of health for instance, no, except probably like the HIV and health system project, we meet at the coordinating level when we attend meetings and ask each other what is happening in their projects, but in terms planning, the synergy is not there. You see, what we have said to the Bank... most of these projects like HIV, health system, education, agriculture etc... financed by the*

World Bank ... We have suggested that a forum be established where there will be synergy discussion so as to avoid duplication... when these projects are already signed there is competition and we operate as defined... but if there is synergy, then we avoid duplication because we do some similar things—for instance two projects have borehole construction. If there is synergy, then one project constructs boreholes for social use while the other constructs boreholes for economic use such as in abattoirs - but this is not happening. There should be some synergy at project level as well as at World Bank level"[14].

The government's project talks about gender and 30% representation of women. It accomplishes this by, for example, encouraging rural women farmers to register cooperatives and access the grants through the project. The project was renewed in September 2009 as FADAMA III.

Conclusion

An important way of looking at poverty is from the viewpoint of deprivation; that those who are poor do not have access to their most basic human needs. From this viewpoint, poverty is then captured in terms of an ends perspective — the actual levels of deprivation, or a means perspective — the adequacy of resources to avoid deprivation (Kabeer, 1994). The conceptualization and measures of poverty from a needs perspective, while informing the poverty line measurement in itself, fails to fully capture needs and is not adequately informed by a rights-based approach.

The needs perspective seems to be the predominant view in conceptualizing and implementing poverty intervention projects in Nigeria. Therefore, programs of the poverty agencies reviewed in this paper do not seem to consider other dimensions of poverty. Their work is limited in providing resources to avoid and reduce the level of deprivation. They fail to understand other dimensions of poverty such as gender, or the interconnectivity between poverty and health, as well as reproductive and other rights. Perhaps the inability to create those link between poverty and health in general, and sexual and reproductive rights

specifically, explains the slow pace of, and at times, failure of some poverty programs. While acknowledging the interconnectivity between poverty and health, no attempt has been made to act upon those links. NAPEP, the State Ministry on Poverty Alleviation and FADAMA II agricultural programs do not have collaborations with the state agency on HIV/ AIDS. As such, there is no single presentation to programme beneficiaries and skills acquisition training and provision of micro credit to patients of VVF at the Ahmadu Bello University Teaching Hospital Zaria.

A perspective that considers poverty beyond income levels and takes stock of the multiple layers of exclusion and vulnerability would have enabled poverty programs to deepen connections between poverty and health/ SRH issues. Such an approach would have paved the way in making linkages between poverty and sexual rights, limits to freedom, and wellbeing. Amartya Sen (1999) points out that poverty depends on capacities and capacities depend on freedom. Therefore, sexual rights violations imply loss of freedom, and as such, poverty. Poverty therefore leads to exclusion and the inability to participate in taking decisions on important issues, which in turn reinforces the description of poverty by poor people (World Bank, 2002). The visible loss of capabilities in people is related to many domains of life, including health. Henry Armas (2007) argues that when we think of sexual rights, we have to think of other domains of freedoms that are affected and are directly related to poverty. If sexual rights are included as part of a poverty strategy, it enables building the relationship between personal dimensions, with social and economic arenas. Such a link is sorely missing in the current conceptualization and implementation of poverty programs in Nigeria, even when the programs reviewed are tied to, and make references to the achievement of the MDGs. This implies that the MDGs will just remain a dream, owing to the inability to integrate sexual and reproductive health with poverty strategies.

This is clearly reinforced by the World Health Organization's (WHO) definition of sexual rights. Based on WHO, people are poor because:

- they cannot reach the highest attainable standard of sexual health, including access to sexual and reproductive health care services;

- they cannot seek, receive and impart information related to sexuality;
- they cannot receive sexuality education;
- respect is lacking for people's bodily integrity;
- people cannot choose their partner;
- people cannot decide to be sexually active or not;
- people are not free to have or not have sexual relations;
- people are not free to get or not get married;
- people are not free to have or not have children when they want; and
- people cannot pursue a safe, satisfying and pleasurable sexual life (Glasier, et al., 2006).

Nigeria's mid-point MDG assessment stated that the attainment of the poverty MDG — eradicating extreme poverty and hunger – may not be achieved by 2015. Based on Nigeria's mid-point MDG assessment and WHO's definition of sexual rights – it is clear that poverty strategies need to take cognisance of sexual and reproductive rights – in line with the Maputo Plan for sexual and reproductive rights (Glasier, et al., 2006).

The challenges faced by Nigeria's limited poverty scope are further compounded by civil society activists working on poverty issues. They argue that the nation does not seem to have a poverty framework, owing to what they claim is an absence of a vision; a well-articulated plan; and actual targets that deliver services in order to achieve the vision of a poverty-free society. These arguments are further premised on the fact that there is no concise systematic funding for poverty programs despite the presence of NAPEP, the MDG virtual poverty fund and numerous other poverty programs. The MDG virtual poverty fund for instance came on stream in 2006 following the production of the NEEDS document which was supposed to be the framework for poverty eradication and designed without the debt relief funds. The MDG virtual poverty fund, on the other hand, derives its financing from debt relief given to the nation by the Paris club[15]. The question remains what is the connection between the MDG poverty fund, the NEEDS document and NAPEP, especially given the fact that NAPEP does not operate under the MDG programme? [16]

Weak synergies across agencies working on poverty reduction, and with ministries such as the Ministry for women's affairs and health, result in the almost complete non-application of gender mainstreaming in policy development and implementation. To this end, poverty programs hardly take into consideration how their programs impact upon men and women. At best, some activities within programs target women as beneficiaries. However, issues on how decisions are made in spending family income or issues such as causes of vesicovaginal fistula (VVF) that are related to early marriage and inability to access medical care for various socio-economic reasons.

The Nigerian Millennium Development Goals (MDGs) Implementation Agenda and Sexual and Reproductive Health

There is strong political commitment to the MDG agenda in Nigeria, as evidenced by the various development programs in the country, and with the MDGs serving as a central theme in Nigeria's 2004 National Economic Empowerment and Development Strategy (NEEDS). Nigeria's commitment to the MDGs is further reinforced by the creation of governmental bodies such as the Presidential Committee on the MDGS, and the Office of the Senior Special Assistant to the President on the MDGs (OSSAP-MDGs)[17] in July 2005.In addition both chambers of the country's National Assembly (National Legislature) have Committees on MDGs. As the legislative arm of government, the committees are charged with the responsibility of overseeing government processes, specifically with respect to the monitor and evaluation of MDGs, resource allocation, and policy decisions that would have impact on the attainment of MDGs target in Nigeria.

President Yar'adua's seven-point agenda for development is said to have the MDGs at its centre, a further indication that at the highest level of governance there is a commitment to the MDG agenda. With technical assistance from the UNDP, Nigeria has produced three MDG reports for 2004, 2005 and 2006. In addition there are four sub-national reports in progress, while others states are being encouraged to develop their own MDG reports.

The table below highlights key summaries of the three Nigerian MDG reports.

Table 6 Summary of Nigeria's MDG reports

2004	2005	2006
..based on available information, it is unlikely that the country will be able to meet most of the goals 2015, especially the goals related to eradicating extreme poverty and hunger ;reducing child and maternal mortality; and combating HIV/ AIDS, malaria and other diseases.	There is high potential to attain some of the Millennium development targets for goals 2,7, and 8, while sustained efforts are needed if the country is to meet the other goals – 1,3,4,5,6	...potential to achieve some of the goals – 2,6,7,8 but serious challenges in the area of reducing child maternal mortality (goals 4 and 5).

Source: National Population Commission, 2004b; 2005; 2006.

Nigeria's MDG mid-point assessment presented to the UN in September 2008 showed that Goals 1, 4and 5 are not achievable by 2015, while the other five goals (2, 3, 6, 7, 8,) are achievable (Federal Republic of Nigeria et al., 2008). Goals 1, 4, 5 and 6, related directly to this research, show the following progress/ lack of progress in the period 2000 to 2007.

Goal 1: Eradicate Extreme Poverty and Hunger – The proportion of the population living in relative poverty is expected to fall to 28.78% in 2007 if the MDG target is to be met in 2015. However, five out of ten Nigerians in the same year were still living in poverty. An analysis of poverty incidence by sectors indicated that poverty was more pronounced in rural than in urban areas. Similarly, while poverty was more pronounced among farmers and larger households headed by persons with lower levels of education, income inequality was more pronounced in urban centres. Unemployment rates in Nigeria rose from about 12 out of 100 working age people in 1999 to 18 in 2005, with the rate of youth unemployment rising in the urban areas, than in the rural.

Goal 4: Reduce Child Mortality – The emerging trend in child mortality is of great concern at this mid-point. The infant mortality rate rose from 81 per 1000 live births in 2000 to 110 per 1000 live births in 2005/ 06, which brings Nigeria further away from the global target of 30 per 1000 live births in 2015. Additionally, the target of 100 percent fully immunized one

year olds was expected but so far, the proportion achieved was only 60% in 2007. This represents an increase of about 50% over a period of eight years. The slow pace in progress is accounted for by an increase in avoidable diseases such as polio, which rose from 201 cases in 2007 to 651 cases in 2008, placing Nigeria at 86% of the total number of polio cases in the world. The under-5 mortality rate also increased from 184 per 1000 live births in 2000 to 201 per 1000 live births in 2007.

Goal 5: Improve Maternal Health – Reducing maternal mortality rates is a major challenge faced by Nigeria. Midway to the target date for achieving the MDGs, the Maternal Mortality Rate (MMR) should be 440 per 100,000 live births. In rural areas, Nigeria's MMR is at 828 deaths per 100,000 live births; and 531 deaths per 100,000 live births in urban areas. Disparity between zones was very wide. Approximately two-thirds of all Nigerian women and three-quarters of all rural women deliver outside the care of health facilities, and without medically-skilled attendants present. The factors responsible for this include poor attitudes to antenatal and postnatal care, low quality of health care delivery, as well as poor attitudes to reproductive health. Overall, progress towards the attainment of the target is slow. Given the centrality of infant and maternal health to all health indicators due to their synergistic effects, it may be necessary to declare primary health care as a national emergency. Health sector reform offers opportunities that could impact positively on this goal. Although several policies have been instituted – such as the implementation of National Health Insurance Scheme (NHIS), Safe Motherhood Programme, the development of the National Vital Registration System and Making Pregnancy Safer Initiative – minimal impacts on maternal health are discerned. This is an indication of a weak policy environment, and weak commitments toward implementation.

Table 7 MDG Mid-term assessment Indicators

Indicators	1990	2000	2001	2002	2003	2004	2005	2006	2007
Maternal mortality ratio (per 100,000)		704	704	704	800	800	800	800	800
Antenatal care coverage At least 1 visit At least 4 visits					 61 47	 61 47	 59 -	 59 -	 59 -

Indicators	1990	2000	2001	2002	2003	2004	2005	2006	2007
Proportion of births attended to by skilled health personnel (%)	45	42	42	37.3	36.3	36.3	43.5	43.5	43.5
Contraceptive prevalenc rate					8.2	8.2	12	12	12
HIV prevalence among 1 to 24-year-old pregnant women (%)	5.4	5.8	5.8	5.0	5.0	4.3	4.3	4.3	4.3
Percentage of young people aged 15-24 who both correctly identify ways o preventing the sexual transmission of HIV and who reject major misconceptions about H transmission					18.3	18.3	25.9	25.9	25.9
Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner					43.9	43.9	63.8	63.8	63.8

Source: Federal Republic of Nigeria and UNDP, 2008.

Goal 6: Combat HIV&AIDS, Malaria and Other Diseases – Remarkable progress has been made on tackling HIV/ AIDS since 2003, reflecting a downward trend. For instance, the prevalence rate of HIV/ AIDS has dropped from about 5 in every 100 Nigerians in 2003, to about 4 in 2005. Among pregnant women aged 15-49 years, HIV/ AIDS has also declined over the last few years (from 6 out of every 100 pregnant women in 2001; to 5 in 2003; and 4 in 2005). Notwithstanding this decline, there continues to be disparity across various regions and states. The number of orphans with HIV/ AIDS was estimated at 1.97 million. Since HIV prevalence in the younger age bracket (15-24 years) is generally accepted to be indicative of the level of HIV/ AIDS incidence, overall progress suggests a modest decline in the number of new infections in the country.

MDG funding

Funding for the MDGs comes primarily from debt relief extended to Nigeria by the Paris club in 2005. The over US$ 18 billion accrued by Nigeria in savings from these debts were agreed to be spent on pro-poor projects. The federal government has incorporated the use of debt relief gains into the national budget through the OSSAP-MDGs. This has benefited ten sectors, including agriculture, education, health, housing and women's affairs. The debt relief budget amounted to about Nbn 100 billion each in 2006 and 2007.

Table 8 MDG funds allocation across sectors 2006-2007

SECTOR	2006 (Nbn)	2007 Appropriated (Nbn
Education	18.2	15,353,043,361
Health	21.3	15,348,000,000
Agriculture	9.4	15,000,000,000
Water Resources	19.2	13,848,572,250
Power and Steel	17.0	10,108,557,527
Housing	.495	3,000,000,000
FCT	-	1,800,000,000
Women Affairs	1.0	1,015,000,000
Youth	0.99	1,000,000,000
NACA	-	1,000,000,000
Works	9.9	0
Environment	1.5	0
Conditional Grants	-	20,000,000,000
Safety Nets	-	10,000,000,000
Monitoring and Evaluation	1	2,000,000,000
Total	99.9	109,473,173,138

Source: Ibrahim, 2008.

In the process of executing its mandate, the OSSAP-MDGs soon realized the need to sharpen its MDG focus spending by: costing the MDGs; establishing funding gaps and evolving a financial strategy that bridges identified gaps; and, finally, formulating complementary policies for achieving the MDGs. In collaboration with the OSSAP-MDGs, the UNDP undertook a National MDGs costing exercise in phases, between October 2006 and July 2008. The study was conducted in eight key sectors – agriculture, health, education, roads,

energy, water resources, environment and housing. The costing exercise focused on the first seven MDGs, their 11 targets and 32 indicators (UNDP, 2009).

2006 was used as the baseline for the costing exercise, which covered the period 2006 to 2015. The costing exercise arrived at cost estimates for the three tiers of government and the private sector in order to achieve the MDGs. The study revealed that cumulatively, the projected cost of meeting the MDGs up to 2015 is US$ 247.54 billion. On an annual basis, the total cost rises from US$ 19.65 billion in 2009, to US$ 43.33 billion in 2015, averaging US$ 27.50 billion. In per capita terms, the cumulative cost is US$ 1,475.00. The estimated per capita cost rises from about US$ 127.72 in 2009 to US$ 233 in 2015, and averages about US $164 (UNDP, 2009).

Table 9 Sectoral distribution of aggregate cost of achieving the MDGs

Sector	Cumulative (20072015) (US$/ billions)	Annual Average (US$/ billions)	Share (%)
Agriculture	55.12	6.12	22.3
Education	48.04	5.34	19.4
Energy	38.84	4.32	15.7
Environment	1.77	0.20	0.7
Health	34.94	3.88	14.1
Housing	6.42	0.71	2.6
Roads	39.74	4.42	16.1
Water & Sanitation	22.68	2.52	9.2

Source: UNDP, 2009.

Federal and state government funding of the MDGs between 2003 and 2006 accounted for 34.5% and 48% respectively while local governments spent 17.5%. Based on this, total MDG interventions would amount to US$ 85.40 billion at the federal level; US$ 118.82 billion at the state level; and US$ 43.32 billion at the local government level by 2015?

Financing gaps and strategies

As noted earlier, the costing estimates indicate sizable financial requirements to meet the MDGs by 2015. Table 10 below shows the aggregate annual costs and the estimated contributions made by government, households and development partners. Development partners contribute in the form of external assistance to meet the costs.

Table 10 Summary of financing sources for Nigeria's MDGs (Scenario B – with higher projections of Government Financing) (US Billion Dollars)

Financing; Source/Estimate Amount of Contribution	2007	2008	2009	2010	2011	2012	2013	2014	2015	Annual average (2007-2015)	Annual average (2007-2015)
Households	1.13	1.41	1.72	2.10	2.45	2.86	3.34	3.85	4.28	2.57	23.11
Government	9.40	11.01	13.39	15.97	19.05	22.71	27.09	32.32	38.58	21.06	189.54
External	4.83	4.94	4.54	4.59	4.67	4.54	3.66	2.65	0.47	3.88	34.82
Total MDGs Cost	15.36	17.36	19.65	22.66	26.17	30.11	34.09	38.82	43.33	27.51	247.54
MDGs Cost per capital	106.30	116.43	127.72	142.67	159.66	178.04	195.28	215.49	233.11	163.86	1,474.70

Source: UNDP, 2009.

In estimating government contribution towards financing MDGs-related initiatives, two scenarios are considered: the first is based on lower government revenue projections (scenario A), and the second is based on higher government revenue projections (scenario B). Considering scenario A, in order to meet the MDGs, Nigeria needs to spend a total of US$ 116.43 per capita in 2008, increasing to US$ 233.11 by 2015. This translates to a cumulative investment of US$ 247.54 billion between 2007 and 2015, which is equivalent to an average annual per capita need of US$ 163.86. Of the US$ 163.86, the estimates show that US$ 122.63 (74.84%) will be financed domestically through household and government contributions. Government contributions alone account for US$ 107.33 or 65.5%. On the other hand, the supplementary financing expected from external sources averages the amount of US$ 41.18 (25.13%) per capita, over the period. This appears very high

considering the current reality of about US$ 5.0 per capita ODA inflow. Therefore, scenario B, which projects higher government financing, and less reliance on ODA is preferred.

For scenario B, the role of external assistance is reduced significantly. Out of the average US$ 163.86 per capita cost estimate, US$ 139.50 (85.13%) will be financed domestically through household and government contributions. On its own, the government is expected to contribute US$ 124.40 (75.92%) per capita. The residual contribution expected from external sources is US$ 24.25 (14.87%) per capita. Figures in table 10 also show the absolute magnitude of the contributions for each year, and throughout the entire period. For the period 2007 – 2015, the cumulative contributions are as follows: households (US$ 23.11 billion); government (US$ 189.54 billion); and external (US$ 34.82 billion). One issue that arises from the projected cumulative government contribution of US$ 189.54 billion is how to distribute the financial responsibility in each tier of government – federal, state and local.

Federal/state level interface

OSSAP-MDGs execute some projects directly from its offices, with assistance from some federal level ministries such as the provision of ambulances and employment of midwives for all states of the federation. Advocacy on reproductive health is largely executed in collaboration with the Federal Ministry of Health, women's affairs and NGOs. In addition to this, the MDG office now works with state governments. An MDG office (state level equivalent of OSSAP-MDGs) is located in each state, with the responsibility for coordinating MDG debt relief funds at state implementation level.

Through the Conditional Grants Scheme (CGS), OSSAP-MDGs funds MDGs-related projects at the state and local council levels. To draw from this fund, states have to meet qualifying conditions, as well as provide matching grants each year for projects under this scheme. Matching funds generated through this scheme are considered additional resources that scale up investments towards the achievement of the MDGs.

Kaduna State MDG Office

The Kaduna State MDG office received a total of US$ 10,277,162.16 between 2007 and 2008. State government counterpart funding for this period totalled US$ 7,590,824.94[18].

This amount was spent on sectors determined by the OSSAP-MDGs. The state MDG office working through the concerned ministries executes the identified and approved projects. The national committee on MDGs[19] decides areas of focus based on indices in each sector. For instance, the 2009 CGS will focus on health because the country was found to still have poor health indices. States can, however, decide which of the identified areas to seek funding for depending on their need. This was clarified by an official of the Kaduna State MDG office:

> *"So the OSSAP-MDG are giving us areas that the national committee has decided on... They drew out huge areas they want the MDG funds to be targeted this year (2009) which are innovations; the other year it has been only the presidential committee but this year it was the national economic council that actually drew up huge areas the MDG should intervene. So now that the guidelines are out and they are saying that the health indices are still the problem so the emphasis is on water; I mean from health, water, poverty, agriculture which is tied to poverty reduction. So those are the areas and each of the sectors has some sub-sectors. So each state will now look at its needs within the selected area to produce its own proposal taken into consideration the state budget and where more resources have been deployed"[20].*

In 2007, the CGS and its state counterpart funding was used for installing solar electrification and Ventilated Improved Pit (VIP) latrines. In 2008, the MDG funds were used to expand and rehabilitate Primary Health centers, supplying these with furniture, anti-malaria drugs and treated mosquito nets. In 2009, the projects focused on primary healthcare systems and infrastructure, potable water and sanitation, skills acquisition, conditional cash transfers and agriculture. At state level, all concerned MDAs submit their requests through the MDG office which is then sent to the governor for approval. The MDG office does not initiate projects itself and only supports the MDAs concerned. In terms of gender mainstreaming the MDG office interprets this as inviting the ministry of women's affairs to make a submission. Gender mainstreaming is considered the ministry's business, including the provisioning of projects for women and children.

"Last year (2008) when we implemented the MDGs, the commissioner of women affairs and the permanent secretary are members of the implementing committee but they have not enjoyed any kind of funding of project... so we now agreed that we find a way of bringing them into the scheme. When we came back from the joint internal workshop which was organized by the OSSAP-MDGs this year (2009), we invited all the ministries that we thought will qualify for the step down training to discuss how they will participate or help us package the application... it's a complex process and we invited the ministry of women affairs.....I told them last week sincerely that there is need for them to participate because how can we talk about bringing about gender equality, without involving the whole ministry in charge of gender"?

International action towards achieving the MDGs at local levels

In addition to the work of the OSSAP-MDGs, there are other MDG initiatives in Nigeria, which when added up, suggests that Nigeria is an ideal MDG model. These include the Millennium Cities Initiative (MCI) and the Millennium Villages Project (MVP), which are being implemented through a joint partnership amongst the Earth Institute at Columbia University in New York, UNDP, the MDGs Centre-west and central Africa and with counterpart contributions from each host Government. The Kaduna State in North West Nigeria is the site for both of these initiatives, namely Kaduna MCI and Pampaida MVP. The Pampaida village in Ikara local government area was selected as one of the 12 hunger hotspots in the 10 agro-ecological zones in Africa. It is a site where the MVP concept is currently being implemented. As such, the Kaduna MCI as a pilot Millennium city also hosts a millennium village.

The reason behind having an MCI and MVP in one state is to allow linking opportunities for commercial production in villages. Cities are sites of investment opportunities and most often than not, draws the attention of investors.

***Kaduna Millennium City Initiative (MCI)*:** The MCI aims at helping mid-sized cities across sub-Saharan Africa to achieve the MDGs. It will help cities to engender a climate in which investment can thrive (including, and in particular, foreign direct investment (FDI)), thereby creating employment, stimulating domestic enterprise development and fostering economic growth. In the context of this work, commercially-viable investment opportunities are identified (paying special attention in creating urban-rural linkages in order to capitalize from increased agricultural production in the Millennium Villages), and in turn, brought to the attention of the national and international investment community (Earth Institute Columbia University, n.d.).

Kaduna MCI is still in its formative stage is currently collecting social sector and investment baseline data. It is hoped that the information will form the basis of appraising municipal and national governments, arriving at accurate, actual costs of achieving the MDGs.

***The Pampaida Millennium Villages Project (MVP)*:** The Millennium Villages Project is a community-level initiative that complements the national-level policy focus emphasized by governments and the UN Millennium Project to accomplish the Millennium Development Goals. Its purpose is to empower impoverished African rural communities to accomplish all the MDGs by 2015[21].

MVP exists as a 'proof of concept' that the MDGS can be achieved. The model is based on UN-estimated costs for achieving the MDGs in rural Africa – US$ 110/ capital/ year, of which the household share is US$ 10/year; government share at US$ 20/year; donor share at US$ 60/year; and other development partners share at US$ 20/year. The interventions in the village benefit various sectors including: agriculture and nutrition taking 15% of the budget; education (20%); infrastructure (20%); health (30%); and water and sanitation, environment and others including gender and community development (15%)[22].

Reproductive Health Rights, Gender and Poverty in Pampaida: Since the commencement of the project in May 2006, a clinic has been built, and free medical services, OPD consultation, antenatal services, outreach to constituent settlements and immunization are being rendered at no cost. The clinic provides 24 hours of service. Babies are delivered on a regular basis, and the clinics are adequately equipped and staffed with an appropriate stock of medicine.

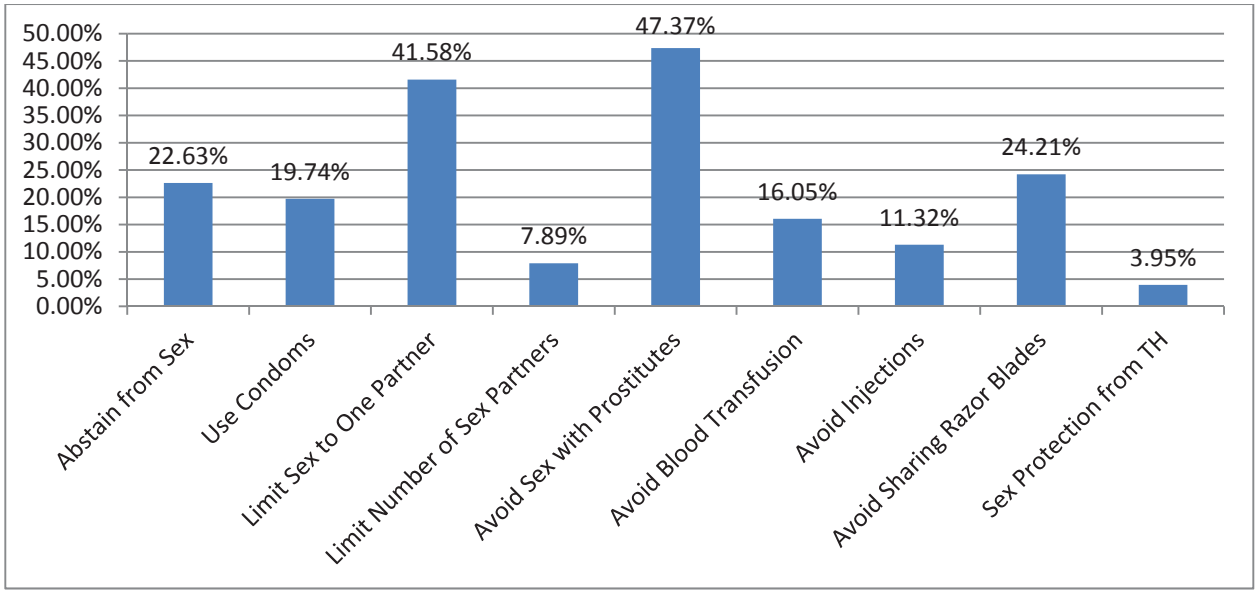
Table 11 Health Statistics at the Pampaida MVP: (Using ICPD indicators)

INDICATOR	
Total fertility rate	NA
Contraceptive prevalence	As of 2009, 111 women utilized the clinic family planning services; 98 women opted for injectables, while 13 opted for pills as compared to a contraceptive prevalence baseline of 3%. There is no data on condom usage.
Maternal mortality ratio	Maternal mortality rate for 2009 was 311.5 per 100,000 live births.
Antenatal care coverage	Over 80% antenatal coverage made possible by the continuous sensitization and mobilization of pregnant women by The village health workers (VHWs).
Births attended by skilled health personnel	44% of births were attended to by skilled health professional SHP
Availability of basic essential obstetric care	Basic essential obstetric care is available within the cluster
Availability of comprehensive essential obstetric care	Comprehensive essential obstetric care is rendered at the Ikara general hospital.
Perinatal mortality rate	Perinatal mortality rate was 6.2 per 1,000 live births.
Low birth weight	Based on clinic records, no low birth weight of babies was recorded in 2009
Positive syphilis serology prevalence in pregnant women	3.8% [based on clinic register 2009]
Prevalence of anemia in women	10% of women showed clinical pallor, not too accurate, laboratory diagnosis of pallor in pregnant women is a new development in clinics.
% of obstetric and gynaecological admissions owing to abortion	40% [2 out 5 gynecological admissions were due to abortion].
Reported prevalence of women with FGM	None
Prevalence of infertility in women	NA

Reported incidence of urethritis in men	8 cases of confirmed urethral discharge cases in 2009
HIV/ AIDS prevalence in pregnant women	1.8% in 2009.
Knowledge of HIV/ AIDS-related prevention practices	Of the 380 individuals sampled, about 83% claimed knowing at least one HIV/ AIDS preventive method while only 17% confirmed not knowing any preventive method.

Source: Earth Institute Columbia University, Millennium Promise and Millennium Villages, 2010.

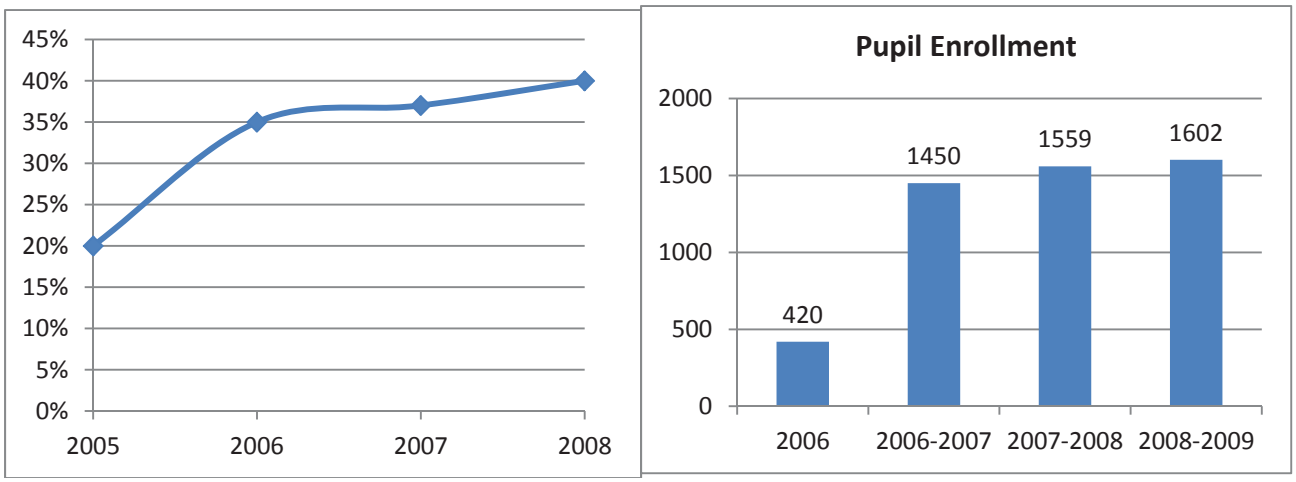
Figure 1 Preventive methods of contracting HIV/ AIDS



Source: Earth Institute Columbia University, Millennium Promise and Millennium Villages, 2010.

Girl child education has received a massive boost since the MVP intervention. From a baseline girl – boy ratio of 1: 5, it now stands at 2:3. The trend is fast closing the gap that existed between the numbers of girls to boys in school as many more girls are transiting from primary to secondary school.

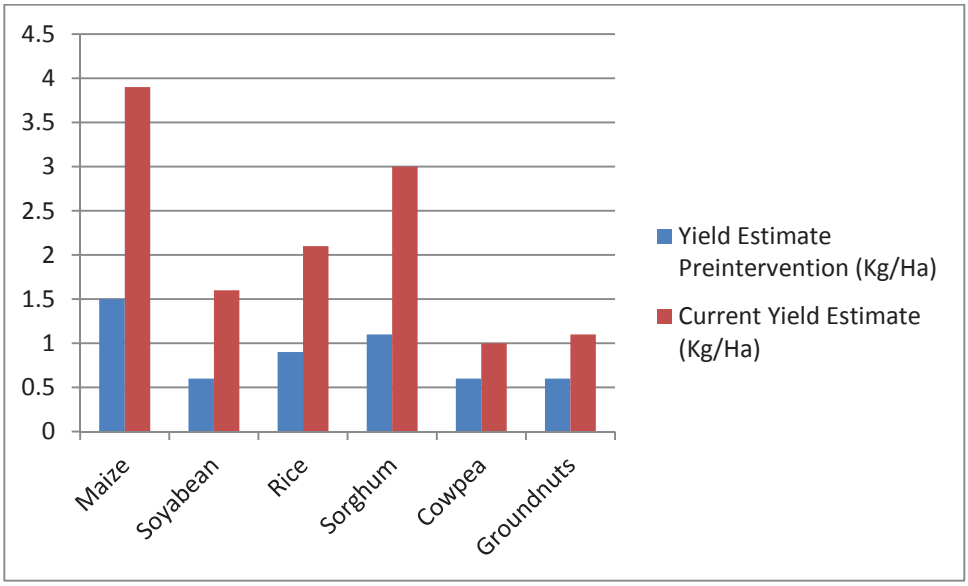
Figure 2 Girl child enrollments



Source: Earth Institute Columbia University, Millennium Promise and Millennium Villages, 2010.

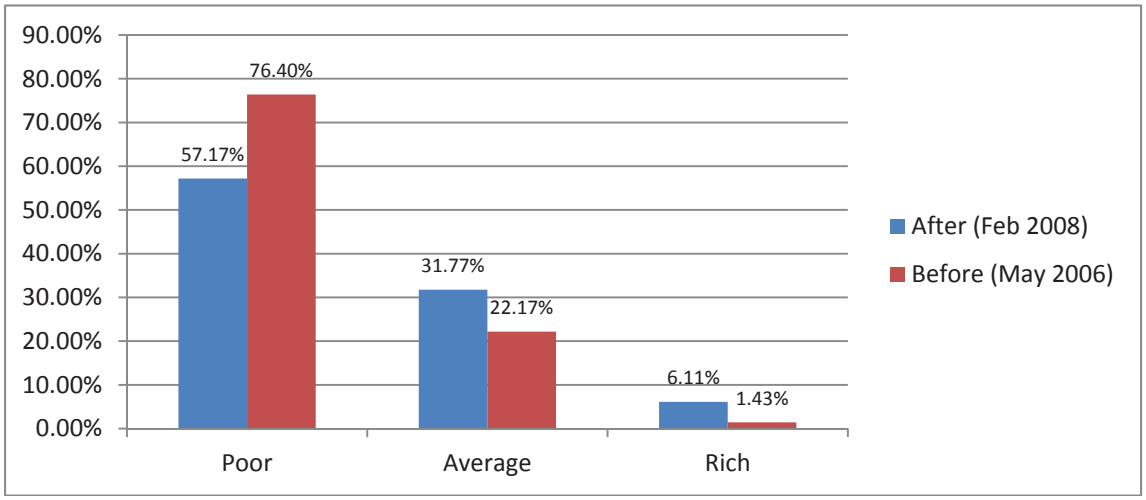
There is also improved capacity for growing food. Maize yield, which was 1.5 tons per hectare pre-intervention in 2005 went up to 3.5 tons per hectare one year later (2006). By 2008, it has reached 4.0 tons per hectare (a yield increase of about 167%). Good yield responses were also obtained for other crops such as soybean, cowpea, rice etc. Women's groups were also given input loans for agricultural production to increase access to credit and markets. The project had also managed to link 952 households in Pamapaida MV1 with three banks (Bank PHB, Unity Bank and NACRDB) and three major food processing companies (Nestle, Grand Cereals, Olam Nigeria) for guaranteed market access and stable product price.

Figure 3 Average yields of major staple food crops in Pampaida MV1



Source: Earth Institute Columbia University, Millennium Promise and Millennium Villages, 2010.

Figure 4 Country Report



Source: Earth Institute Columbia University, Millennium Promise and Millennium Villages, 2010.

Indicators from the various sectors show that that the quality of life in Pampaida MVP has improved tremendously and more people, especially women, have greater access to quality health care services and a higher level of involvement in community issues and decision making processes. Interviews with the various sector committee representatives confirm this. The responses of the women leader and the secretary of the Apex Committee in Pampaida

capture the feelings of all the beneficiaries interviewed in the village. The women leader said:

> *"MVP style of project implementation is a lot different from the previous development intervention here in Pampaida and around Ikara. For those ones, only the men in the community were involved in the meetings where community issues were decided. But now, women are part of community meetings and are able to contribute to the issues and decision-making processes. We have our own money and we can engage in farming and small businesses. I also know that more women are choosing family planning methods now because of proximity to the clinic. It has been helpful. For confidentiality I cannot mention their names, but so far I have not heard of any complaints about its effectiveness and safety".*

According to the Secretary of the Apex Committee:

> *"I cannot quantify the many benefits of this project. But we are most grateful to God for our community to have been chosen. From agriculture, to health, to education and all other areas of our life, we have improved. But as humans we still ask for more to be done. My wives are using family planning methods.*

Sexual and reproductive health targets in the MVP focus on maternal and child mortality, antenatal care and family planning. There is nothing that particularly targets the broader issues of SRH and adolescent sexual and reproductive health. The failure to have a broader SRH agenda – even when the age of first marriage for girls in Pampaida is between 13-15 years indicates a need for young people to access information about their sexual and reproductive health – may be attributed to the design of the project interventions, which are based on the MDG agenda.

Based on the indicators from the MVP it is apparent that the quality of life of the people has improved and they are taking maximum advantage of the different infrastructure and services put in place. However, the real impact of the project can only be measured after the exit of international donors. As it is, the project is heavily dependent on donor funding. At

the end of the project, when project staffs are no longer there to ensure that the community has maximum utility from services, when donor funding is no longer contributing to making the clinic services completely free, when agricultural inputs and other services are no longer provided, then only the true level of success of the MVP can be measured. At the moment, the MVP project is considered a success so much so that the OSSAP-MDGs plans to replicate it in 111 local government areas across the country[23].

Conclusion

Nigeria is considered to have the ideal model of the MDGs in place – beginning with the UNDP offering technical support to the federal government and some states of the federation to produce MDG reports and calculate the costs required to achieving the MDGs, to the establishment of the OSSAP-MDGS, national legislature oversight committees on the MDGs, State level offices on the MDGs, as well as setting up millennium villages and cities – to assist the country in meeting the MDGs by 2015. Despite these initiatives, mid-term reports indicate that achieving many of the MDGs may not happen. To illustrate, the 2008 mid-point assessment shows that Nigeria may only achieve three out of the eight goals; that is, universal basic education, ensuring environmental sustainability and developing global partnership for development. The health and poverty MDGs remain a daunting challenge for Nigeria.

The mid-term assessment has many implications on poverty alleviation and sexual and reproductive health. By 2015, Nigeria would not have been able to meet any of the targets for these two goals (health and poverty) and the problems will not be substantially reduced. This scenario re-affirms the Maputo framework on sexual and reproductive health, which emphasizes the importance and need of addressing poverty and SRHR as mutually reinforcing. Hence, meeting the SRHR needs of people requires a multi-sectoral approach. This approach is generally missing in Nigeria, as poverty alleviation programs do not integrated with SRH.

While it is obvious that there is political will to meet the MDGs, the UNDP says that a critical barrier to planning for achievement is the availability of up-to-date data on most of the indicators, and limited funds available for data collection and management. Such raises questions on the extent of political will. If there was genuine political will, is this not sufficient in setting in motion the process of collation of proper data, given the fact that anyway, structures already exist and only require improvement? Sexual reproductive health rights activists say that the barriers to policy implementation in SRH are very serious and deep-seated.

> *"I think the only disconnect there is the implementation and dissemination. Even government officials that are party to the development of policies do not seem to disseminate it to their offices at the state level so you have all these energy at the center talking about rights and policies and issues but by the time you get to the state you find out that people in the state don't even know what is happening. And, I think sometimes the people in the state may not find the right people to be on the desk where these things should happen so those people that go to the meeting at the center when they are given these things to disseminate, either they don't believe in it or they don't want to share it or they are afraid of the environment. So you find out the policies are there, they have been sent to the state, but the state operators themselves don't get to see it... change is one thing that is imperative, is constant and most feared thing and if you have not clarified your values, you have not balanced your own beliefs and identified where you can help in getting things done, most times you can't get it done especially if you cannot balance your beliefs and the changes that are happening... For instance you have a health personnel on working on reproductive health issues and that person is not sensitive or has not clarified their values, they may not take the issues far or go in depth in an attempt to address root causes... it is not just professionalism, but there is also that social orientation that we all need to put in place. The social orientation for us is the key issue here. If you put somebody who has a health background but doesn't believe in women's rights or doesn't believe in gender equality or doesn't believe that even equity (not even*

equality) – that equity should be exhibited, you can't get your result or desired result, because that person will clog the wheel of progress"[24].

Reproductive health services offered at the MVP focus around the issues covered by the MDG targets and does not seem to go beyond that. However, the MVP has taken steps to empower women to give them more say in decision making. Thus, in homes where there is more than one wife, the eldest wife and her husband benefit as one household in terms of agricultural inputs, while the other wives are all treated as heads of their own individual households. The project also insists that husbands must attend antenatal clinics – at least accompanying their wives during their first visit to the clinic – as this provides an opportunity to share information on the need for child spacing; helps the couple make the links between income, women's health, poverty and the quality of life for the child and the family as a whole; and thus, encourages men to commit to the use of modern family planning methods[25]. One of the areas sorely missing in the MVP is in its failure to meet adolescent sexual and reproductive needs despite the fact that there is a very young population and where there is a tendency for girls to marry young. This may most likely be a result of how the targets of the MDGs had been defined, but, equally as important, the observed failure of project staff to recognize these SRHR needs as a result of their own cultural and religious beliefs about issues of sexuality, and the lack of knowledge on the ICPD PoA and the SRH framework for Africa. Such is also exemplified by the absence of reports on men and women's fertility issues in the ideal village. While the village concept makes connections between poverty and health issues and focuses on family planning, antenatal and child care and malaria, there lacks a strong SRH component or connection.

There is also a concern that the MVP concept is not sustainable, and at the end of the project, the whole thing will collapse and the villages will go back to what they were before the intervention. This argument is based on the fact that 70% of the funding comes from donors. At the end of the project where will the state and local governments get funding to fill the gap?

The ideal MDG model in Nigeria may not lead to an achievement of all goals and may be left unaddressed upon the withdrawal of donor funds – this could undermine successes achieved. Most importantly, what is referred to as a "perfect" 'proof of concept', carries in it fundamental flaws. To date, this concept continues to fail in showcasing the complete range of SRH interventions previously identified and captured by the ICPD, and further reinforced in the African SRH framework.

Final reflections: summary and conclusion

The MDG agenda serves as the main agenda informing many policies established between 2000 and 2008 in Nigeria, at federal and state levels, in line with international discourse and its current focus.

The poverty alleviation framework for the country has the MDGs as a focal point. Several other interventions post-2000 aimed at poverty alleviation can be said to also be in line with MDG 1. As far as executing projects under the OSSAP-MDGs office is concerned, MDAs, through the state MDG offices receive support for projects in line with nationally-agreed focus areas. These projects are implemented with the involvement of local councils. Gender equality is not a main consideration for many interventions, particularly at state and local levels, as exemplified by the state MDG office's call for funding proposal extended to the Ministry of women's affairs and social development. Gender is generally equated with women and children's issues. Also, no indications are given in terms of understanding how projects and services impact differently on men and women. In general, the MDG office's focus at state level is mostly directed towards construction (such as boreholes); the dimension of gender does not seem to be adequately taken into account (even in construction). Weak (or even the absence of) political will in mainstreaming gender is also evident in all the poverty alleviation projects reviewed for this study; in particular, in their failure to integrate SRH in project design and implementation as recommended by the continental framework on SRH.

There are clear links between the MDG and poverty agendas from the national to the local, as is seen in the NAPEP at state level, as well as the FADAMA agricultural projects. The state ministry of poverty alleviation uses the SEEDS document as its poverty framework, which is in itself, a reflection of the national economic development frame of the NEEDS. In terms of poverty there is, however, no link between national and state level agendas to the local government level. A local government poverty official interviewed did not know what the poverty framework for the country was, neither did members of his local council, nor had they heard of the ICPD. Most local government councils never produced a LEEDS document, which would have also served as a poverty alleviation framework. At the local level there is an apparent lack of knowledge about the framework that should guide their work.

At local government levels there exists no MDG office that connects and works directly with the state or federal level MDG office. As host of the MVP, Ikara's involvement in the MVP project is limited to the provision of support staff from time to time, for instance in agricultural extension. This clearly indicates that the MVP has little impact on its host local government – despite claims by the MVP Coordinator that the education unit of the local council intends to replicate the MVP's education model. At the level of local government, each unit, such as those working on health and poverty, conducts its own planning and implementation.

Gender equality, similar to federal and state levels, is certainly not an issue of concern. At the local level, there does not seem to be any understanding of gender, nor an awareness of what gender mainstreaming entails. State and local level poverty officials' response to mainstreaming gender in their work is the same:

> *"... for instance if we want to give 20 people micro-credit we give ten to women, and men..."*[26]

For the poverty agent at the local level, men are poorer than women because men take care of the home and some women just sit at home doing nothing. State level poverty agencies acknowledge the need to involve health and women's affairs, and gender issues in program

planning and implementation. However, in practice, this does not necessarily take place. For instance, the ministry of women's affairs executes some poverty alleviation projects without consulting with poverty agencies; while poverty agencies execute their projects with minimal input from the ministry of women's affairs. Further, gender mainstreaming and equality are operationalized in very limited ways by MDAs. To many MDAs, gender mainstreaming and equality is achieved when specific programmes have women as their target beneficiaries. Finally, despite the acknowledgement that health and poverty are interlinked, there is no obvious connection in planning for and executing programs between poverty and health ministries. Interviews conducted reflect that in general, policy makers do not view sexual and reproductive health as having any relationship to poverty and vice-versa; even when this is clearly outlined in the continental SRH framework.

> *"... I think our policy makers do not even think that reproductive health is an issue. It is not an issue at all; for them it is education, and that education is the one that is in school; that is it. They don't believe that when you are talking about education you should be talking about reproductive health or poverty alleviation, if not they will be designing functional education...They don't even see sexual and reproductive health... that it has any relationship with poverty. I always give them this story: the woman that cannot feed her five children and decides to sell her body to feed her children; what is involved? Is there no reproductive health there? Is there no poverty there? Because this is what happens" (Mairo V. Bello, AHIP Kano, North West Nigeria).*

> *"... talking about local government governance structure, they don't have a budget for reproductive health. The sad thing is that they are the ones in charge of primary health care. For them to even accept that it is their responsibility... is a problem. They don't employ the right calibre of staff. The minimum you should have at that level is qualified staff nurse and staff midwife. They refuse to employ them because they have to pay them money, they don't motivate the right people to go and work in rural areas; they don't motivate them. So they don't fund them properly, they don't equip them properly, they don't build the capacity of the workers... so primary health care that is supposed to be delivering services; that's what I was talking about system that*

are not, they are not there, that's what is going on..."(Hajia Bilkisu Yusuf, HERFON, Abuja, Nigeria).

Civil society activists working in the area of sexual and reproductive health agree that there are a lot of policies that govern sexual and reproductive health, but there is a disconnect in the dissemination and implementation of such policies. While there is a lot of energy at the centre, there is a failure to share information at the state level.

"... I think sometimes the people at the state level may not find the right people to be on the desk where these things should happen, so those people go for meetings at the centre, receive the information to disseminate... either they don't believe in it or they don't want to share it, or they are afraid of the environment... some people have not clarified their values... balance your beliefs and find out where you can help in getting things done... most times you can't get things done..."[27]

This failure to make the relevant connections between SRH and poverty by people in policy making is expressed in this interview with a local government council official.

"SRH issues are private and thus really do not come out officially even though everyone knows the issues are there, such as women's consent to have sex not respected by husband, issues of child spacing may not be acceptable to husbands, women's inability to voice out other cases of violations, since it is assumed to have taken place in the privacy of their homes".

There is also the question of whether there is a shared understanding of what is meant by the terms poverty and SRH. Without this, civil society activists on SRHR[28] say that people will continue to conduct work that is either overlapping with or duplicating that of others. This is reinforced by Mairo V. Bello when she said that pregnancy and delivery are considered reproductive health by government because that is what the MDGs talk about. The government does not address the holistic range of reproductive health concerns. But if government were to work based on the Maputo declaration[29], then they will take better cognizance of sexual and reproductive health as the protocol addresses these issues. This is

an opinion also shared by Hajia Bilkisu Yusuf who said that the Maputo Protocol is a very good guide for the African continent (and Nigeria) on sexual and reproductive health. He adds, if domesticated and implemented, such will certainly produce great gains for Nigeria. The country plans developed in October 2009 provide very clear road maps for African governments, as well as civil society activists (UNFPA, 2009). SRH Activists in Nigeria are currently lobbying government to domesticate the protocol and implement the country guide in Nigeria's country plan, for the period between 2007 and 2010.

Barriers and constraints toward achieving an integrated approach to SRH in Nigeria

Few civil society organizations have integrated poverty and SRH, such as AHIP in Kano, north central Nigerian and COWAN in south west Nigeria. This may be explained by donor funding requirements as well as by the lack of capacity to have an integrated approach. Dr Uwem Esiet of Action Health Incorporated Lagos says:

> *"People who work on SRH, work on SRH; people who work on poverty, work on poverty. There are only a few donors that fund SRH, poverty and human righst in one integrated program. And therefore it is very easy if you are funded from such an SRH portfolio for only a poverty person will not say you cannot take up poverty issues, and a human rights person cannot say you can't take up HR issues. But if you are funded solely by an organization that funds SRH what is their business with poverty; that is one. Two, not too many organizations have the capacity to bring multiple issues to the table, and work with other community groups and NGOs to drive these issues – people will just focus on their areas of interest. The third is that, is the environment ready for crossbreeding of programs? Is it ready, or is it an assumption? Four, even if the environment is ready, are there learning templates that are easily accessible for those who want to take up multiple issues. Take for instance HIV/ AIDS – a lot has been given to poverty... how many successful programs have we had in Nigeria that have tried to empower people living with HIV? How many are successful? If somebody is already infected or affected and I want to empower him or her and the person ends up not servicing my debts when it is due, will I get another circle of funding from my*

donor when I am reporting an 80% loss? Also, there are several issues. For me, I don't want to lay the blame on anybody but I am saying that if we are sincere, that is a lot that needs to be done. Oftentimes, people look at the top and say what is government doing? But who is government, we are all government. The people in government... where are they from mars or Jupiter? We are Nigerians. What do they know? So if they do not know, they cannot formulate programs in a specific effort, in that direction".

However, CSOs can begin to establish platforms that integrate different projects on health and poverty, while maintaining funders' expectations:

"The CSO implementers of projects should be talking; planners should be talking like we are talking now. That is the important thing. I think there is a need for people to talk to funders that they need to link those people... look at the lady in COWAN... she was doing poverty alleviation but using family planning, sexual reproductive health into it because she didn't see sense in just saying she is alleviating poverty using a grant. So, when we do something with a women's group and it is a political program to uplift women's political knowledge... such as to be able to access power in decision making but this should include sexual and reproductive health so that if the women are thinking of doing something to be able to have power they must have power to be able to control their fertility that is, when they want to have children and when they do not. That is the beginning of their power. So it makes sense for you to connect; poverty is also about powerlessness in fact that is what poverty is really about – powerlessness to change your life. Women's groups working on issues of gender and other issues must begin to link with SRH" (Hajia Bilkisu Yusuf, HERFON, Abuja, Nigeria).

Government's inability to take a holistic approach to the issue of SRH therefore compounds the problems on ground. This is illustrated in an interview with Mario V. Bello, an informant in this study, who explained that:

"... for government, reproductive health is pregnancy and delivery... reproductive health is much more than that. And, if you take only pregnancy and delivery, where do you leave the men, where do you leave LGBTs, where do you leave the young

people. Okay... we can say okay young people are embedded in our women because most of our women of reproductive age are from thirteen (13). But then there are other parts of the country where they don't fall into that category, where do you leave them. We can't pay lip service to the issues of young people and even when we have all sat down to develop a sexuality curriculum, it is still not been implemented, and by the time we start pushing for it to be implemented, state representatives go back to their states and defuse everything and just threw everything into different subjects where they do not have any relevance where they will be lost. Now they redesigned the entire curriculum, took the sexuality education and just distributed it to different subjects. By the time you start looking for it is like when you have a big fifty litres of soup and you put one chicken there, it will just melt inside. So now the other challenge is how to even work to bring that out for young people because is lost in the curriculum. There are always challenges and this thing about government dancing to the tune of misguided and misconceived religious cries of wolf and all that; that also will not take us anywhere because everything has been politicized. The life of the women is the most politicized and something that government should be not be condoling all the time.... I say sexuality education go to all schools then you come and say sexuality education cannot go to schools just because somebody thinks that these people have received money to push this agenda and they are not sharing it with them; that is the problem. I think we still need a lot of reorientation at policy level. People need to understand that every human being is a sexual being—whether you are rich or poor, high or low" (Mairo V. Bello).

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Notes

[1] Referred to as the Maputo protocol, it is also called the optional protocol of the AU on women's rights.
[2] In 1999, 70% of all Nigerians lived on less than US$ 1 a day. With the new poverty line of US$ 1.25 set by the World Bank in 2008, the number of Nigerians living below the poverty line may have increased significantly.
[3] Sectoral policies refer to policies that focus on specific health problems such as primary health care, drug, breastfeeding, reproductive health, traditional medicine, blood transfusion etc. There are 24 of such policies and the most recent of them is on public-private partnership in health, which was adopted in 2005.

[4] The 1999 constitution of the Federal Republic of Nigeria defines the roles of federal, state and local authorities on health matters because of the identified need for stronger clarity in the health system by officials in the ministry of health and other stakeholders.
[5] The bill has been passed by the National Legislature in May 2008 and awaits the consent of the Acting President to become law. Activists in the Health sector hope that the Vice-President will sign this bill into law before the end of 2010
[6] This 2001 policy replaced the 1994 Maternal and Child Health Policy when it became clear that the later placed a greater emphasis on child health than maternal health. Interview with a senior government official of the Federal Ministry of Health, Abuja, Feb. 7, 2008.
[7]EHANSE report on reproductive health in Nigeria in 2005
[8] Using an exchange range of N148.00 to US$ 1.00
[9] EHANSE report on reproductive health in Nigeria in 2005
[10] Based on interviews with a poverty alleviation agent and civil society poverty activist.
[11] NAPEP was charge with coordinating and monitoring activities of 14 core poverty alleviation ministries and 37 core poverty alleviation parastals and agencies. CISCOPE, performance evaluation of NAPEP, October 2003
[12] NAPEP has state offices in all 36 states of the federation.
[13] Based on an interview with a respondent working in a poverty alleviation agency.
[14] Based on an interview with a staff member in the FADAMA Office.
[15] The Paris Club is an informal group of creditor countries with no permanent members functioning under principles of burdensharing and general concensus.
[16] Interview with civil society activists on poverty and education
[17] The Presidential Committee on the MDGs guides the nation towards the achievement of the MDGs and is made up of Line ministries, government agencies, state governors, representatives of the national assembly, private sector, civil society organizations and international partners. OSSAP-MDGs functions as a secretariat to the Presidential Committee on the MDGs. It has the primary responsibility of guiding the utilization of the Paris Club Debt Relief Gains (DRG) by relevant Ministries, Departments and Agencies (MDAs) on specific MDGs related projects and programmes through the Virtual Poverty Fund (VPF) for the DRGs.
[18] At Central Bank Exchange rate of N118.00 to US$ 1.00 this stands at US$ 9,520,695.69.
[19] The areas of focus for 2009 were drawn up by the National Economic Committee which comprises all state Governors.
[20] Interview at State MDG Office
[21] Based on interview with MVP Coordinator, Pampaida.
[22] MVP Pampaida
[23] Interview with MVP Coordinator, Pampaida
[24] Based on interviews with SRH Activists in Kano, North West Nigeria.
[25] Based on an interview with an MVP Coordinator.
[26] Based on an interview with the head of the Local Government Poverty Unit.
[27] Mairo V. Bello, AHIP, Kano, North West Nigeria
[28] Based on an interview with Dr Uwen Esiet of Action Health Incorporated, Lagos.
[29] The Maputo Protocol was originally adopted by the “Assembly of the African Union” in Maputo, Mozambique on July 11, 2003. The official document is titled “Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa.”

DAWN Statement: MDG 5
In need of Rescuing from the Depths of the Silo

MDG5 MATERNAL MORTALITY

In need of rescuing from the depths of a silo

Statement by Development Alternatives with Women for a New Era

September 22, 2010

DAWN is a network of feminist scholars, researchers and activists from the economic South working for economic and gender justice and sustainable and democratic development. DAWN provides a forum for feminist research, analyses and advocacy on global issues (economic, social and political) affecting the livelihoods, living standards, rights and development prospects of women, especially poor and marginalized women, in regions of the South.

World leaders gathering in New York for the 2010 High-level Plenary Meeting on the Millennium Development Goals will proudly unveil pledges and commitments to accelerating the achievement of the goals by 2015[1] . In this midst is frenzy over how to rescue the poor performance in reducing maternal mortality particularly in low and middle income countries of the economic South where 98% of maternal deaths occur. But will the show of sincerity assuage the grief over the losses and the shortfalls?

The MDGs have created silos of intervention in development strategies and plans. Government programs and official projects are focused on targets and indicators and less concerned about inter-sectoral approaches and complementarities. Nowhere is this clearer than in the area of maternal mortality. Lacking the holistic analytic of the Programmes of Action from the International Conference on Population and Development and the Fourth World Conference on Women and often de-contextualized from past global consensuses around human rights, gender equality, and development, tracking "progress" of the MDGs dangerously resembles a demographic numbers game.

India and Nigeria in the economic South and Mexico now a member of the OECD[2] are countries where high rates of maternal mortality have been a key issue for many years and continue to be a vital concern. Here, the MDGs have had varying influence over public and policy discourses on rights, gender, health, and development. The MDGs have had less of a direct impact on policies and programs in India and Mexico while in Nigeria the MDG is at least in part an engine fuelling state programs. On a positive note, civil societies in both India and Mexico are using the MDGs as a means to check state accountability especially in regard to public provisioning for the poor.

DAWN's global research on SRHR in these countries had uncovered comparable trends pointing to dire consequences of a maternal mortality silo, as follows.

- Maternal Mortality narrowly channels concern on deaths instead of also calling attention to the serious range of morbidities and injuries women face in pregnancy and in the course of their sexually active and reproductive years.

- There is the creeping return of family planning and population control discourse. While some NGOs engage the MDGs to direct discussion to SRHR issues, a growing number of funders and other stakeholders take on the MMR bandwagon along with a revival of the pre-ICPD population control and population management language that is often directed at the poor. In Nigeria this had led to a side tracking of the comprehensive and integrated

SRHR agenda found in the Maputo Plan of Action.

• The maternal health focus of local level SRHR programs in Mexico, Nigeria and India subtly ignores and excludes the unmarried and younger groups within the population without recognising their rights to access contraception. In the case of Mexico, despite a specific Action Plan from the Federal Health Ministry ordering the public health system to address the reproductive health of teenagers, few steps have been taken to enforce it. The SRHR of young people is also oft neglected when linkages between the MDG on reducing HIV/AIDs and the MDGs on gender equality are weak. The link to safe abortion which is of particular importance to young women is perhaps one of the weakest within the silos of the MDGs.

• Donor influence also facilitates fragmentation into policy and programmatic silos. In contexts where aid is the main if not exclusive source for funding specific MDG related programs and projects, as in the case of Nigeria, governments take on a donor's preferred focus instead of being in a position to make lasting health investments in infrastructure and quality of care.

Realizing that one of the biggest policy victims of the MDG was the ICPD Programme of Action, government leaders meeting at the World Summit in 2004 adopted the additional target of achieving universal access to reproductive health (MDG Target 5B). Yet, the World Health Organization had recently reminded leaders that "... Greater attention to improving sexual and reproductive health care and universal access to all its aspects are required to prevent unintended pregnancies and unsafe abortions, to manage abortion complications, to prevent morbidity and mortality due to sexually transmitted infections (including HIV) and to provide high-quality pregnancy and delivery care, including essential obstetric care." [3]

In 2015 both the MDGs and the ICPD POA will end. Even now, decisive steps need to be taken to rescue maternal mortality from the MDG 5 silo. DAWN calls on world leaders to resurrect, reconfirm and return to center stage the more holistic and integrative rights-based sexual and reproductive health and rights agenda of the ICPD.

[1] SG Ban is set to announce the Global Strategy for Women and Children's Health. The Clinton Global Initiative Annual Meeting is dedicating an entire track to women's and girls' empowerment. There is also the G8's Muskoka Initiative for the reduction of maternal mortality rates and improvement of maternal and child health care.

[2] Organization for Economic Cooperation and Development is an association of some of the world's high income countries that are committed to increased world trade and economic growth.

[3] Accessed from http://www.who.int/making_pregnancy_safer/topics/mdg/en/index.html

"We want a world where inequalities and discrimination based on gender and all other identities are eliminated from every country and from the relationships among countries and peoples; where development processes are founded on social solidarity and economic, political, ecological, social, and personal justice; where poverty and violence are eradicated; where human rights in their fullest and most expansive sense are the foundation of laws, public policies, and private actions.

We want a world where the massive resources now used to produce the means of destruction are diverted to building ethical and socially responsive development alternatives, promoting lasting peace, and justice within and outside the home; a world where people interact with ecological systems in humane and sustainable ways. Such a world would ensure bodily integrity and security of personhood in every dimension of our lives, promote inclusiveness and respect for diversities, and realize sexual and reproductive rights for all.

Women would share equally in determining priorities and making decisions at all levels and in every location and all institutions would be committed to inclusive, participatory and democratic processes.

We believe that respecting and realizing the human rights of all peoples in this way will affirm the ethical basis for a just and humane world."- DAWN Vision

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