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RECLAIMING & REDEFINING RIGHTS

ICPD + 20: Status of Sexual and Reproductive Health and Rights in Asia Pacific

asian-pacific
resource and
research centre
for women

RECLAIMING & REDEFINING RIGHTS

ICPD + 20: Status of Sexual and Reproductive Health and Rights in Asia Pacific

championing women's sexual and reproductive rights

Sivananthi Thanenthiran, Sai Jyothir Mai Racherla and Suloshini Jahanath

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GLOSSARY

AE	Adolescence Education Programme
AFR	Adolescent Fertility Rates
AIDS	Acquired Immunodeficiency Syndrome
ANASF	Afghanistan National HIV and AIDS Strategic Framework
ANC	Ante-natal Care
ANM	Auxiliary nurse midwife
ARH	Adolescent Reproductive Health
ARROW	Asian-Pacific Research and Resource Centre for Women
ART	Anti-Retroviral Therapy
ASEAN	Association of South East Asian Nations
AWAM	All Women's Action Society
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CME	Community Midwifery Education
CPR	Contraceptive Prevalence Rates
CQC	Continuum of Quality Care
CRC	Clinical Research Centre
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
D & C	Dilation & Curretage
DHS	Demographic Health Survey
HDR	Human Development Report
EC	Emergency Contraception
EDPS	External Development Partners
EMOC	Emergency Obstetric Care
ESP	Essential Service Packages
EVAW	Law on the Elimination of Violence against Women
FFPAM	Federation of Family Planning Associations, Malaysia
FP	Family Planning
FOGSI	Federation Of Obstetric Societies of India
FSW	Female sex worker
GEM	Gender Empowerment Measure
GDI	Gender Development Index
GDP	Gross Domestic Product
GII	Gender Inequality Index
GK	Gonoshasthaya Kendra
HCT	HIV Counselling and Testing
HDR	Human Development Reports
HEF	Health Equity Fund
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HRC	Human Rights Council
ICESR	International Covenant on Economic, Social an Cultural Rights
ICOG	Indian College of Obstetrics and Gynecology
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IHS	Institutes of Health Sciences
ILO	International Labour Organisation
IUDS	Intrauterine Devices
JSY	JananiSurakshaYojna
KABP	Knowledge, Attitudes, Behaviour and Practices
LAC	Latin America and the Caribbean
LDC	Least Developed Countries
LGB	Lesbians, Gays and Bisexuals
LGBT	Lesbians, Gays, Bisexuals and Transgenders
LGBTI	Lesbians, Gays, Bisexuals, Transgenders and Inter-sexes
LLDC	Land Locked Developing Countries
LPPKN	National Population and Family Development Board
MDGS	Millennium Development Goals
MDR	Maternal Death Reviews
MICS	Multi Indicator cluster survey
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MOPH	Ministry of Public Health
MR	Menstrual regulation
MSW	Men Having Sex With Women
MSM	Men Having Sex With Men
IDUS	Injecting Drug Users
MVA	Manual Vacuum Aspiration
NASP	National Policy on HIV/AIDS and STD Related Issues
NCHADS	National Clinic for STI and Dermatology and STD Control
NCW	National Commission for Women (India)
NHA	National Health Accounts
NGOS	Non-Governmental Organisations
NRHM	National Rural Health Missions
NSAP	National Strategy and Action Plan 2006-2010
NSP	National Strategic Plan
ODA	Overseas Development Assistance
OECD	Organisation for Economic Cooperation and Development
OHCHR	Office of the United Nations High Commissioner for Human Rights
OSCC	One-Stop-Crisis-Centre
PAC	Programme Advisory Committee
PDVA	Prevention of Domestic Violence Act
PHC	Public Health Care
PITC	Provider Initiated Testing and Counselling
PLHAS	People Living with HIV/AIDS
PLHIV	People Living with HIV/AIDS
PLWHA	People Living with HIV/AIDS

PMTCT	Preventing Mother-to-Child Transmission of HIV
PNG	Papua New Guinea
POA	Programme of Action
PPH	Post-Partum Haemorrhage
RH	Reproductive Health
RHM	Reproductive Health Matters
RTI	Reproductive Tract Infection
SAARC	South Asian Association for Regional Cooperation
SBA	Skilled Birth Attendants
SDIP	Safe Delivery Incentive Programme
SEA	South-East Asia
SOWM	State of the World's Midwifery
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive and Health Rights
SRVAW	Special Rappoteur on Violence Against Women
STDS	Sexually Transmitted Diseases
STIS	Sexually Transmissible Infections
TBA	Traditional Birth Attendants
TFR	Total Fertility Rates
TOT	Training of Trainers
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAMA	United Nations Assistance Mission in Afghanistan
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nation Population Division
UNGASS	United Nations General Assembly Special Session on Aids
UNICEF	United Nations Children's Fund
UP	Uterine Prolapse
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
VIA	Visual Inspection Approach (with acetic acid)
WAO	Women's Aid Organization
WFR	Wanted Fertility Rates
WHO	World Health Organization

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Within this perspective, it is also essential to recognize the different ARROW staff who contributed to this effort, to ensure credit is given adequately to all involved.

The ARROW Global South project management team comprises of Executive Director, Sivananthi Thanenthiran and Sai Jyothir Mai Racherla, ICPD+20 Programme Officer.

This final version of this report is written by Sivananthi Thanenthiran, Sai Jyothir Mai Racherla and Suloshini Jahanath. Nida Mustaq provided first drafts for some key sections. Janet Kehinde Ajao provided secondary data research and generated key tables. Initial secondary data research for the report was done by Ambika Varma, Maria Melinda Ando, Nalini Singh, Nida Mustaq, Sai Jyothir Mai Racherla, Sivananthi Thanenthiran, Suloshini Jahanath, and Uma Thiruvangadam. Shama Dossa and Maria Melinda Ando provided valuable internal reviews. Gaayathri Nair finalized all endnotes.

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PREFACE

2014 marks the twentieth anniversary of the International Conference on Population and Development's Programme of Action, one of the landmark consensus documents, in which governments agreed to and signed off on commitments towards improving women's sexual and reproductive health and reproductive rights. Monitoring government achievements and performance is a critical way of holding governments and development stakeholders accounTable to those international commitments. ARROW and her partners have been involved in monitoring work at community, national and regional levels across the Asia-Pacific and the Global South.

ARROW has been consistently monitoring the implementation of the ICPD Programme of Action at the +5, +10 and +15 intervals. For the ICPD+20 with support from regional networks and donors, we were able to upscale our efforts and replicate the monitoring work across the Global South regions – Eastern Europe, Latin America & the Carribbean, Africa, Middle East & North Africa and Asia-Pacific. For the Asia-Pacific region, the monitoring was done by ARROW, while in the other regions the monitoring was done in partnership with relevant regional networks. The aim was to show the evidence around the critical need for the continued sustenance of the sexual and reproductive health and rights agenda across the Global South.

This work presented here is our effort to ensure that the achievements and gaps in achievements in the Asia-Pacific region are contextualized and duly recognized. Spanning 21 countries in the region, this report presents a comprehensive look at progress and lack of progress for a range of sexual and reproductive health and rights indicators. This is our contribution to helping create the momentum to ensure that the regional SRHR agenda stays on track for inclusion within the post-2015 development framework.

Sivananthi Thanenthiran
Executive Director

EXECUTIVE SUMMARY

Countries monitored as part of the Global South ICPD+20 monitoring initiative in the Asia-Pacific region include Afghanistan, Bangladesh, Bhutan, Myanmar, Cambodia, China, Fiji, India, Indonesia, Kiribati, Lao PDR, Malaysia, Maldives, Nepal, Pakistan, Papua New Guinea, Philippines, Samoa, Sri Lanka, Thailand and Vietnam. Given the status of uneven progress in the area of sexual and reproductive health and rights, it is imperative to continue political commitment and financial investment in the SRHR agenda by governments and donors in the Asia-Pacific region.

Most of the 21 countries under review are signatories to major human rights instruments including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). However, at least 10 out of the selected 21 countries have made reservations and/or general declarations on different articles in CEDAW especially on Article 16 relating to issues of marriage and family.

In the 21 countries reviewed, total expenditure on health as a percentage of GDP falls below 5% in 12 out of the 21 countries. The increasing trend of privatization of healthcare in Asia Pacific coupled with higher rates of out-of-pocket expenditures pose a significant barrier towards achieving universal access to health in general and women's SRH services in particular.

The region has shown some progress towards universal health coverage with three countries in South East Asia: Indonesia, the Philippines and Vietnam achieving 50% health coverage while two countries Malaysia and Thailand have achieved near universal coverage. China has reportedly provided nearly-universal basic health insurance coverage. The challenge however remains with health care packages not being comprehensive and inclusive of all SRH services.

Universal access to SRH services seems to be difficult to achieve even in countries where there are efforts to promote universal health coverage with challenges in both supply and demand side barriers including cultural factors and gender power relations. Socio-economic inequalities play a determining role in the access to contraception, maternal health services and other SRH services. This is validated by the DHS data showing women with lower or no education, poor women, women who lived in remote, hard-to-reach areas having less access to contraception and other SRH services.

Current national aggregate data on key SRHR indicators reported for MDG purposes hides disparities within countries. This is further validated by the available demographic and health surveys (DHS). In the region, women who are poor, less educated, live in remote areas and/or rural areas face greater difficulties in accessing sexual and reproductive health services and realising the autonomy of their bodies. Women from ethnic minorities, women from lower castes, and younger women are also marginalised.

Key SRHR indicators across sub-regions

Key Regional Indicators	South Asia	South East Asia	East Asia	Oceania
Population below 1$(PPP) per day	34.40 %(2008)	17.20 %(2008)	13.10%(2008)	38.20% (2008)
Seats held by women in national parliament (%)	18.50%(2012)	17.60 (2012)	19.50% (2012)	2.60% (2012)
Maternal Mortality ratio/100,000 live births	220 (2010)	150 (2010)	37.0(2010)	200(2010)
Contraceptive Prevalence Rate (%) (Females 15-49 yrs)	55.60 (2010)	62.80 (2010)	83.90 (2010)	38.20 (2010)
Unmet need for family planning	15.60 (2010)	13.40 (2010)	3.7 (2010)	
Births attended by skilled health personnel	49.0% (2010)	74.0%(2010)	99.0%(2010)	-
Adolescent Birth Rate /1000 women	46.00 (2010)	44.80 (2010)	6.00 (2010)	62.10 (2010)
Antenatal care coverage (one visit)%	71%(2010)	93%(2010)	92%(2010)	
Antenatal care coverage (4 visits)	48% (2009)	80% (2009)		
People living with HIV % (Female 15+)	37.00 (2010)		28.00 (2010)	56.00 (2010)

Source UNSD MDG REPORT 2012

Most recent sub-regional estimates and country data on key SRHR indicators point to the following trends in the region.

Fertility

While the average total fertility rate (TFR) for the Asia-Pacific region for 2010 was at 2.1, TFR in South East Asia and the Pacific was above the regional aggregate figure at 2.2 and 2.4 respectively. The TFR in South Asia was recorded as 2.7. Countries in the region - Bangladesh, Bhutan, Maldives and Nepal in South Asia, and Cambodia and Lao PDR in South East Asia - have shown declines in TFR over the two decades.

A rights based analysis of the fertility among women would look at the ability of women to control their fertility and give birth to the number of children they actually want. The difference between the wanted fertility rates (WFR) and TFR are highest in Nepal, India, Bangladesh and Kiribati where women are having more children than they desired to have.

Contraception

Contraceptive Prevalence Rates (CPR) is both an indicator of access to contraception and reproductive health services in general. Contraceptive prevalence rates are the highest in East Asia region (83.90%), followed by South East Asia region (62.80%) and South Asia region (55.60%). CPR is lowest in the Oceania region at 38.20 %. In the 21 countries reviewed under the Global South ICPD +20 monitoring initiative in the Asia-Pacific region, CPR for any method is highest in China (84.6%) and lowest in Afghanistan (21.8%).

Among the 21 countries reliance on traditional methods is highest in Malaysia (16.7%), Cambodia (15.7%), and Sri Lanka (15.3%) and the Philippines (12.6%). Method-mix continues to be skewed in favour of one or two methods in almost all countries. Women continue to shoulder the burden for contraception and male involvement, as equal partners, in decision-making on reproduction as stipulated in the ICPD PoA seems to have had limited headway in all 21 countries in the past 15 years.

Unmet need for contraception is highest in South Asia (15.6%) followed by South East Asia (13.4%). In the 21 countries reviewed under the Global South ICPD +20 monitoring initiative in the Asia-Pacific region, the unmet need for contraception is highest in Samoa (47.7%) followed by Lao PDR (27.3%), Nepal(27.0%), Pakistan (25.2%) and Cambodia (23.5%), Philippines (22.0%) and India (20.5%).

Adolescent births

Adolescent births continue to be a challenge in the Oceania (62.10), South Asia region (46.00) and South East Asia region (44.80). Adolescent birth rates are highest in Bangladesh (133.4), Lao PDR (110.0), Afghanistan (90.0), Nepal (81.0) and Papua New Guinea (70.0). In South Asia, early marriage, early childbearing and insufficient access to health services are the main causes of relatively high mortality among adolescents and young women.

Safe abortion

Unsafe abortion continues to be a major factor in maternal deaths in the region. Mortality due to unsafe abortion for South East Asia is estimated at 14% of all maternal deaths, and 13% for South Asia. About 2.3 million women in the region are hospitalised annually for treatment of complications from unsafe abortion. The usage of medication abortion is increasing access and changing the dimensions of policy and programme work. With regards to abortion law reforms since ICPD, five countries (Bhutan, Cambodia, Fiji, Indonesia and Nepal) liberalized their laws. Even when laws are liberalised, policies need to be backed up by comprehensive and quality programmes and services.

Maternal mortality

Globally the MMR declined between 1990 and 2010 with the highest reduction in East Asia (69%), while in other sub regions of Asia-Pacific it declined by 64% in South Asia and 38% in the Pacific and 35% in Central Asia. Sub-regional maternal mortality ratios are highest in South Asia (220/100,000 live births), followed by Oceania (200/100,000 live births). While the number of women dying of pregnancy and childbirth related complications has nearly halved (47%) in the last two decades from 543,000 in 1990, to 287,000 in 2010, it needs to be noted South Asia bears the brunt of largest number of maternal deaths outside of sub-Saharan Africa.

Reproductive cancers

Cancers of the sexual and reproductive system are a major threat for women. In the 21 countries reviewed under the Global South ICPD +20 monitoring initiative, the highest incidence of cervical cancer occurs in India, China, Bangladesh, Indonesia and Pakistan. Cervical cancer is the most frequent cancer among women in Bhutan, Cambodia, India, Lao PDR, Nepal, and Papua New Guinea. Governments in the region are not at all adequately prepared to provide screening, preventive measures, treatment and care services for reproductive cancers.

HIV/AIDS

Women (15+) living with HIV constitute highest percentages in the Oceania region (56%), followed by South Asia (37%) and East Asia (28%). HIV related stigma and discrimination are barriers to universal access to HIV prevention treatment, care and support in the region.

Sexual Rights

With respect to laws that protect the bodily integrity and autonomy of women, legislations around rape, marital rape and sexual harassment, the region shows the following trends. In the 21 countries reviewed under the Global South ICPD +20 monitoring initiative, 18 countries with the exception of Myanmar, Maldives and Samoa have laws against rape and these usually exist within the penal code or the criminal code. Marital rape is a contested issue in almost all the countries in the region. Anti- sexual harassment in the workplace provisions exist in 11 countries however only the Philippines has a specific anti-sexual harassment act. No anti-sexual harassment legislation or provisions exist in China, India, Indonesia, Lao PDR, Vietnam and in all four countries in the Pacific. Existence of the law, although an indicator, is no guarantee of implementation and availability of a redressal mechanism.

Persons of diverse sexualities and gender identities face similar aspects of marginalization. They face stigma and discrimination with respect to sexual and reproductive health services.

Half of the world's young people reside in the Asia-Pacific region however provision of youth friendly health services that are confidential, non-judgmental and non-discriminatory to enable young people to make informed choices free from sexual violence, coercion, unintended pregnancies, sexually transmitted infections, including HIV are far from reality.

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

chapter 1

introduction

1. INTRODUCTION

1.2 MONITORING ICPD+20

This is nineteenth year of the implementation of the ICPD Programme of Action (PoA) and 2014 will mark the target year for reviewing the commitments stipulated in the ICPD PoA. The UN General Assembly mandated a comprehensive review of progress towards meeting the Cairo commitments in December 2010 in the United Nations General Assembly resolution 65/234 calling for:

- Extending the ICPD Programme of Action and the key actions for the further implementation of the ICPD Programme of Action beyond 2014;
- Affirming no renegotiation of existing agreement contained within the Progamme of Action In the past two decades the implementation of the PoA has not received the adequate political commitment and financial support by governments across the board. In 1999, much investment of energies went into the Hague the ICPD+5 review which resulted in the Key Actions for the Further Implementation of the Programme of Action of the ICPD. However, both the PoA and the ICPD+5 key actions were side-lined by the Millennium Development Goals (MDGs). Additionally, the Global Gag Rule which was in force for eight years of the Bush administration hampered US development funding for abortion and contraception services in developing countries.[1] The environment for the full realisation for SRHR for all continues to be a challenge in the world today in the lead-up to the ICPD+20 review process and the lead-up to the post-2015 development framework. The environment is increasingly hostile to several dimensions of SRHR. There is a renewed battle over women's rights especially their sexual and reproductive rights, a discourse which is often clouded by the cultural and religious relativism. The discourse in rights needs to be sharpened and strengthened as it is currently being hijacked. This is most evident in the arguments of religious rights, socio-cultural and traditional rights, men's rights over women, as well as foetal rights. The discourse in rights needs to be strengthened and based on key premises such as the following:
- The discourse on rights needs to be argued from the premise of enabling communities which are marginalised, disempowered, disenfranchised to enjoy the full spectrum of human rights;
- The discourse on rights should not be used to strengthen and privilege groups with power over groups without power; and an analysis of power should be based on access to resources, institutional strength, political and economic strength;
- The discourse on rights should be limited to those who are already born;
- The discourse on rights should enable choices for all people without infringing on the choices of others.[2]

In the last two years, the lack of rights and the integration of the rights based approach to developement has been widely recognised as a huge gap within the MDGs. This has resulted in human rights mechanisms being harnessed in order to provide impetus to the SRHR agenda.

A noteworthy success has been the Human Rights Council (HRC) Resolution 11/8 on maternal mortality and morbidity. The Human Rights Council, at its eleventh regular session in 2009, adopted a landmark resolution on "prevenTable maternal mortality and morbidity and human rights."[3] In this resolution, governments expressed grave concern for the unacceptably high rates of maternal mortality and morbidity, and acknowledged that this is a human rights issue and have committed to enhance their efforts at the national and international levels to protect the lives of women and girls worldwide.

"The HRC resolution is important as a human rights approach to maternal health places specific legal and ethical obligations on states, such as establishment of accountability measures such as maternal death audits. A human rights approach will also reinforce equity, calling for disaggregated data on maternal mortality to see if vulnerable groups are benefitting from health programmes."[4] However, we should ensure that rights have to be fully integrated into programme implementation and do not only remain in the legal context as ensuring redress through legal mechanisms till today is a route which is inaccessible for much of the world's population.

In the same span of time, there also has been a siloed approach to development, which have been fortified by single-issues international funding mechanisms employing vertical health interventions such as the Global Health Initiatives. These have further weakened health systems in many low income countries in the region.

These single-issue focused interventions paid scant attention to social determinants and did not seek to redress inequities in health.[5] Additionally, the commodification and monetisation of health has eroded the ability of people to access essential health services, including vital sexual and reproductive health services.

Monitoring government commitments to women's health especially their sexual and reproductive health and rights using the framework of the ICPD Programme of Action, which till today remains the most comprehensive outline and approach to women's health and equality, has been an important strategy at ARROW. ARROW has consistently monitored the ICPD Programme of Action since 1994. This current ICPD+20 monitoring builds on the ICPD monitoring work done during

the ICPD+5, ICPD+10 and ICPD+15. In 2014 and 2015 as the target dates for the ICPD Programme of Action as well as the Millennium Development Goals, reach their respective time bound goals, ARROW realised the importance of bringing together not only the voices and realities of the Asia-Pacific region, but also the other regions from the Global South to articulate southern voices and southern agenda in the lead up to 2014-2015 development agenda.

ARROW's experience in monitoring using key SRHR indicators was an added dimension.

ARROW collaborated with our Global South partners from Africa, Middle East and North Africa, Central and Eastern Europe, Latin America and the Caribbean, to generate respective regional monitoring reports. It is our aim that these reports will inform the regional processes in the lead up to the 2014-2015 UN General Assembly Special Session for the ICPD review and the MDG review.

In this ICPD+20 monitoring work in the Asia-Pacific region, ARROW identified 21 countries for the purposes of this study. in order to gain an understanding of the key emerging issues and trends in the region to enable a contextual update for the existing ICPD/Cairo agenda, ARROW also organised a regional CSO consultation meeting in May 2012, "Beyond ICPD and the MDGs: NGOs strategising for SRHR in the Asia-Pacific" that brought together 127 participants from 30 countries in the Asia and the Pacific regions.

1.3 HOW WERE THE INDICATORS CHOSEN

For the ICPD+15 monitoring in 2009, ARROW made a conscious attempt to divide the ICPD monitoring indicators into 5 different components: women's empowerment, health financing reproductive health, reproductive rights, and sexual health and sexual rights. This ensured that each aspect of SRHR and cross-cutting gender empowerment indicators were adequately covered.

The indicators were consolidated after a thorough review of ARROW ICPD+5 and ICPD+10 monitoring initiatives in 2007. In November 2007, ARROW held a regional meeting on SRHR research and monitoring where SRHR indicators were further consolidated for their specificity, measurability, achievability, relevancy and time-bounded characteristics.

Those indicators, which were applicable across countries and for which comparable data was available, were taken into the regional SRHR indicator set in order to feed into the regional analysis. Important references for the final consolidated indicator set include:

- A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing;[6]
- ARROW ICPD+10 monitoring indicators;[7]
- Women of the World: Laws and Policies Affecting their Reproductive Lives; and
- WHO reproductive health indicators.[8]

In 2011, at the initial project planning meeting of all Global South partners, ARROW shared the indicators with the Global South partners and the monitoring framework for the Global South project. 69 indicators were prioritised and finalised for the Global South monitoring process.

1.4 TIMELINE

The first Global South partner planning meeting was held in August 2011, in Kuala Lumpur, Malaysia. Research and monitoring by respective regional partners began in January 2012. Key draft findings were shared at the April 2012 Global South Regional Research Writing and Review meeting held in Kuala Lumpur, Malaysia. The findings were reviewed, and inputs and suggestions were provided by technical resource persons and Global South peer partners invited to the meeting.

1.5 SCOPE OF INDICATORS

The scope of this monitoring covers specifically reproductive health, reproductive rights,[9] sexual health,[10] sexual rights,[11] women's empowerment, and health financing. UN conventions and conferences such as CEDAW, CRC, ICPD, Beijing and Vienna and the MDGs endorsed the concepts of reproductive health, reproductive rights and sexual health.

These documents, particularly the ICPD PoA, do not explicitly state 'sexual rights.' Although 'sexual rights' was written for the first time in the ICPD PoA draft, it was not retained in the final text. The ICPD PoA, however, acknowledges sexual rights when it mentions "a safe and satisfying sex life."

The interpretation of what constitutes a 'safe and satisfying sex life' and the conditions that provide for this include key aspects of sexual rights such as consensual sexual relations, the choice of sexual partners, and the achievement of sexual pleasure. Sexual rights, therefore, are embedded in the ICPD PoA and it is important to monitor these.[12]

1.6 METHOD AND FORMAT OF THE REPORT

In the first section, we deal with the overall regional context, outlining key developments in the region including the food, fuel and financial crises; demographic trends including migration; as well as disasters and emergency situations. This is followed by a close look at women's empowerment and health financing, and how they impact the realisation of SRHR in the region.

The second section deals with reproductive health and rights, more specifically issues of contraception, abortion, maternal health, and reproductive cancers.

Box 1:
Key Definitions

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

Progress of regional and sub-regional trends, and the progress or lack of it across selected indicators, are assessed across the 21 countries.

In the third section sexual health and rights are discussed, with the focus on adolescent sexual rights, STIs, HIV and AIDS, and sexual rights. Similar to the second section, the progress, or lack of it, and regional and sub-regional trends are assessed across selected indicators.

The last section focuses on key conclusions and recommendations.

1.7 DATA SOURCES FOR THE INDICATORS

The sources of data for this report are: World Contraceptive Use, World Abortion Policies of the United Nations Department of Economic and Social Affairs (UNDESA), United Nations Development Programme's (UNDP) Human Development Report (HDR), International Labour Organisation (ILO), Maternal Mortality Estimates of the World Health Organisation (WHO), UNICEF, UNFPA and World Bank National Health Accounts, WHO Global Database, UN Data, UN Secretary-General's Database on Violence Against Women, Demographic Health Surveys (DHS) or comparable national studies such as family or population surveys, 18 United Nations General Assembly Special Session on Aids (UNGASS) progress reports, the Centre for Reproductive Rights, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) government reports and NGO shadow reports of the respective countries, scientific papers from journals such as The Lancet, International Journal of Gynaecology and Obstetrics, Reproductive Health Matters (RHM) and country studies.

ENDNOTES

1 Barot, S. (2009). Reclaiming the lead: Restoring U.S. Leadership in Global Sexual and Reproductive Health Policy. *Guttmacher Policy Review*, 12(1), 12-17.Retrieved from http://www.guttmacher.org/pubs/gpr/12/1/gpr120112.html.

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4 The Lancet. (2009). Cash Transfers for Children—Investing into the Future. *The Lancet*, *373*(9682).

5 Ravindran, T. K. S. (2012). Universal Access to Sexual and Reproductive Health. *Thematic Papers –Beyond ICPD and the MDGs: NGOs strategizing for Sexual and Reproductive Health and Rights in Asia-Pacific.* Kuala Lumpur, Malaysia: Asian-Pacific Research and Resource Centre for Women (ARROW).

6 Abdullah, R. (2000). *Framework of Indicators for Action on Women's Health Needs and Rights after Beijing*. Kuala Lumpur, Malaysia: The Asian-Pacific Resource and Research Centre for Women (ARROW).

7 The Asian-Pacific Resource & Research Centre for Women (ARROW). (2005). *Monitoring Ten Years of ICPD Implementation- The Way Forward to 2015: Asian Country Reports*. Kuala Lumpur, Malaysia: ARROW.

8 Department of Reproductive Health and Research, World Health Organization (WHO). (2006). *Reproductive Health Indicators: Guidelines for their Generation, Interpretation and Analysis for Global Monitoring*. Geneva, Switzerland: WHO.

9 While the term 'reproductive health' was first developed by institutions such as the World Health Organization (WHO) in the early-1980s, the term 'reproductive rights' was initially first used in feminist meetings in the late 1970s and was clearly defined in the International Women and Health Meeting (IWHM) of 1984 as described in: Petchesky, R. P. (2003). Transnationalising Women's Health Movements. *Global Prescriptions: Gendering Health and Human Rights* (p. 4). London, The United Kingdom: Zed Books.

10 The term 'sexual health' has been defined as early as in 1975 by WHO. This can be found in: World Health Organization (WHO). (1975). *Education and Treatment in Human Sexuality: The training of Health Professionals - Report of a WHO Meeting. World Health Organization Technical Report Series No. 572.* Geneva, Switzerland: WHO. Retrieved from http://whqlibdoc.who.int/trs/WHO_TRS_572.pdf

11 Correa, S. & Careaga, G. (2004). *Is Sexuality A Non Negotiable Component of the Cairo Agenda?*. Manila, The Phillippines: Dawn. Retrieved from http://www.dawnnet.org/uploads/documents/PAPER_SONIA_Is%20Sexuality%20a%20Non-Negotiable%20Component%20of%20Cairo%20Agenda_SRHR.pdf

12 Although "sexual rights" as a term has not been established in international agreements, its definition and content were adopted within the human rights framework in the Beijing Platform for Action Paragraph 96. It is worth noting that even governments expressing reservations in opposition to "sexual rights" used the term in their statements at the closing session of the Beijing Conference.

chapter 2

setting the context

2.
SETTING THE CONTEXT

2.1 KEY EMERGING REGIONAL TRENDS

In 1994, 179 governments committed to advance the Programme of Action of the landmark International Conference on Population and Development (ICPD) in Cairo. The Programme of Action put women's empowerment and autonomy at the centre of development and shifted the paradigm from demographically driven population-control goals to a human rights-based approach promoting women's sexual and reproductive health and rights. Many of the governments in Asia endorsed and signed the ICPD Programme of Action.

In 2011, the Asia and the Pacific region made up 61% (4.2 billion) of the world population.[1] The region is often considered as a success story in terms of having been able to curb the population explosion; to reap the demographic dividend; and to develop economically. Additionally, if the ICPD Programme of Action agenda were to be considered primarily from the lens of reducing fertility rates, then the region has made tremendous strides in this direction as well. The region-wide fertility rate at present stands at approximately 2.1 births per woman, with East and North-east Asia at 1.6 births per woman, South and South-west Asia at 2.6, and the Pacific Island countries at 3.6.[2]

However, if we are looking at the ICPD Programme of Action as an agenda of achieving and ensuring equality, equity and well-being, especially for the vulnerable and marginalised groups such as women, then challenges for the region are significant and continuing, especially on the front of reducing poverty, income inequalities and gender inequalities.

Additionally, key trends such as the impact of demographic shifts, climate change and disasters, migration, the global financial crises, the food crises, the privatisation of social services and increasing religious extremism will determine the realisation, fulfilment and protection of sexual and reproductive health and rights for all in the Asia-Pacific region in the coming years. In this chapter, we closely examine two key trends of persistent gender inequality and health financing in the region which help locate the current status and situate the future trends on sexual and reproductive health and rights in the region.

Reducing poverty, and closing the gap with regards to income inequalities and gender inequalities are key challenges which need to be focused on in the coming years. Despite extensive economic gains, the benefits have not tricled down. Consider the stories of the rapid economic growth in Asia and contrast this with these facts: that the region hosts more than 900 million of world's poor, a significant proportion of people suffering from hunger and malnutrition, and a very high proportion of people who lack access to basic sanitation facilities.[3]

The pace of poverty reduction in the region is slow; the worst impact is experienced by the South and South-West Asia sub-region, which accounts for 44% of the world's poor. Inequalities in the region are growing between and within regions, and income inequality in the Asia and the Pacific economies has been rising at a worrying pace, having a significant impact on the social progress in the region.

Measures of achievement pertaining to health and education when adjusted for inequality are considerably lower for many countries in the region. The Asia-Pacific region records a high Gini coefficient[4] of around 39.6; with a number of countries registering above 40, and with three – Indonesia, India and Hong Kong – having extremely high Gini coefficients (57, 53.6 and 52.5, respectively, all of which are 50% higher than the OECD average).[5,6] The economic crisis has negatively affected achieving the Millennium Development Goal (MDG) of halving the extreme poverty in Bangladesh and India, among the countries under the ICPD+20 review.[7]

In addition to income inequalities, gender inequalities and gender power imbalances also continue to remain a formidable barrier to achieving equality, equity and well-being. Gender inequalities are rooted in and perpetuated by son-preference and male-dominance in socio-cultural practices throughout the region. Gender inequalities, which are disadvantageous to women in the region, are also barriers to achieving universal access to sexual and reproductive health. Strengthening gender equality and eliminating gender power imbalances are centrally related to eliminating all forms of violence against women and ensuring women's ability to control their own fertility.

However, making progress with regard to universal access to sexual and reproductive health is not achieved in a vacuum: there are key global and regional developments that we need to be cognisant of as we move towards this goal. The region faces two vastly different demographic shifts: an ageing population and a youth population at the same time.

On the one hand, the number of older persons (age 65 and above) in the region is estimated to increase threefold, from 420 million in 2010 to almost 1.3 billion by 2050 – or almost one quarter (25%) of the population of the region. Japan, China and other countries in East and North-East Asia are expected to have one third of their population is expected to be over the age of 60 years by 2050.[8] On the other hand, 750 million or 60% of the world's youth live in Asia-Pacific; and almost half of these youth are concentrated in South and South-West Asia.[9]

The first key trend which needs to be recognised is that the Asia-Pacific region remains adversely affected by the impact of climate change, with most impact on the poor who contribute trivially to the release of huge quantities of fossil carbon.[10] The

region has witnessed consequences of climate change in terms of increased frequency and intensity of climate induced natural disasters with 45% of world's natural disasters occurring in the Asia-Pacific in the last three decades.[11] The region is vulnerable to many types of disasters, including floods, cyclones, earthquakes, droughts, storms and tsunamis. In the past decade, on average, more than 200 million people were affected in the region, which represent 90% of world total; more than 70,000 people were killed by natural disasters, which represent 65% of the world total annually.[12]

Among the countries under the ARROW ICPD+20 review, floods affected Bangladesh, Myanmar, Cambodia, China, Pakistan, Philippines, Thailand and Vietnam. Earthquakes affected Myanmar, China, Indonesia and Japan. China suffered extreme temperatures, flood and storms. The 2004 Indian Ocean tsunami affected 14 countries in the region, and left in its wake an estimated 230,000 people dead and 1.69 million people displaced.[13] As natural disasters, some of which occur on a cyclical manner such as the floods in Bangladesh, affect the region's economies and the lives of the people, it is essential to factor them in when planning for people and development.

The UNESCAP/UNISDR Asia-Pacific Disaster Report 2012, *Reducing Vulnerability and Exposure to Disasters,* notes that "from 1970 to 2010 the average number of people exposed to yearly flooding in Asia has more than doubled from 29.5 million to 63.8 million and the population resident in cyclone-prone areas has grown from 71.8 million to 120.7 million." The inequality dimension of disasters is worth noting. While disasters *per se* do not distinguish between high and low income countries, and rich and poor people, it is seen that the effect of disaster is lowest in high income countries.

More people in the lower-middle income group were affected than people in the low-income countries.[14] There is an urgent need for both adaptation and mitigation actions, and disaster risk reduction strategies, for building resilient societies in the Asia and the Pacific region, and a people-oriented approach and dialogue on climate issue[15,16]

The second key trend is migration, and in the Asia-Pacific region, migration is complex and is determined by both economic and political factors.[17] Globalisation[18] has changed not only the scope, but also the patterns of migratory movements, from traditional, more permanent movement in one direction, to a repeated and bi-directional movement of people that is referred to as circulatory migration or repeated return.[19] Migration can be temporary or permanent, forced or voluntary, and internal or external. Forced movement includes movement or displacement due to 'natural,' environmental or climate-change-induced disasters, wars, internal conflicts, famine or development projects.[20]

Migration influences the demographic profiles in both sending and receiving countries, mostly depleting youth cohorts in sending countries and youth bulge in receiving countries. Migration for employment, also known as labour migration, has become one of the more predominant forms of migration in the region, with environmental migration becoming another recent phenomenon.[21]

Migration as a process and experience plays out differently for women, men and people of diverse sexualities. For example, a gendered understanding of labour migration shows that while migration may provide new opportunities to improve women's lives and change oppressive gender relations, it can also perpetuate and entrench traditional roles and inequalities.[22] Outcomes of migration can include exposure of women to new vulnerabilities as the result of precarious legal status, exclusion and isolation.[23]

Women migrants, especially those working in the service sector, are especially vulnerable to a host of abuses, including sexual violence, economic exploitation, physical and verbal abuse and labour rights violations. While such vulnerabilities can happen to women who migrate either through regular and irregular circumstances, the latter are more disadvantaged because they often have limited options in seeking legal remedies or redress and have less access to correct information and services.[24]

Another important aspect of migration is marriage-migration. Although these countries are not part of the ARROW ICPD+20 review, it is important to note that Japan, Taiwan, South Korea and Singapore have witnessed record numbers of international marriages. In Taiwan, 20-32% of all marriages are international marriages; in South Korea the corresponding proportion is 11-13% and is lowest in Japan at 5-6%.[25,26]

International agencies are estimating that between the years 2000 and 2021, 1 million South Korean males and 23.5 million Chinese males will be seeking brides.[27] Marriage migration puts immigrant women in a position of risk and vulnerability, and exposes them to potential violations of their rights. Additionally, they may not have access to support systems nor familiarity with the socio-legal context in order for them to sufficiently counter and end these violations.

Many governments institute increasingly repressive entry regimes. Approximately 60 governments have established health-screening procedures, often discriminatory and violate migrant rights, upon application, arrival and renewal of work permits. Many developed countries in Asia (e.g., Brunei, Malaysia, Singapore and Taiwan) and the Middle East (all the Gulf Cooperation Council countries) that rely on migrant workers to keep their economies functioning have instituted migration policies that use health as a primary criterion for permitting migrants entry and stay for employment.

Under these policies, migrants are being screened for up to 22 conditions and diseases, including pregnancy and HIV. Sexual and reproductive health and rights in the context of migration is even

more invisible, and this is evidenced by the scant amount of data and information on SRHR conditions of women migrant workers in the region.[28]

The third (and continuing) key trend to consider is the protracted global financial crises which presents a challenging external environment for the Asia and the Pacific region. The slowdown in the global economy, as well as structural problems within the region's economies, is having an impact on economic development in the region.[29]

The recovery from the global financial crises proved to be short-lived in 2010 and the world economy has entered the second stage of crises in 2011. Slow economic growth in developed countries, and effects of measures to revive the respective economies of the developed countries such as that of loose monetary policies and trade protection policies continue to directly affect the Asia and the Pacific region.

The region is exposed to risk from an increase in protectionist policies in the developed economies.[30] The impact of developed economies is different for different countries in the Asia and Pacific region, based on their export dependency. Countries such as those of Least Developed Countries (LDC) and Land Locked Developing Countries (LLDC) are affected greatly, as these economies have a relatively high share of their GDP accounted for by exports.

LDCs in the region are facing a series of harmful measures, as several developed countries impose trade restrictive measures on their trade flows. Countries such as India and Indonesia, which are among the 21 countries under ARROW ICPD+20 review, seem to be less affected with large and robust domestic markets, and limited reliance on exports as a driver for growth.[31]

However, other countries including the economies in East and South East Asia, such as China, Malaysia, the Philippines and Thailand seem to be significantly affected.[32] UNESCAP estimates that failure to resolve the issues around global economy, would lead to the slowing down of growth in the Asia-Pacific economies by 2.2 percentage points in 2013, with countries under ARROW ICPD+20 review such as China and Malaysia being mostly affected.[33]

This has an impact on the fourth key trend – privatisation of health care and health services in the region. One of the key aspects to look at is social spending as per Gross Domestic Product (GDP) in the region. The regional average is 5.2%, with most of the countries falling below the regional average (which is boosted by countries such as Japan with a social spending of 18.6%).[34]

Additionally, when there is a resource crunch, it is social sector spending that experiences budgetary cuts and, as a result, only a limited or narrow scope of tax-funded government health services, especially sexual and reproductive health services, are offered and people are often driven to seek necessary services from private providers.

These expenses, often out-of-pocket, prove catastrophic especially for the poor.[35] Governments have been experimenting with pre-payment schemes and micro-insurance schemes, social franchising and public private partnerships.[36] A review monograph of four countries in the region – Thailand, Cambodia, Lao PDR and Pakistan – by ARROW, shows that relatively better resourced countries such as Thailand with a political commitment to universal health care coverage make available a comprehensive range of publicly funded sexual and reproductive health services to a vast majority of their citizens.[37]

The global economic slowdown also has its impact on food and nutrition security in the Asia-Pacific region, which is the fifth key trend in the region. Declining investments in agriculture and other market dynamics is increasingly pushing more people into hunger and malnutrition, and the progress towards reducing the proportion of hungry people in the world is slow and serious.[38] Despite decline, South Asia region reports high levels of hunger in 2012.[39] In the countries under ARROW ICPD+20 review, despite its strong economic growth, India is lagging behind in reducing its hunger index score.[40]

Bangladesh and Vietnam saw the largest improvements in the region in improving their Global Hunger Index (GHI) scores between 1990-2012. Though these countries show improvements in the GHI scores, alarming levels of hunger continue to occur in Bangladesh, India, and Nepal.[41] The state of hunger and malnutrition does and will impact the sexual and reproductive health outcomes of individuals.[42]

Lastly, trends in the region show an inclination for South-South cooperation especially in matters of trade and investment. Reports show an increase in the trade and foreign direct investment flows between Asia and the Pacific, Africa and Latin America and the Caribbean (LAC) has grown substantially. Between 1990-2010, imports from Africa and LAC to developing Asia and the Pacific increased from an estimated $6 billion to $107 billion and $158 billion, respectively, while exports from developing Asia and the Pacific to Africa and LAC increased to $114 billion and $194 billion from $5 billion and $4 billion, respectively.

The trend of increasing religious extremism is also important to note in relation to fulfilment of the ICPD agenda. Within the South-South context, Christian and Muslim extremist interpretations of religious texts puts limitations on women's autonomy and rights especially with regards to access to contraception, access to safe abortion services, comprehensive sexuality education, reducing child marriage, ending female circumcision and ending all forms of violence and discrimination against women across the region.[43] This has specific implications

Table 1:
Signatories to major international human rights instruments

Name of the Country	International Covenant on Civil and Political Rights (1966)	International Covenant on Economic, Social and Cultural Rights (1966)	Convention on the Elimination of All Forms of Discrimination Against Women (1979)	Convention on the Rights of the Child (1989)
East Asia				
China	1998*	2001	1980	1992
South Asia				
Afghanistan	1983	1983	2003	1994
Bangladesh	2000	1998	1984	1990
Bhutan			1981	1990
Sri Lanka	1980	1980	1981	1991
Maldives	2006	2006	1993	1991
Nepal	1991	1991	1991	1990
Pakistan	2010	2008	1996	1990
India	1979	1979	1993	1992
South-East Asia				
Cambodia	1992	1992	1992	1992
Myanmar			1997	1991
Lao PDR	2009	2007	1981	1991
Malaysia			1995	1995
Philippines	1986	1974	1981	1990
Indonesia	2006	2006	1984	1990
Thailand	1996	1999	1985	1992
Vietnam	1982	1982	1982	1990
Pacific				
Fiji			1995	1993
Kiribati			2004	1995
Papua New Guinea	2008	2008	1995	1993
Samoa	2008		1992	1994

Source: United Nations Treaty Collection

on sexual and reproductive rights of women and marginalised groups. This trend appears to be prevalent cross-regionally with the outcome of reducing women's access to contraception and abortion, young people's access to comprehensive sexuality education and SRH services, and the right to live a life free from discrimination and violence regardless of sexual orientation and gender identity.[44,45]

In the Philippines, after 10 years of intense lobbying, the Reproductive Health Bill was passed. However, religious institutions are still endeavouring to hamper its implementation by utilising legal mechanisms. Secular spaces for policy-making and programme implementation are being increasingly invaded by religious institutions.

The link between demographics and religions –(i.e. identifying majority populations and the nation with a specific religious identity which then needs to be propagated and populated) continues to be problematic, and recent information also demonstrates that this trend is observable not only in Muslim

majority countries and Christian countries but also in Hindu extremists in India[46] and Buddhist extremists in Sri Lanka and Myanmar.[47,48,49]

Hence, 2015 and beyond will present a complex and dynamic environment for us to work and advocate for policies and programmes that will help move the region towards a more equal, equiTable and just world for all, especially women.

2.2 OVERALL STATUS OF ACHIEVING WOMEN'S EMPOWERMENT AND GENDER EQUALITY IN THE REGION

In this chapter, we provide an overview of the status of women's empowerment and gender equality in the selected 21 countries of Asia and the Pacific region. This is to contextualise the analysis of the SRHR indicators in the chapters following this within a human rights framework. The chapter, first of all, assesses the governments' commitments to the advancement of women's sexual and reproductive health and rights by analysing the following indicators: status of signing of CEDAW, existence of dedicated and functional governmental institutions for women development, status of national legislations against domestic violence and finally, their ranking on the inequality-adjusted human development index.

i. Status of the governments' commitment to CEDAW

Table 1 shows the majority of the selected 21 countries are signatories to major human rights instruments including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) as shown in Table 1. With the exception of countries involved in conflicts and/or occupied, all the focused countries participated in and endorsed the ICPD Programme of Action and the subsequent Beijing Platform for Action. Many of the rights that protect, promote, and fulfil different aspects of sexual and reproductive health, reproductive rights, and sexual rights are enshrined within these human rights instruments and declarations.

Such rights include the rights of individuals and couples to enjoy and control their sexual and reproductive lives, the right to choose whether or not to marry, whether and when to have children, the right to found and plan a family; the right to health care and health protection, the right to access sexual and reproductive information, health and care free from discrimination; the right to privacy; the right to benefits of scientific progress; and the right to be free from all forms of violence, ill treatment, torture and death.[50]

Despite having a significant level of commitment from governments and civil society movements, the ICPD PoA lacked both a monitoring mechanism and an accountability mechanism through which progress could be measured in a systematic way and governments could be held accounTable for their commitments.

CEDAW is the first document, in 1979, that explicitly mentioned "reproductive rights as a binding aspect of human rights." Article 16 of the Convention document highlighted the "notion of women's equality [as it relates] to their ability to choose the number and spacing of their children."[51] It is to this end that CEDAW still serves as one of the major accountability mechanism and is popular among the women's rights movement as an advocacy avenue. It is also through the CEDAW reporting processes that women's human rights regarding women's sexuality and their reproductive roles are reported on and argued for.

Ten out of the selected 21 countries have made reservations and/or general declarations on different articles in CEDAW. Of the contested articles, four countries (Bangladesh, India, Malaysia and Maldives) have reservations on Article 16 relating to issues of marriage and family[52] and seven countries (Myanmar, China, India, Indonesia, Pakistan, Thailand and Vietnam) have reservations on Article 29 that refers to settling disputes between State Parties on interpretation of different articles in the Convention.[53]

The reservations on Article 16 made by countries with majority Muslim population such as Bangladesh, Malaysia and Maldives, highlight that the importance of Islamic Sharia Law and that their Constitutions based on Sharia Law take precedence over the Article as stated in the Convention.

In addition to this, only three countries have reservations on further Articles including: Bangladesh's reservations on Article 2 (which addresses policy measures on discrimination against women);[54] India's reservation on Article 5-a that calls to address the harmful cultural practices to eliminate discrimination against women[55] and Malaysia's reservation on Article 9 (2)[56] urging State Parties to grant women equal rights with respect to the nationality of their children. India's reservations are based on the consideration of non-interference of the State in the personal affairs of the Community; while that of Bangladesh and Malaysia are based on the consideration for the Sharia Law; and Pakistan has an overall deference to the national Constitution.

The signing and ratification of the CEDAW and the subsequent reporting mechanisms which involves both government and shadow reporting procedures, has led to greater accountability on the part of the government, and incremental changes at national levels for women.

ii. National Machinery Facilitating Women's Empowerment

The status of national-level mechanisms aimed at women development in different countries can be assessed through their periodic reports submitted to the CEDAW Committee by

Table 2:
Status of Laws against Domestic Violence in the 21 countries

Country	Anti-Domestic Violence Law
East Asia	
China	Law on the Protection of the Rights and Interests of Women, as amended in 2005
South Asia	
Afghanistan	Law on Elimination of Violence Against Women 2009
Bangladesh	Domestic Violence Act 2010
Bhutan	Draft Domestic Violence Bill 2010
Sri Lanka	Prevention of Domestic Violence Act (No. 34 of 2005)
Maldives	Prevention of Domestic Violence Act 2012
Nepal	2009 Domestic Violence (offence and punishment) Act 2066
Pakistan	National Commission on the Status of Women Bill 2012 Draft Domestic Violence (Prevention and Protection) Bill 2009
India	Protection of Women from Domestic Violence Act 2006
South-East Asia	
Cambodia	Acid Attack Law 2011; Law on the Prevention of Domestic Violence and the Protection of Victims 2005
Myanmar	
Lao PDR	Article 29 of the Law on Family 2004 Law on the Development and Protection of Women 2004
Malaysia	Domestic Violence Act 1994
Philippines	Magna Carta for Women 2009
Indonesia	Law No. 23 of 2004 regarding Elimination of Household Violence
Thailand	Protection of Domestic Violence Victims Act B.E. 2550 (2007)
Vietnam	Law on Prevention of and Control over Domestic Violence 2007
Pacific	
Fiji	Domestic Violence Decree 2009
Kiribati	Penal Code 1995 (mentioning marital rape and sexual violence)
PNG	Criminal Code (Sexual Offences and Crimes against Children) Act 2002
Samoa	Draft Domestic Violence Bill 2008

Source: The UN Secretary-General's Database on Violence against Women

each country. In the following section, we have analysed the national institutional mechanisms ensuring gender equality and monitoring the progress in the women population development of the 21 countries reviewed.

Except for Afghanistan and Kiribati, the governments of all the other 19 countries have reported to CEDAW highlighting the governments' attempts at creating gender equality and eliminating discrimination against women through the

programming of development plans targeting women.
Eleven countries out of the 21 selected countries in the Asia-Pacific region have dedicated Ministries for women affairs and development,[57,58,59,60,61,62,63,64,65,66,67,68] while Pakistan previously had a Federal Ministry of Women Development[69], which was devolved as a result of the 18th amendment to the constitution of Pakistan among other ministries.

One of the indicators to assess the functioning of these institutional mechanisms is to see whether specific action plans for women development are in place in these countries. In 19 out of the 21 countries, there are specific development plans[70] for women:

- Afghanistan: National Action Plan for the Women of Afghanistan (2007 – 2017)
- Bangladesh: National Women Policy 2010
- Bhutan: National Action Plan on Gender 2008 – 2013
- Cambodia: Five-Year Strategic Plan of the Cambodian National Council for Women 2010 – 2014 and Neary Rattanak III (2009 - 2013)
- China: Programme for the Development of Chinese Women (2001 – 2010)
- Fiji: Women's Plan of Action (1999 – 2008)
- India: National Gender Budget 2010 and Eleventh Five Year Development Plan (2007 – 2012)
- Indonesia: National Plan of Action, Follow-up of the Fourth World Conference on Women in Beijing (1995)
- Lao: National Policy Plan on the advancement of women (2006 – 2010)[71]
- Malaysia: National Woman Policy (2009)
- Maldives: National Gender Equality Policy (2009)
- Nepal: National Action Plan on the Implementation of Security Council Resolutions 1325 and 1820 (2011 – 2016)
- Pakistan: National Gender Reform Action Plan (2005 – 2010) and National Policy for Development and Empowerment of Women (2002)
- Papua New Guinea: National Gender Policy and Plan on HIV and AIDS (2006 – 2010)
- Philippines: National Action Plan on the Implementation of SC Resolution 1325, (2010 – 2016), Project on Strengthening Government Mechanisms in Mainstreaming Gender in the reproductive Health, Population and Anti-VAW Programs (2005) and Philippine Plan for Gender-Responsive Development (1995 - 2025)
- Samoa: National Policy for Women (2001 – 2004)[72]
- Sri Lanka: Plan of Action supporting the Prevention of Domestic Violence Act (2006)
- Thailand: Thai Women's Development Plan in the 10th National Economic and Social Development Plan (2007 - 2011)
- Vietnam: National Strategy for Gender Equality (2011 - 2020)

However, it is difficult to assess the resource allocation to these national institutions and development plans, and it is essential for us to consider some key indicators to see if these plans and mechanisms are indeed achieving their purposes.

iii. National Legislation Addressing Violence Against Women

Of all the inequalities that women face, none is more pernicious than violence. Physical, sexual, psychological, and verbal violence are reminders of the perceptions of the society on the status of women. The ICPD PoA addresses this issue of eliminating violence.[73] For the purpose of this section, we will only look at legislation eliminating domestic violence, which aims to protect women within the most personal sphere in their lives.
Table 2 shows all but one of the 21 countries have legislations on prevention, protection from and elimination of domestic violence against women.

Only Malaysia (1994), Bangladesh (2000) and China (2001) passed these laws early on. The rest of the countries passed their anti-domestic violence laws after 2004. Anecdotal evidence suggests that in almost all countries, there was a considerable gap between the initiation of the law and its being passed. One reason is that, in some countries, especially the larger ones, there are many stages to passing the law and this process, itself, takes time. The second and more pertinent reason is that in most of the Asia Pacific region, domestic violence is considered a private matter of the family and is not encouraged to be discussed as a social issue of gender inequality.

In all countries surveyed, these VAW laws were a result of the persistent efforts of grassroots and national women's organisations.

Laws on domestic violence, although they do not immediately eradicate all violence against women are important incremental steps in recognising women's rights to live life free from all forms of violence. However, ensuring that these laws are backed up by comprehensive health-sector responses to survivors of violence including preventive services and counselling services, is the next challenge as well as to ensure necessary and just legal recourse.[74,75]

iv. Measurement Of Women's Empowerment

The term 'women's empowerment' is a loosely defined term, and this has simultaneously been its strength and its weakness. Its strength lies in the fluidity of its interpretation, enabling women to shape its meaning according to their contexts, while its weakness is its lack of operational clarity at the policy and programme levels that make it difficult for NGOs and activists in the women's rights movement to hold governments accounTable to certain set standards of women empowerment. In order to compare progress across countries with regards to women's empowerment, however, it is necessary to think through the term, attribute key indicators to it, and track governments' progress in this area.

Nevertheless, this is not meant to limit women's empowerment only to these aspects that are measured.

From a broader aspect, women empowerment can be viewed from the perspectives of resources they own or have access to, their agency and their achievements.[76] These resources could include material, human and social resources while agency is defined as the ability to define one's goals and act upon them'[77]

v. Gender Inequality Index

We have reflected,in Table 3, for the selected 21 countries from the Asia and the Pacific region, the Gender Inequality Index (GII) recently introduced by the UNDP. The GII is reflective of the loss in human development due to inequality between

Table 3:
Gender Inequality Index and its indicators for the selected 21 Asia-Pacific countries

Country	Gender Inequality Index		MMR	AFR	% of women in national parliament	% of female population with at least secondary education	% of male population with at least secondary education	% of female labour force participation	% of male labour force participation
	Rank	Value							
East Asia									
China	35	0.213	37	9.1	21.3	54.8	70.4	67.7	80.1
South Asia									
Afghanistan	147	0.712	460	99.6	27.6	5.8	34.0	15.7	80.3
Bangladesh	111	0.518	240	68.2	19.7	30.8	39.3	57.2	84.3
Bhutan	92	0.464	180	44.9	13.9	34.0	34.5	65.8	76.5
Sri Lanka	75	0.402	35	22.1	5.8	72.6	75.5	34.7	76.3
Maldives	64	0.357	60	10.2	6.5	20.7	30.1	55.7	76.8
Nepal	102	0.485	170	86.2	33.2	17.9	39.9	80.4	87.6
Pakistan	123	0.567	260	28.1	21.1	18.3	43.1	22.7	83.3
India	132	0.610	200	74.7	10.9	26.6	50.4	29.0	80.7
South-East Asia									
Cambodia	96	0.473	250	32.9	18.1	11.6	20.6	79.2	86.7
Myanmar	80	0.437	200	12.0	4.6	18	17.6	75.0	82.1
Lao PDR	100	0.483	470	30.1	25	22.9	36.8	76.5	79.5
Malaysia	42	0.256	29	9.8	13.2	66	72.8	43.8	76.9
Philippines	77	0.418	99	46.5	22.1	65.9	63.7	49.7	79.4
Indonesia	106	0.494	220	42.3	18.2	36.2	46.8	51.2	84.2
Thailand	66	0.36	48	37.0	15.7	29.0	35.6	63.8	80.0
Vietnam	48	0.299	59	22.7	24.4	24.7	28.0	73.2	81.2
Pacific									
Fiji	-	-	26	42.8	-	57.5	58.1	39.3	79.5
Kiribati	-	-		16.4	8.7	-	-	-	-
PNG	134	0.617	230	62.0	2.7	6.8	14.1	70.6	74.1
Samoa	-	-		25.5	4.1	64.3	60.0	42.8	77.8

Source: Human Development Report 2013: The Rise of the South: Human Progress in a Diverse World.

men and women from three dimensions – reproductive health, empowerment and the labour market.

The GII is introduced as an improved index in place of the previously used Gender Development Index (GDI) and Gender Empowerment Measure (GEM) that we have used for analysis of this section in the previous reports on ICPD+15.[78] The GII is an improved indicator over the previous indicators as it includes the dimensions of reproductive health - maternal mortality ratios (MMR) and adolescent fertility rates (AFR) for each country. This was recommended in our previous ICPD+15 monitoring report in 2009 and was taken up.

The GII also emphasises secondary education, as this is a critical area for girls' education. The GII has also overcome the methodological gaps of those indices.[79] However, while analysing the data through the GII, we are also aware of the limitations of GII due to unavailability of national-level data in many countries for dimensions such as asset ownership and gender-based violence and the burden of care giving and housekeeping.

Relatively more gender-equal societies are observed in China, Malaysia and Vietnam ranking globally at 35, 42 and 48 – respectively, and where the GII value tends towards zero.[80] Countries that rank the lowest on the gender equality index i.e. tending towards the value 1 are Afghanistan, Papua New Guinea and India ranking globally at 147 134 and 132 – respectively.[81] Sub-regionally, the better performing countries in South Asia are Maldives, Sri Lanka and Bhutan; in South East Asia are Malaysia, Vietnam, Thailand and the Philippines; in East Asia, China seems to have a strong rank because of its performance in all of these key dimensions equally.

In the Pacific, ranks were not assigned due to lack of data across dimensions and only PNG has data available, and is ranked only above Afghanistan. Countries that have high maternal mortality ratios and adolescent fertility rates score lower and the converse is true – which explains why Malaysia, with a meagre percentage of women in parliament and a comparatively lower female labour force participation scores higher on the GII.

In this section, we will look at achievements in the areas of education, labour force participation and political participation, whereas achievements in reducing maternal mortality and adolescent fertility will be discussed in the following chapters.

vi. Education of Women

As shown in Table 3, the highest percentage of female population with at least secondary education is observed in Sri Lanka (72.6.%), Malaysia (66%) and the Philippines (65.9%). The smallest gender differentials are seen in Sri Lanka, Vietnam, Bangladesh and Fiji; while Bhutan is almost at par with regards to secondary education.

The gender differentials in secondary education are the highest in some of the countries from the South Asia region. In Afghanistan, this disproportion is highest and records a 5.8% of women while 34% of men with at least secondary education, Pakistan and India has about a 25% difference between men and women having had secondary education and Nepal has a 21% difference between men and women in this regard.

In other countries in this sub-region such as Bangladesh, Bhutan and Maldives, however, the gender differential is quite low. In Bangladesh, the government aims to have universal primary education. The government provides free education to girls till class twelve as well as monthly incentives are offered to girl students if they maintain high levels of attendance record.[82] Interestingly, in the Philippines, Samoa and Myanmar, the gender differential shows that more females than males have at least secondary school education.

In comparison to South Asia, Pacific island countries seem to have lower gender differentials although in Papua New Guinea overall access to secondary education is poor.

vii. Labor force Participation

As shown in Table 3, women's participation in the labour force of is above 50% in 12 of the total of 21 countries under consideration here. It is the highest in Nepal at 80.4%, followed by Cambodia at 79.2% and Lao PDR at 76.5% of female economic activity rate. However, these figures stand in clear contrast with the labour force participation of men that is almost above 75% is all the 21 countries.[83]

Female participation in the economic activity was the lowest in Afghanistan (15.7%), Pakistan (22.7%) and India (29%). Despite India being considered a rising economy, women in India still encounter greater difficulties in access to employment and only form a bare minority in decision-making and managerial positions.[84]

While in Pakistan and Afghanistan, the cultural and religious barriers to women's employment and participation in formal economic activity have strengthened in the last decade.
Apart from this, higher gender differentials are observed in labour force participation between men and women, around 30% in Sri Lanka, Malaysia, Indonesia, Bangladesh, Samoa and Fiji. In all of these countries, women are either working in agriculture or in the informal sector.

In Sri Lanka, despite the composition of more than 23.4% of households in Sri Lanka now headed exclusively by women as a result of the 30 years of the internal war where they lost their male family members,[85] in 2009, the Quarterly Report on Sri Lanka Labour Force Statistics reported that "only 21% of women who have education above senior secondary high school are employed while 47.9% of women with similar educational

qualifications are unemployed." [86] Although the data for the previous indicator shows little difference in the educational levels of men and women in Fiji, occupational discrimination against female workers in their labour markets are obstinate. Of the economically active population, women form only about 30% of the formal economy, are concentrated at the low-pay end of the labour market in both the public and private sector, and of these women, a large proportion work in semi-subsistence employment or self-employment.[87]

viii. Political participation of Women

The oft-quoted goal for governments is to have at least 30% of women in parliament. Nepal has the highest percentage of women in Parliament at 33.2%, followed, interestingly enough, by Afghanistan (27.6%), and Vietnam (24%).

The East Asian countries are observed to have improved in this regard in the last two decades. In the Cambodian Parliament, there has been a numeric increase since 1993, when women only represented 5% of the candidates, until the 2008 elections, when women represented 17.02% of the candidates.[88] The number of women elected in the Philippines has also been on the rise in the last two decades from 12.7% in 1995 to 22.1% in 2011.

Papua New Guinea (PNG) is the lowest in the entire Asia Pacific region with 0.9% of women in the national parliament, while Samoa and Kiribati only have about 4% of female representation in the Parliament.

An insight into why this happens can be glimpsed in a report on Fiji: "[t]here is tension between customary practices protected under the law and the objective of achieving women's equal participation because women do not have equal access to the customary title, chiefly or noble systems, which are all considered prerequisites for political representation in Fiji." [89] Both structural and social barriers continue to inhibit women's political participation in the region.

3. HEALTH FINANCING

Health financing is increasingly becoming a matter of concern in the Asia-Pacific region. It is the costliest part of the world to fall sick in due to high out-of-pocket payments in comparison to other regions of the world.[90]

Health financing refers to the how financial resources are allocated within the health systems, so that sufficient resources are raised to address the health needs of people, and the removal of financial barriers to accessing an efficient mix of health services in an equiTable environment.[91] The health care spending is uneven and insufficient in many countries in the region and many people in the region face financial catastrophe as a result of health care costs. The trend in the region points to privatisation and high out-of-pocket spending in the financing of health care, details are shown in Table 4.*The Health Financing Strategy for the Asia-Pacific Region (2010-2015),* released by the WHO regional office for Western Pacific and agreed by all member states urges countries in the region to reduce out-of-pocket spending to no more than 30-40% of total health expenditure, and raise health expenditure per country to at least 4-5% of GDP. The strategy also calls upon member states to cover over 90% of population by some form of pre-payment and put in place extensive safety net provisions for especially vulnerable sections of the population.[92]

The total health account of a given country factors in both public and private sector financing patterns. Total health expenditure of a country can be publicly or privately financed. Public financing consists of tax-based funding as well as government backed health insurance or health savings schemes. Private health financing, on the other hand, includes out-of-pocket health expenditure by individuals and health plans provided by private companies. Privatisation of health is used here to encompass all for-profit health schemes; the shifting of responsibility of service provision from public to the private and commercial sector; and the shifting of financing of health to out-of-pocket payments by households.

Drawing on the framework of Health Financing Strategy for the Asia-Pacific region (2010-2015), we assess the progress made in the ARROW ICPD+20 countries by looking at total expenditure on health as percentage of GDP; general government expenditure on health as percentage of total health expenditure; out-of-pocket expenditure on health as percentage of total health expenditure; and efforts by member states to protect poor and vulnerable.

i. Total expenditure on health as percentage of GDP

In terms of the total expenditure on health as percentage of GDP, it is observed that 12 of the 21 countries under the ARROW ICPD+20 review, spend less than 5% of GDP on health in 2010. These countries include Myanmar (2.0%), Pakistan (2.8%), Indonesia (2.8%), Sri Lanka (3.5%), Bangladesh (3.7%), Philippines (4.1%), PNG (4.1%), Thailand (3.9%), India (3.7%), Malaysia (4.4%), and Fiji (4.2%). The highest spending on health as percentage of GDP is by Kiribati at 10.7%.

ii. General Government expenditure on health as percentage of total health expenditure

Removing financial barriers[93] would mean moving away from out-of-pocket expenditure towards a greater share of government expenditure on health. The World Health Assembly resolution 58.33 in 2005 - sustainable health financing, universal coverage and social health insurance on financial protection - is a step forward to remove financial barriers to seeking health care. An examination of the general government expenditure on health as percentage of total health expenditure in 2010, shows respective

Table 4:
Key Health Financing Indicators

Country	Total expenditure on health as % of GDP (2010)	General government expenditure on Health as % of Total Health expenditure	Out-of-pocket (OOP) expenditure on health as % of Total Health expenditure
East Asia			
China	5.0	54.3	36.6
South Asia			
Afghanistan	10.4	22.5	83.0
Bangladesh	3.7	36.5	63.4
Bhutan	4.3	84.6	11.9
Sri Lanka	3.5	45.6	44.9
Maldives	6.2	60.8	28.2
Nepal	5.1	37.4	54.4
Pakistan	2.8	28.2	50.4
India	3.7	28.2	61.1
South-East Asia			
Cambodia	6.0	21.5	40.3
Myanmar	2.0	12.1	81.1
Lao PDR	2.6	45.6	51.1
Malaysia	4.4	55.5	34.1
Philippines	4.1	36.1	54
Indonesia	2.8	36.1	38.2
Thailand	3.9	75.0	13.9
Vietnam	6.8	37.1	57.6
Pacific			
Fiji	4.2	70.2	19.6
Kiribati	11.2	81.2	0.1
PNG	4.1	75.2	15.9
Samoa	6.3	87.5	7.7

Source: WHO Global Health Repository, National Health Accounts

governments contribute to more than half of the total health expenditure (50% and above) in only 9 out of the 21 ARROW ICPD+20 review countries. These countries include Bhutan (84.6%) and Maldives(60.8%) in South Asia; China(54.3%) in East Asia; Malaysia (55.5%) and Thailand(75.0%) in South East Asia; and all the four Pacific countries - Fiji (70.2%), Kiribati (81.2%), Samoa (87.5%) and PNG (75.2%).

iii. Out-of-pocket expenditure on health as percentage of total health expenditure

"In 2005, about 80 million people faced catastrophic health expenses and some 50 million people were impoverished in the Asia Pacific region because of out-of-pocket payments, which are associated with poor health status and use of health services."

In addition, we see that in the 21 countries under review, the share of out-of-pocket expenditure on health is above 40%[94] in 11 of the 21 countries. These countries include Afghanistan (83%), Myanmar (81.1%), Bangladesh (63.4%), India (61.1%), Nepal (54.4%), Vietnam (57.6%), Philippines (54%), Lao PDR (51.1%), Pakistan (50.4%), Sri Lanka (44.9%) and Cambodia (40.3%). Among the ARROW ICPD+20 countries, the out-of-pocket expenditure is below 40% in 10 countries. These countries include Indonesia (38.2%), Malaysia (34.1%), China (36.6%), Maldives (28.2%), Fiji (19.6%), PNG (15.9%), Thailand (13.9%), Bhutan (11.9%), Samoa (7.7%), and Kiribati (0.15%). It also needs to be noted here that a low out-of-pocket expenditure would not mean better access to services, however, high out-of-pocket expenditure is a deterrent to the accessibility to services.[95]

iv. Efforts by member states to protect poor and vulnerable

Studies in South East Asia point to the attempts of respective countries to protect the poor and vulnerable through targeted schemes such as health equity funds. These health services for the poor were financed through tax revenue and additional support from donors as in the case of Lao PDR and Cambodia. Key barriers in the implementation of such schemes include the lack of proper identification of eligible poor people for the schemes, limited government resource allocation and poor coverage of all who need the assistance.

The Health Equity Fund (HEF) in Cambodia, mostly financed by donors, covered 68% of poor population in 2008. Studies have suggested that this fund has improved and expanded access to health facilities for the poor with an increase in hospital use by poor members of the fund. Financial sustainability and the government capacity to expand the services to include all poor people, however, remains a challenge.[96]

In Cambodia, the user fee policy introduced in 1996, created a barrier for the poor with the absence of an effective exemption system. A WHO study found 36% of HEF patients still borrowed money for current episode of care in addition to older debt. Borrowing for the current episode was much less among

Box 2

Economic barriers to accessing srh services

Case 1

"In Luang Prabang, a young mother with a nine month old baby and unemployed husband had been bleeding for 3 months. The family already borrowed 100,000 kips from a neighbour who charged 30000 kips interest. They could no longer afford treatment."

Source: Paphassarang, C.; Philavong, K.; Boupha, B.; Blas, E. 2002. "Equity, privatization and cost recovery in urban health care: the case of Lao PDR". Healthpolicy and planning vol. 17, Supp. 1: Pp. 78. Cited in Sundari Ravindran (2010). Reclaiming & redefining rights - Thematic Studies Series 2: Pathways to universal access to reproductive health care in Asia.ARROW. pp51

Case 2

"A 70 year old woman from vientiane suffering from frequent urination; was asked to do blood and urine tests in the hospital, which cost 100,000 kips, she could not afford and did not have the tests done."

Source: Paphassarang, C.; Philavong, K.; Boupha, B.; Blas, E. 2002. "Equity, privatization and cost recovery in urban health care: the case of Lao PDR". Healthpolicy and planning vol. 17, Supp. 1: Pp. 78. Cited in Sundari Ravindran (2010). Reclaiming & redefining rights - Thematic Studies Series 2: Pathways to universal access to reproductive health care in Asia.ARROW. pp51

Case 3

"We are very afraid of the high tariff ... everybody here knows that she (health personnel) is very expensive ... we did not know about the special letter to get discounts for the delivery at the public health centre ... and we had no time to arrange it." – Ani's husband

Source: Atashendartini Habsjah. (2010) Decentralisation and its impact on contraception access in Indonesia : A study from Bogor. Reclaiming & Redefining rights - Thematic Studies Series 3: Reproductive autonomy and Rights in Asia.2010.ARROW pp 75

Case 4

I had a miscarriage and the doctor did a d&c (dilation and curettage). For that i stayed in the private hospital for two days. The expenses were about rs. 5000. We didn't have such a huge amount to meet the expenses so my husband obtained a loan by pawning my jewellery (gold chain)
– abn 5

Source: P. Balasubramanian & TK. Sundari Ravindran.(2010) Utilisation of health facilities for reproductive health services:a Acase study from rural Tamil Nadu, India. Reclaiming & Redefining rights - Thematic Studies Series 4: Maternal Mortality and Morbidity in Asia. pp 87

HEF patients (4%) against those who were not supported by HEF (17%) in urban areas.[97] Whereas for Lao PDR, there is the provision of a comprehensive coverage for social health insurance, and a lower level of funding results in small service package.[98]

In Indonesia, a tax-financed targeted scheme for the poor reached out to 33.4% of total population by 2008, covering the poor and near poor. However, the full implementation is marred by fiscal constraints, thus, resulting in low levels of service provision and financial protection.[99]

In addition to this, conditional cash transfers have been initiated in some countries such as in India and Nepal. An assessment of these schemes in India showed an increase in the rates of institutional delivery among poorest women, which are the criteria for cash transfer. The assessment also showed that the poorest and most socially marginalised households did not benefit from the scheme as they did not meet the eligibility criteria such as birth order being higher than 2, and lack of documentation to support their economic status. In Nepal, the wealthiest 20% of women actually benefitted from 60% of conditional cash transfers.[100]

These above studies and data on health financing indicators point to the fact that while efforts are being made by respective countries to especially protect poor and vulnerable people, these continue to be insufficient to protect the poor from catastrophic health expenses. The ICPD Programme of Action called for the availability of universal access to a range of sexual and reproductive health services through the primary health care system and referral system.[101] Countries in the region should aim to arrive at an essential service package that includes key SRH services, with a plan to expand these services over time with additional resource allocation and making these services available to all, particularly poor and vulnerable especially adolescents, young people and women without any financial barriers. Countries, as part of the ICPD+20 review, have to increase government expenditure on health to provide a range of services including SRH services, covering all people who need the services. Data needs to collected on a disaggregated basis to show sub-accounts and the allocation of financial resources for different health needs of people including their sexual and reproductive health needs.

ENDNOTES

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4 The Gini co-efficient is a number between 0 and 1, where 0 corresponds with perfect equality (where everyone has the same income) and 1 (100 on the percentile scale) corresponds with perfect inequality (where one person has all the income and everyone else has zero income). Income distribution can vary greatly from wealth distribution in a country. List of countries by income equality. (2013, March 31). *Wikipedia, the free encyclopedia*. Retrieved April 8, 2013, from http://en.wikipedia.org/wiki/List_of_countries_by_income_equality

5 The incidence and depth of poverty have been declining fairly consistently. For income inequality, however, the trend is less clear. One means of assessing income equality is by considering the proportion of national production consumed by the poorest quintile of the population. The poorest quintile of the population receive a small share in a number of middle and high-income countries, such as Singapore (5.0%), Turkey (5.4%), Thailand (6.1%), the Islamic Republic of Iran (6.4%), and Malaysia (6.4%). Those in the poorest quintile do relatively better in India (8.1%), Pakistan (9.1%), and Bangladesh (9.4%). Similar results come from application of the Gini index, an aggregate measure of inequality that takes into account the complete distribution of income. Inequality in Bhutan, Cambodia, China, Georgia, Nepal, Papua New Guinea, Philippines, the Russian Federation, Singapore, Sri Lanka, Turkey, Turkmenistan, and Thailand are the highest according to the latest available data, with all the countries listed having a Gini index above 40. No clear regional trend emerges for inequality. Since the early 1990s, inequality seems to have increased in some countries such as Bangladesh, Cambodia, Nepal and Sri Lanka; while it has decreased in others, such as Indonesia, Islamic Republic of Iran, Malaysia and Thailand. For more

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18 A working definition of globalisation for the purposes of this section is: "*Globalisation is a multi-dimensional process characterised by:*

- *the acceptance of a set of economic rules for the entire world designed to maximise profits and productivity by universalising markets and production, and to obtain the support of the state with a view to making the national economy more productive and competitive;*
- *technological innovation and organisational change centred on flexibilisation and adaptability; the expansion of a specific form of social organisation based on information as the main source of productivity and power;*
- *the reduction of the welfare state, privatisation of social services, flexibilisation of labour relations and weaker trade unions;*
- *de facto transfer to trans-national organisations of the control of national economic policy instruments, such as monetary policy, interest rates and fiscal policy;*
- *the dissemination of common cultural values, but also the re-emergence of nationalism, cultural conflict and social movements."*

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53 Article 29 (1): Any disputes between two or more State Parties concerning the interpretation or application of the present Convention which is not settled by negotiation shall, at the request of one of them, be submitted to arbitration. If within six months from the date of the request for arbitration the parties are unable to agree

on the organisation of the arbitration, any one of those parties may refer the dispute to the International Court of Justice by request in conformity with the Statue of Court.

54 Article 2: States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake: (a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realisation of this principle; (b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women; (c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination; (d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation; (e) To take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise; (f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women; (g) To repeal all national penal provisions which constitute discrimination against women.

55 Article 5: State Parties shall take all appropriate measures (a) to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles of men and women

56 Article 9: State Parties shall take all appropriate measures to eliminate discrimination against women in the political and public life of the country and, in particular, shall ensure to women, on equal terms with men, the right: (2) State Parties shall grant women equal rights with men with respect to the nationality of their children.

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chapter 3

reproductive health and reproductive rights

3. REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS

Strides have been made in the area of reproductive health in the Asia and Pacific region with reductions in maternal mortality ratios, yet many issues such as the high unmet need for contraception and abortion remain contentious and sensitive. Obstacles in accessibility and affordability continue to undermine efforts to improve SRHR in the region and highlight the need for sustained efforts.

Providing reproductive health (RH) services is an important commitment in the ICPD Programme of Action (PoA). The ICPD PoA defines the components of reproductive health to include: family planning counselling, information, education, communication and services; education and services for pre-natal care, safe delivery and post-natal care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood; referral for family-planning services; further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV and AIDS which should always be available, as required; and active discouragement of harmful practices, such as female genital mutilation.

The PoA recommends that the full range of reproductive health services should be an integral component at the primary health care level: the level of health care system which is accessible to most of the population, especially women. However, this is not to limit the full range of services *only* to the primary health care.

- The ICPD PoA extensively covers contraception and family planning:removal of demographic targets (Paragraph 7.12);
- universal access to a full range of safe and reliable family-planning methods (Paragraphs 7.16 and 7.23);
- safer, affordable, convenient and accessible information and services (Paragraphs 7.19 and 7.23);
- free and informed choice, quality of care and service, privacy and confidentiality (Paragraph 7.23).

These paragraphs of the ICPD PoA refer to the right of individuals and couples both to services on contraception and self-determination to regulate fertility.

3.1 CONTRACEPTION

The politics of birth control have been so embedded within the psyche of the region that there are women's NGOs who feel that contraception has been regarded in turn as a tool of the North, big pharma, racist eugenicists, Malthusian environmentalists and economists.

We find it important to recognise that "[b]ecause of demographically driven politics, the effectiveness of contraception in preventing unwanted pregnancy sometimes appears to have become important only for the purpose of reducing high population growth rates. This is probably the single most important cause of feminist suspicion of methods like contraceptive vaccines, implants, and injecTables. Thus, something intrinsic to the purpose of contraception and that women very much need from contraception can come to be identified – by those who support women's right to contraception – as a negative quality."[1]

We need to acknowledge modern contraceptive methods offer women a range of choices of fertility control which are effective and safe and this in itself is empowering. In this section, we will analyse the available data on indicators related to total fertility rates (TFR), wanted fertility rates, contraceptive prevalence rates (CPR), contraceptive provision, non-use of contraception, unmet need, male contraception, and informed choice on contraceptive

Box 3
Contraception administration

Case 1
The doctor was busy with her routine with (out) patients... [The paramedic] took the client for IUCD insertion. After examining the client it was found that there were no instruments on the trolley... (Paramedic) started searching for instruments in the cupboard with the gloves on her hands. Meanwhile the client was lying exposed on the couch and pulled her own shawl on her exposed body due to embarrassment... the instruments (which were eventually located) were soaked in tap water in a kidney dish... while adjusting the size of the multiload the thread came out of the adjusting tube and the multiload and thread were on her (paramedic) hands. When suggested to use a new multiload the suggestion was ignored and the same iucd was inserted into the woman's uterus.

Source: US Agency for International Development (USAID).2006. Mid-term assessment of social marketing program (2003-2008). Washington D.C.: Cited in Sundari Ravindran (2010). Reclaiming & Redefining rights - Thematic Studies Series 2: Pathways to Universal Access to Reproductive Health Care in Asia. ARROW pp65

Table 5
Total fertility rates in 21 countries in Asia-Pacific

Country	Year		
	1995	2003	2012
East Asia			
China	2.0	1.8	1.6
South Asia			
Afghanistan	6.9	6.8	6.0
Bangladesh	3.3	3.0	2.3 (2011 DHS preliminary report)
Bhutan	5.9	5.0	2.3
India	3.39	2.85	2.68
Maldives	6.8	5.3	2.5
Nepal	4.6	3.1	2.6
Pakistan	5.4	-	4.1
Sri Lanka	2.5	2.0	2.4 (2007 Preliminary Report)
South-East Asia			
Myanmar	4.2	2.9	1.9
Cambodia	4.1	3.4	3.0
Indonesia	2.9	2.6	2.6
Lao PDR	4.7	4.1	3.2
Malaysia	3.6	2.9	2.6
Philippines	3.7	3.5	3.3
Thailand	2.1	1.9	1.5
Vietnam	2.7	1.9	-
Pacific			
Fiji	3.0	2.9	2.6
Kiribati	-	-	3.8
PNG	5.1	4.1	3.8
Samoa	4.5	4.1	3.8

Source: Bangladesh Demographic and Health Surveys (DHS) 1996-7, 2004, 2007 and 2011 preliminary report; Cambodia DHS 1998, 2005, 2010; India DHS 1992-3, 1998-9, 2005-6; Indonesia 1994, 2002-3, 2007; Maldives DHS 2009; Nepal DHS 2006,2011; Pakistan 1990-1, 2006-7; Philippines DHS 1998, 2003, 2008; Samoa DHS 2009; Sri Lanka DHS 2007; Vietnam DHS 1997, 2002, Kiribati DHS 2009. Human Development Report (HDR) 1995, 2003, 2012 for Afghanistan, Kiribati (1995 & 2003), Malaysia, Thailand, Fiji, Maldives (1995 & 2003), Myanmar, PNG, Lao Social Indicator Survey 2012 Preliminary Report, China, Sri Lanka (1995 & 2003), Samoa (1995 & 2003), Nepal Family Health Survey 1996

use of women in the 21 selected countries in the Asia-Pacific region. Based on the ICPD PoA and Beijing Platform for Action, the progress of these indicators is a reflection of the status of women's rights and their empowerment in the region.

i. Total Fertility Rates (TFR)

TFR represents the average number of children a woman would have in her lifetime if the current fertility rates remained constant. For data comparability, Demographic Health Surveys (DHS) are used and where unavailable, Human Development Report data (1995, 2003, 2012) on total fertility has been reported.

Based on the data presented in Table 5 , a number of trends are important to note. Overall, the region experienced steep

declines in fertility rates over the last two decades and this can be observed in all of the countries (with the exception of Afghanistan, Pakistan, Samoa and PNG). The decline was remarkably steep in Bhutan, Maldives, Nepal in South Asia as well as Myanmar in South-East Asia during this time period. A number of countries are experiencing below replacement level TFRs – of less than 2.1 – and these are mainly East Asia and in the Mekong region of South-East Asia - China, Myanmar, Thailand and Vietnam.

Fertility differentials have been noted between women living in rural settings and of those in urban settings. For example, in Lao PDR, women living in rural areas have a higher fertility rate (3.6) as compared to women in urban areas with 2.2 of TFR in 2012.[2]

The fertility rates also vary considerably depending upon the education levels of women. For example, in Afghanistan, based on 2010 data, women with higher education have 2.8 children as opposed to women with lower or no education having 5.3 children during their lifetime.[3] While in Laos, the differential is higher with 4.8 children of women with no education to 1.7 children of women with higher level of education.[4] Similar trends have been observed even in countries where the TFR has increased over the observed period. Kiribati has 3.5 TFR amongst women living in urban areas while those in rural areas have 4.1 TFR.[5] Similarly, the reverse trend between fertility and education levels can be seen as Kiribatian women with no education having 4.1 children while better educated women have lower number of children (3.3).[6]

BOX 4

Contraception Discontinuation

Case 1

"I used an IUD for 2 years, then i heard about a woman who died who was an IUD user. I got scared and went to ask for removal of the IUD and took pills for several months only. Now i do not use any method." – FP discontinuer aged over 25.

Source: Oukvong Vathiny and Kruy Kim Hourn (2010). Barriers to contraceptive use in Cambodia: a study in Takeo and Siem Reap. Reclaiming & Redefining Rights - Thematic Studies Series 3: Reproductive Autonomy and Rights in Asia.2010.ARROW pp 54

Case 2

"My wife was using pills because it is affordable for my family, but later on, her legs were paralysed and she could not walk. It took lots of money to cure this." – Married man.

Source: Oukvong Vathiny and Kruy Kim Hourn (2010). Barriers to contraceptive use in Cambodia: a study in Takeo and Siem Reap. Reclaiming & Redefining Rights - Thematic Studies Series 3: Reproductive Autonomy and Rights in Asia.2010.ARROW pp 54

Case 3

"One of my close relatives used an IUD as her spacing method. As result, she had vaginal bleeding and This caused a serious health problem for her until she died. As for my family and relatives, we will never again use iuds." – Married man.

Case 4

"Based on my experiences, i observed that some of my young FP clients have become infertile after they used the modern methods for two or so years, especially for those who had not yet had a baby." – Family planning service provider.

Source: Oukvong Vathiny and Kruy Kim Hourn (2010). Barriers to contraceptive use in Cambodia: a study in Takeo and Siem Reap. Reclaiming & Redefining Rights - Thematic Studies Series 3: Reproductive Autonomy and Rights in Asia.2010.ARROW pp 54

Case 5

"I heard that a woman developed a tumour in her uterus after using FP. Thus, i decided not to use any method." – FP discontinuer. aged 24 years.

Source: Oukvong Vathiny and Kruy Kim Hourn (2010). Barriers to contraceptive use in Cambodia: a study in Takeo and Siem Reap. Reclaiming & Redefining Rights - Thematic Studies Series 3: Reproductive Autonomy and Rights in Asia.2010.ARROW pp 56

Case 6

"When clients come for family planning services, I inform them at the counselling session of all methods which are available in this health facility. Then they decide the most preferred method." – FP service provider

Source: Oukvong Vathiny and Kruy Kim Hourn (2010). Barriers to contraceptive use in Cambodia: a study in Takeo and Siem Reap. Reclaiming & Redefining Rights - Thematic Studies Series 3: Reproductive Autonomy and Rights in Asia.2010.ARROW pp 54

Case 7

"Health care providers came to promote family planning in the community. It was a promotional activity. We can have the services free of charge in the health centre. As a result many women in this community got the services." – Married woman under 25.

Source:Oukvong Vathiny and Kruy Kim Hourn (2010). Barriers to contraceptive use in Cambodia: a study in Takeo and Siem Reap. Reclaiming & Redefining Rights - Thematic Studies Series 3: Reproductive Autonomy and Rights in Asia.2010.ARROW pp 54

Table 6:
Wanted Fertility Rates and Total Fertility Rates[10]

Name of Country	TFR	Wanted Fertility Rate
East Asia		
China	-	-
South Asia		
Afghanistan	-	-
Bangladesh	2.3	1.6
Bhutan	-	-
India	2.7	1.9
Maldives	2.5	2.2
Nepal	2.6	1.8
Pakistan	4.1	3.1
Sri Lanka	-	-
South-East Asia		
Myanmar	-	-
Cambodia	3.0	2.6
Indonesia	2.6 (2012 Preliminary Report)	2.2
Lao PDR	-	-
Malaysia	-	-
Philippines	3.3	2.4
Thailand	-	-
Vietnam	-	-
Pacific		
Fiji	-	-
Kiribati	3.8	2.7
PNG	-	-
Samoa	4.6	3.5

Source: Country Demographic & Health Survey(s) – Bangladesh DHS 2007; Cambodia DHS 2010; India DHS 2007; Indonesia DHS 2007 and 2012; Kiribati DHS 2009; Maldives DHS 2009; Nepal DHS 2011; Pakistan DHS 2007; Philippines DHS 2008; Samoa DHS 2009

Despite having fertility levels below replacement level and despite facing strict criticism, China is maintaining the one-child policy in order to "stabilise its population at about 1.39 billion people by 2015".[7] The government has relaxed the strict conditions of the one-child policy, by stating that couples may have a second child if both spouses are from one-child families or the first child has a disease that is non-inherited. Currently, in some provinces in China, rural couples are allowed to have a second child if the first child is a girl.[8] Ageing, as a population dynamic, is a key concern in some areas of the region, and governments need to tread carefully with regards to this to ensure that women's sexual and reproductive health and rights are not violated in trying to address the challenges of declining fertility rates.

ii. Wanted Fertility Rates compared to TFR.

Having control over one's fertility is an indicator of a woman's reproductive health rights. The difference between TFR and Wanted Fertility Rates (WFR)[9] as seen in Table 6 helps us measure the differences between how many children women wanted to have and how many they had. The WFR represents the level of fertility that would have prevailed in the three years preceding the survey if all unwanted births had been prevented. In this context, as observed in all the 10 countries with available comparable data, the WFR is lower than the TFR indicating that women's need for greater access to contraception are not being met.

In almost all the countries, there was a significant difference between TFR and WFR as shown in Table 6. In a number of countries, on the average, women were having at least one child more than they intended: Bangladesh, India, Nepal and Pakistan in South Asia; the Philippines in South-East Asia; and Kiribati and Samoa in the Pacific. These outcomes are exacerbated for women who are lesser educated, poorer and from the rural areas.

For example, in Kiribati, the WFR for women in rural areas is 2.9 but their total fertility rate is 4.1, whereas the WFR for urban women is 2.5 while the TFR is 3.5.[11] This is true even when the overall TFR is comparatively low as in Maldives, where the WFR for women in an urban environment is 1.9 compared to the TFR of 2.1, and the WFR for women from rural areas is 2.4 compared to the TFR of 2.8.[12]

In the Philippines, women from the lowest wealth quintile want to have 3.3 children but end up with a prevailing TFR of 5.3; and women from the highest wealth quintile have a WFR of 1.6 while they experience a TFR of 1.9 children.[13] This is also true in Nepal where women from the lowest wealth quintile have a WFR of 2.1 compared to the TFR of 4.1, and women from the highest wealth quintile have a WFR of 1 compared to the TFR of 1.5.[14] Women who come from the lowest wealth quintiles and live in rural and remote areas, as well as women who have little or no education, have lesser control over their fertility, Socio-economic inequities

Table 7:
Contraceptive Prevalence Rates and method selection (different method users as proportion of overall contraceptive users)

Country	Any method	Any modern method	Pill users	IUD users	InjecTables users	Implants users	Male condoms users	Female Sterilization users	Male Sterilization users	Any /other Traditional method users
East Asia										
China	84.6	84	1.4%	48.0%	0.0%	0.4%	10.0%	33.9%	5.3%	0.7%
South Asia										
Afghanistan	21.8	16.3	24.3%	5.9%	29.8%	0.4%	7.8%	6.4%		25.6%
Bangladesh	55.8	47.5	51.1%	1.6%	12.5%	1.3%	8.1%	9.0%	1.3%	15.1%
Bhutan	65.6	65.4	11.4%	5.6%	44.1%	0.2%	8.4%	10.8%	19.2%	0.3%
India	56.3	48.5	5.5%	2.1%	0.2%	-	9.2%	66.3%	1.8%	13.9%
Maldives	34.7	27	13.3%	2.3%	3.5%	1.4%	26.8%	29.1%	1.4%	22.5%
Nepal	49.7	43.2	8.2%	2.6%	18.5%	2.4%	8.7%	30.6%	15.7%	13.1%
Pakistan	29.6	21.7	7.1%	7.8%	7.8%	0.3%	23.0%	27.7%	0.3%	26.7%
Sri Lanka	68.4	52.5	11.8%	9.5%	21.6%	0.4%	8.3%	23.8%	1.0%	23.2%
South East Asia										
Myanmar	46.0	45.7	25.0%	4.5%	59.7%		0.8%	7.8%	0.8%	0.8%
Cambodia	40	27.2	31.5%	4.5%	19.8%	0.5%	7.3%	4.1%	0.2%	32.0%
Indonesia	61.9	57.9	22%	6.3%	51.5%	5.3%	2.9%	5.2%	0.3%	6.4%
Lao PDR	49.8	42.1	42.2%	3.2%	27.3%	0.2%	2.2%	9.2%	0.0%	15.5%
Malaysia	49.0	32.3	26.9%	8.5%			14.4%	Other modern method 15.9%		34.0%
Philippines	50.7	34	31.0%	7.3%	5.1%	-	4.5%	18.1%	-	32.9%
Thailand	79.6	77.5	43.9%	1.1%	17.5%	0.5%	2.8%	29.7 Other modern methods 0.3%	2.8%	2.7%
Vietnam	77.8	59.8	12.9%	39.8%	2.1%	0.2%	16.3%	5.0%	0.1%	22.8%
Pacific										
Fiji	-	-	-	-	-	-	-	-	-	-
Kiribati	22.3	18	5.8%	2.7%	34.1%	14.3%	1.8%	10.0%	2.2%	19.3%
PNG	35.7	-	-	-	-	-	-	-	-	-
Samoa	28.7	26.7	20.2%	0.7%	47.7%	-	0.7%	23.3%	-	7.0%

Source: Bangladesh Demographic and Health Surveys (DHS) 2007; Cambodia DHS 2005; India DHS 2005-6; Indonesia 2012 preliminary report; Maldives DHS 2009; Nepal DHS 2011; Pakistan 2006-7; Philippines DHS 2008; Samoa DHS 2009; Sri Lanka DHS 2007; Vietnam DHS 2002, Kiribati DHS 2009. Lao Social Indicator Survey Preliminary Report 2012.
All other countries: World Contraceptive Use 2012

are closely inter-linked with unintended births and it is important to ensure access to contraception to all groups of women giving especial attention to marginalised women and a lesser emphasis on policies and programmes which are based on just reduction of total fertility rates.

iii. Contraceptive Prevalence Rates

While the ICPD PoA specifies and calls for women's access to a range of contraceptives as part of the comprehensive reproductive health services, it does not specifically reflect on the contraceptive prevalence rate (CPR) as such. In addition to revealing information on the distribution of contraceptives, however, it can provide insight into women's contraceptive preferences and usage trends for particular contraceptive methods. This is significant because of the implications this has for contraceptive availability and demand helping to ensure that women are provided with a variety of options based on their needs.

According to World Health Organization (WHO), the "contraceptive prevalence rate is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time."[15]
However, it is also important to note that data on contraception in this region, with the exception of Cambodia and the Philippines, surveys only married women.

Box 5
Contraception and health service provision

Case 1
"My neighbours and i had tried every FP method ... pills, one-monthly injection, three-monthly injection, IUD ... some of us even inserted implants ... the midwives never explained to us why the one-monthly injection made my menstruation never stop, while the three monthly injection gave me a regular period ...and so we just tried every method. According to islamic teaching, intercourse is forbidden if a woman is menstruating, even just a spot of blood ... irregular menstruation complicated my sexual life." – Ibu Ade, health cadre, 43 years old.

Source: Atashendartini Habsjah. (2010) Decentralisation and its impact on contraception access in Indonesia : A study from Bogor. Reclaiming & Redefining Rights - Thematic Studies Series 3: Reproductive autonomy and rights in Asia.2010.ARROW pp-72z

As shown in Table 7,the countries with the highest contraceptive prevalence rates are China (84.6%), Thailand (79.6%), Vietnam (77.8%), and they are with CPRs near and or above 80%. It should be noted that CPR is also considerably high, at over 60%, in Sri Lanka (68%), Bhutan (65.6%), and Indonesia (61.9%). Countries with the lowest CPRs are Pakistan (29.6%), Samoa (28.7%), Kiribati (22.3%), and Afghanistan (21.8%).

An examination of the rest of the countries in the region reveals that in South Asia CPR is the highest in Sri Lanka at 68% and lowest in Afghanistan with a CPR of 21.8%. For those in South-East Asia, Thailand (79.6%) has the highest CPR while Lao PDR has the lowest at 38.4%.

China (84.0%), Thailand (77.5%) and Vietnam (59.8%) rank highest in the use of modern contraceptive methods[16] and it should be noted here that modern methods comprise the bulk of contraceptive use in these countries. However, in China the method mix is largely concentrated on female sterilisation and IUDs; and in Vietnam, a large proportion of contraceptive users use either IUDs or traditional methods. In both of these cases, policies and provider bias seem to influence women's choices in contraception, Traditional methods for contraception prevail in Malaysia (34.0%), the Philippines (32.9%), and Cambodia (32%). In almost all countries, a predominance of one or sometimes two methods prevailed.

This is largely due to provider bias (inference drawn from the respective DHS). In Bangladesh, the Philippines, Thailand, Lao PDR, Cambodia and Malaysia, oral contraceptive pills were the most predominant method. InjecTables predominate in Indonesia, Myanmar, Afghanistan and Bhutan.

It is also interesting to note that in Malaysia, just under half of the population using contraceptive methods relies on traditional methods. Traditional methods generally have higher failure rates and hence, lead to more unplanned pregnancies. Also, it points to questions about the possible lack of information and education amongst women about the available range of contraceptive methods and whether they are empowered enough to exercise the control over their fertility, if they desire.

Within contraceptive methods, it is interesting to look at the figures for permanent methods of contraception. In countries that strongly implement population control policies such as China and India, permanent methods and long-term methods such as sterilisation and IUDs are favoured. Table 7 shows that in the countries surveyed, China has the highest CPR of 84.6% and the most frequently used methods were IUD (48% of all methods) and female sterilisation (33.9% of all methods). India, on the other hand, has the highest rate of female sterilisation in the region, 66.3% of all methods, i.e. two-thirds of all contraceptive users are sterilised women. This is probably in line with the strict population policies that both of these countries have.

Table 8:
Male contraception as percentage of total contraception

Country	Condom users as proportion of all contraceptive users	Male Sterilisation users as proportion of all contraceptive users	Withdrawal method as proportion of all contraceptive users
East Asia			
China	10.0%	5.3%	0.4%
South Asia			
Afghanistan	7.8%		6.67%
Bangladesh	8.1%	1.3%	5.2%
Bhutan	8.4%	19.2%	
India	9.2%	1.8%	4.4%
Maldives	26.8%	1.4%	12.1%
Nepal	8.7%	15.7%	10.9%
Pakistan	23.0%	0.3%	57.8%
Sri Lanka	8.1%	1.0%	8.0%
South-East Asia			
Myanmar	0.8%	0.8%	0
Cambodia	7.3%	0.2%	20.8%
Indonesia	2.9%	0.3%	3.7%
Lao PDR	1.1%	0.0%	
Malaysia	14.4%		7.9%
Philippines	4.5%	-	19.3%
Thailand	2.8%	2.8%	
Vietnam	16.3%	0.1%	8.1%
Pacific			
Fiji	-	-	
Kiribati	1.8%	2.2%	4.5%
PNG	-	-	-
Samoa	0.7%	-	2.1%

Source: Country DHS Surveys - Bangladesh, Cambodia, India, Indonesia, Kiribati, Maldives, Nepal, Pakistan, Philippines, Samoa, Sri Lanka; World Contraceptive Use 2012: Afghanistan, Myanmar, China, Malaysia, PNG, Thailand, Vietnam; Lao Social Indicator Survey Preliminary Report 2012.

In addition, Thailand has the third highest rate of female sterilisation, 29.7% of all methods. Nepal also has a large proportion of sterilisation – female sterilisation comprising 30.6% of all methods. Male sterilisation stands at 5.3% of all methods in China, Bhutan (19.2%) and Nepal (15.7%) but negligible in all other countries. We found it noTable that after 20 years of the ICPD, women continue to shoulder the burden for contraception, especially permanent methods such as sterilisation. This also raises the question on whether the target-driven population control policies aimed at women have really been phased out. It is also important to note that when CPRs are analysed in comparison to TFRs, Myanmar, Malaysia and Maldives experience low usage of modern methods of contraception, but at the same time, total fertility rates in these countries are low. Hence, using TFR as an indicator to support the claim that women have access to contraceptive services is problematic and there needs to be a more detailed inspection on how these societies are transitioning. Overall fertility rates also experience sharp decreases due to migration, as noted in Nepal and most probably applicable to Myanmar due to the prolonged conflict and in Malaysia 16% of women are never-married and never had children, and this impacts the overall TFR.

iv. Male contraception as % of total contraception

Male contraception methods comprise mainly of condom usage and male sterilisation. The importance of male contraception rates indicate shared responsibility for contraception, shared reproductive burden and one form of equality within relationships.

As shown by Table 8, in all countries, male contraception is at appallingly low rates, and is nowhere near the desired ideal of having both men and women share equal responsibility over sexual and reproductive health decisions as couples. Table 8 shows that male contraception rates are abysmally low in all of the countries indicated. When ranking contraceptives according to their ability to protect against infection and prevent pregnancy, condoms routinely out rank other methods as condoms are the safer choice and the only method which provides dual protection,[17] yet condom usage remains low.

Condom usage is highest in Maldives and Pakistan (26.8% and 23% of all contraceptive methods) with Vietnam following at 16.3%. Condom use stands lowest in Samoa (0.7%), Myanmar (0.8%), and Kiribati (1.8%), and Thailand (2.8%), which are all under 3%. Although Maldives and Pakistan have very low CPR rates, it is surprising to note that condom usage in Maldives and Pakistan, contribute 26.8% and 23% of all contraceptive methods, respectively. However, these numbers are based on an overall low CPR.

In Cambodia, despite increasing HIV prevalence in new infections among husband-wife/intimate partners (husband-to-wife-transmission is the main route of HIV transmission, causing two-fifths of new infections), the use of male condom stands at 7.3% among all contraceptive methods.[18] In Cambodia, condom use between husband and wife is culturally viewed as implying mistrust and makes it difficult for the propagation and popularisation of the method, although it is much needed. In Lao PDR, condom usage contributes just 1.1% overall of all modern methods.[19] In Indonesia, the figure is quite similar – 2.1% among all contraceptive methods.

In the Philippines, one-fifth of women reported that their husbands preferred more children, so very few of them use condoms, or take the responsibility of contraception. They also tend to prefer having more children, unlike the vast majority of married women (81%) who either wanted to space their next birth or to limit childbearing altogether."[20]

Male sterilisation is highest in Bhutan and Nepal. At 5.3%, China is only the third country with male sterilisation above 5%, and in all other countries, male sterilisation is recorded at negligible rates. In Thailand, male sterilisation is low despite government attempts to promote male contraception by providing vasectomies free of charge at government hospitals.[21]

Male involvement, as equal partners, in decision-making on reproduction as stipulated in the ICPD PoA seems to have had limited headway in all 12 countries in the past 15 years.

v. Contraceptive use: Informed choice

'Informed choice' with regards to contraceptive methods used refers to the information that is available and provided to those seeking contraceptives. Based on this information, individuals make their decision on which contraceptive to use, thus, making it an important sexual and reproductive rights indicator. Unfortunately, the importance of this indicator is not commonly recognised when analysing the supply/demand of contraceptives and its use. Therefore, not much data is available on this in the DHS(s) of the 21 countries surveyed. Details are shown in Table 9.

The nine countries for which this data is available, the sub-indicators used for trend analysis in this report consist of: information on the full range of methods including traditional and male methods; information on side-effects of all methods and the appropriate course of action; and information on the efficacy of each of the methods.

Generally, more women in Cambodia, the Philippines, Nepal, Samoa and Kiribati received information on all three categories. Less women in Maldives, Pakistan, Indonesia and India received the same information. It may be that in countries where the introduction of contraceptive services are newer, such as Cambodia and Nepal, the more efficacious method to ensure uptake and continuity is through providing comprehensive information. However, in the countries such as India and Indonesia, where there have always been older, stricter

Table 9:
Rate of contraceptive use based on informed choice

Country	Percentage who were informed about side effects or problems of method used	Percentage who were informed about what to do if experienced side effects	Percentage who were informed by a health worker of other methods that could be used
East Asia			
China	-	-	
South Asia			
Afghanistan	-		
Bangladesh	-		
Bhutan	-		
India	32.2	26.0	27.9
Maldives	45.3	42.6	53.7
Nepal	63.3	58.7	54.3
Pakistan	33.4	29.1	37.7
Sri Lanka	-		
South East Asia			
Myanmar	-		
Cambodia	75.7	74.2	71.8
Indonesia	35.3	37.0	42.8
Lao PDR	-		
Malaysia	-		
Philippines	67.6	66.6	63.2
Thailand	-		
Vietnam	-		
Pacific			
Fiji	-		
Kiribati	58.7	47.7	49.0
PNG	-		
Samoa	62	44	52

Source: Country DHS Surveys: India, Indonesia,, Kiribati, Maldives, Nepal, Pakistan, Philippines, Samoa

population control policies in place, less information is made available.

In countries with lower levels of information, which are mostly South Asian countries, only about one-third of modern contraceptive method users were informed about the side effects from or problems with their methods.[22,23,24,25] However, this is an important piece of information to disseminate, as one of the key reasons for non-use of contraception is fear of side effects. In some countries, it was noted that findings on informed choice varied by method. For example, in Cambodia[26] and Pakistan,[27] users of IUDs and implants were most likely to have received all three types of information relating to informed choice, while in Maldives "female sterilisation users generally reported receiving less information than users of other methods."[28] However, in some countries, this trend was reversed. For example, in Kiribati - users IUDs were least likely to receive any of the three types of information[29] and in Samoa, "a large majority of women who were sterilised (94%) were informed that sterilisation is permanent."[30]

It is important to highlight here that women's choices of the use of contraceptive methods can, in some cases, be highly influenced by health personnel they consulted, the quality of services easily available or by the prevalent public service campaigns in the country.[31,32,33] For example, in Kiribati , "a high percentage (91%) of clients attending a family planning clinic are informed of side effects and problems of other methods, as compared with clients attending a government hospital (59%) or government health clinic (61%)."[34]

vi. Unmet Need for Contraception

Unmet need for contraception is defined as "the number of women with unmet need for family planning. Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child."[35] Unmet need is expressed as a percentage of women of reproductive age who are married or in a union or sexually active but are not using any method of contraception. Details are shown in Table 10.

The concept of unmet need is important as it shifts the focus from the limits on family size set by the government to rightly focus "on the 'need' for contraception based on whether and when a woman wants a child."[36]

However, there are certain limitations as to how the data for unmet need for contraception is being sampled and calculated in the national surveys. One limitation is the fact that the sample population for this indicator in most countries in the region, with the exception of Cambodia and the Philippines, is married, heterosexual women and not single, unmarried women, which does not accurately represent a holistic picture of unmet need in a country. Another limitation arises from an assumption that all current users of contraceptive methods are having their needs 'met' when there are examples of women using a particular contraceptive method due to provider bias or government policy and not because of their free choice as earlier discussed.

Lastly, the current analysis around contraception is primarily focused on pregnancy prevention and is not heavily inclusive of the need for reproductive healthcare in general, which also incorporates contraception to prevent STIs.[37] Despite these limitations, it still produces an important analysis for contraceptive as part of the comprehensive reproductive health package service – its provision, quality and accessibility.

Box 6
Poverty, religion and informal charges: barriers to surgical sterailisation

Case 1
Our family is very poor. We do not even have a place to live in. My husband and i are wage workers and we don't, i do not know the age at which i got married. I have 4 boys and three girls. My eldest son should be 15-16 years old. The second child is 12 years. The remaining 5 children are less than 7 years old.My last child was born 6 months ago. I had my delivery at home. All my children were born at home. My mother-in-law was with me and others were not present. The nurse asked me to come to vallipuram phc but i did not go. I had pain and delivered the child there was no time to go to the hospital.

Then after a few days, the area nurse took me for operation. I had my tubectomy operation in Tirukalukundram (chc). I stayed there for 7 days. I spent rs. 1500. I have not yet repaid the debt. We spent rs. 1000 On travel and food. The nurse and 'ayyamma' got rs. 500 From me. The care they provided was good. On the 7th day when i was coming home they gave me rs. 600 As government money.

I am getting older and i cannot take care of my children. These many children are not necessary for us. I did not wish to get into debt by going in for family planning operation. I should have done it after the birth of the third child. But what to do? If i go i need to spend money, what to do?

Source: P. Balasubramanian & TK. Sundari Ravindran.(2010) Utilisation of health facilities for reproductive health services: A case study from rural Tamil Nadu, India. Reclaiming & Redefining Rights - thematic studies series 4: Maternal Mortality and Morbidity in Asia.Pp 83

Table 10:
Unmet need for contraception

Country	Year (%)		
	1995	2003	2012
East Asia			
China	-	-	2.3 (National Survey 2001)
South Asia			
Afghanistan	-	-	-
Bangladesh	19.7(DHS 1996-97)	15.0 (DHS 2004)	11.7 (DHS 2011-12)
Bhutan	-	-	-
India	20.3 (DHS 1992-93)	16.1(DHS 1998-99)	13.9 (DHS 2005-06)
Maldives	-	-	28.6 (DHS 2009)
Nepal	32.4(DHS 1996)	24.7 (DHS 2006)	27.0 (DHS 2011)
Pakistan	30.5 (DHS 1990-91)	-	25.2 (DHS 2006-07)
Sri Lanka	-	-	7.3(2006-07 DHS)
South East Asia			
Myanmar	-	-	19.1(MFRHS 2001)
Cambodia	33.0 (DHS 2000)	25.3 (DHS 2005)	23.5 (DHS 2010/11)
Indonesia	15.3(DHS 1994)	13.2(DHS 2002-03)	11.4(DHS 2012)
Lao PDR	-	27.3(LRHS 2005)	20 (LSIS 2012)
Malaysia	-	-	-
Philippines	24.6(DHS1998)	22.5 (DHS 2003)	22.0 (DHS2008)
Thailand	-	-	3.1(RHS 2006)
Vietnam	7	6.6 (DHS 2002)	-4.3 (2010-11 MICS)
Pacific			
Fiji	-	-	-
Kiribati	-	-	-
PNG	-	-	-
Samoa	-	-	47.7(DHS 2009)

Source: Bangladesh Demographic and Health Surveys (DHS) 1996-7, 2004, 2007 and 2011 preliminary report; Cambodia DHS 1998, 2005, 2010; India DHS 1992-3, 1998-9, 2005-6; Indonesia 1994, 2002-3, 2012; Lao PDR (LRHS 2005, LSIS 2013); Maldives DHS 2009; Nepal DHS 2006,2011; Pakistan 1990-1, 2006-7; Philippines DHS 1998, 2003, 2008; Samoa DHS 2009; Vietnam DHS 1997, 2002, Kiribati DHS 2009.; World Contraceptive Use 2003, 2011 for Afghanistan, Kiribati (1995 & 2003), Malaysia, Thailand, Fiji, and Maldives (2003), Myanmar, PNG, China, Sri Lanka, and Samoa (2003); and Nepal Family Health Survey 1996.

Table 11:
Unmet Need for Spacing and Limiting

Country	Spacing	Limiting	Unmet Need
East Asia			
China	-	-	-
South Asia			
Bangladesh 2011-12	4.4	7.3	11.7
India 2005-06	6.1	7.8	13.9
Maldives 2009	15.0	13.6	28.6
Nepal 2011	9.6	17.4	27
Pakistan 2007	10.8	14.4	25.2
Sri Lanka 2007	3.5	3.8	7.3
South East Asia			
Cambodia 2010-11	6.6	16.9	23.5
Indonesia DHS 2012 (2012 Prel)	4.5	6.9	11.4
Lao PDR (LSIS 2012 Prel)	8	12	20
Philippines 2008	8.5	13.5	22.0
Pacific			
Kiribati 2009	14.4	13.6	28
Samoa 2009	20.6	27.2	47.7

Source: Country DHS Surveys

Indonesia's 2012 Preliminary Report presents unmet need for both the previous definition and the revised definition by Bradley et al (2012) for it "to be simpler and to improve interpretation of trends over time."[38] Using the new definition, the total unmet need is 11% among of currently married women age 15-49; 4.5% as a result from a desire to delay the next birth for two or more years; and 7% from a desire to limit the number of children.
This data is available only for 14 countries out of the 21 surveyed here. Unmet need is highest in Samoa followed by Kiribati, Laos PDR, Cambodia, Pakistan, Nepal and Philippines. Unmet need is the lowest in Thailand, Vietnam and Sri Lanka, and virtually non-existent in China. This is shown in Table 11
The differential trends in unmet need of women in these countries, according to their wealth, area of residence, age and education, provide an in-depth view of the effects of the inequality in socio-economic status of these women.

Unmet need is higher among women living in rural areas compared to those in the urban areas as evident in Pakistan,[39] India,[40] and Lao PDR.[41] Unmet need is also highest among the youngest age group of women (15-19 years) in Vietnam[42] and the Philippines.[43] Unmet need for spacing purposes is higher among younger women in Pakistan[44]and India,[45] while unmet need for limiting births is higher among older women in Pakistan.[46]

In Samoa, where unmet need is the highest, these differentials are not as obvious indicating that the unmet need of women for contraception prevails across the board.[47] According to a World Bank report, there are two ways in which unmet need can be interpreted as an indicator for women's reproductive rights. Firstly, that lower rates of unmet need can be a sign of women's preference for larger families in which case contraceptive use will also be lower.[48]

This is observed in Myanmar where CPR is 41% and only 19% of need is unmet. Secondly, in societies with a tendency for smaller families, the increasing demand for contraception can lead to a higher unmet need.[49] For example, in Nepal, there is a 44% difference between WFR and TFR, and there are higher levels of unmet need for contraception as well (24.6%). Similarly, in Kiribati, the percentage difference between WFR and TFR is 40.7% while the unmet need is also high at 28%.
Given these trends, it is important to further explore the reasons for unmet need in these countries.

One of the most common reasons given by married women with an unmet need for not using contraception is associated with the supply of methods and services and within this category, concerns about the side effects, health consequences and inconvenience of methods were the most prominent reasons. The prevalence of these concerns is particularly high in South and South-East Asia.[50]

Table 12:
Reasons for non-use of Contraception

Name of the Country	Fertility related	Fatalism	Opposition to use	Respondent opposed	Husband opposed	Others opposed	Religious prohibition	Lack of knowledge	Method related	Health concerns	Fear of side effects
East Asia											
China	-	-	-	-	-	-	-	-	-	-	-
South Asia											
Afghanistan	-	-	-	-	-	-	-	-	-	-	-
Bangladesh	74	14.6	8.3	5.3	3.0	0	3.8	0.3	-	1.7	3.7
Bhutan	-	-	-	-	-	-	-	-	-	-	-
India	-	5.9	-	5.5	4.4	0.3	5.0	0.4	-	5.0	4.3
Sri Lanka	-	-	-	-	-		-	-	-	-	-
Maldives	19.7	-	45.3	38.8	-	0.2	0.8	0.4	19.1	12.0	5.5
Nepal	1.5	-	-	-	1.5	-	-	-	6.1	-	24.2
Pakistan	-	-	-	7.7	-	0.4	5.0	0.8	-	3.6	5.4
South-East Asia											
Cambodia	46.6	-	2.0	1.2	0.6	0.2	0.1	0.7	42.1	35.8	4.0
Myanmar	-	-	-	-	-	-	-	-	-	-	-
Lao PDR	2.1	1.6	-	-	11.8	0.2	-	-	-	11.8	-
Malaysia	-	-	-	-	-	-	-	-	-	-	-
Philippines	49.9	-	9	2.8	-	0.1	2.9	0.6	39.2	20.9	13.9
Indonesia	1.1	0.4	-		0.6				7.4	10.6	18.1
Thailand	-	-	-	-	27.0	-	-	-	-	-	-
Vietnam	17.2	-	-	-	-	2.0	-	1.9	-	6.7	2.9
Pacific											
Fiji	-	-	-	-	-	-	5.0	0.4	-	5.0	4.3
Kiribati	25.1	-	12.5	4.9	-	0.4	28.8	2.9	-	7.4	10.8
Papua New Guinea	-	-	-	-	12.8	-	-	-	-	-	-
Samoa	16.8	-	59.2	56.9	8.6	-	0.5	1.3	19.3	14.1	1.7

Source: Demographic & Health Survey(s) of countries surveyed.

If most unmet need is caused by women's concerns about side effects, health consequences and inconvenience of methods of contraception, it is also important to look closely at other reasons for non-use of contraception.

vii. Non-use of contraception

The most common reasons given by women for non-use were associated with fertility-related reasons, fear of side effects, opposition to use be it partner-opposed, religion or culture opposed, and lack of knowledge of and access to modern contraceptive methods.[51] It is observed that in South Asia the main reasons included "opposition by the woman and/or partner followed by infrequent sex."[52] Whereas in South East Asia, "health concerns and side effects were cited most, followed by infrequent sex."[53]

The data available for this indicator is for only 11 out of the 21 countries surveyed (as shown in Table 12). In countries such as Bangladesh, Cambodia, Philippines, Vietnam and Kiribati where fertility-related reasons are higher, it is important to note that these numbers include women who do not want to or do not need to use contraception at all. The reasons for their non-use of contraception includes: "they are not having sex, having infrequent sex, are menopausal, are infecund, or are post-partum amenorrheic; or because they want to have children."[54] However, it is interesting to note that in the Philippines, where fertility-related causes is one of the highest in the region, it is because 15.5% of the respondents state that they "want to have as many children as possible."[55]

Opposition to contraceptive use by husband is a key factor in Thailand (27.0%), Papua New Guinea (12.8%) and Lao PDR (11.8%); while in Samoa (56.9%) and Maldives (38.8%), the respondent themselves oppose the use of contraceptives. At the same time, it is to be noted that there is a large number of respondents in Samoa and Maldives stating non-use of contraception because of health concerns. It is also the case in Cambodia and in the Philippines, where method-related reasons rank highly for non-use of contraception. This calls for policy actions and systematic interventions to widely disseminate information on contraception use and issues around it, including counteracting myths and misconceptions. Ma king available a range of methods for all women will also help address method-related reasons for non-use.

Religious prohibition is another key factor in non-use of contraception, most noTable in Kiribati (28.8%) and in Pakistan, although the respondents did not classify the reason for non-use as prohibited by religion, a vast majority (28.4%) stated that fertility and child bearing is "up to God."[56]

Viii. Emergency Contraception

Emergency contraception was first made available by prescription in 1998 although the technology behind it is decades older.[57] There is a need to realise the absolute necessity of ECP – especially due to the fact that one of the key reasons for non-use is 'infrequent sex.' Post-coital methods, for women who consider themselves having infrequent sex, are essential for prevention of unintended pregnancy.

The use of emergency contraception is not currently captured in the Contraceptive Prevalence Rates (CPR), however, it is included as part of the 'ever-use of contraception' data within the national health survey methodologies.

Table 13 indicates that the countries with available data reveal there is a generally low level of knowledge about emergency contraception throughout the region. We discovered that between 70% to 95% of women do not know about contraception.

In Maldives, Nepal, and Kiribati, as example of countries where comparable data regarding emergency contraception is available, it is noted that the knowledge of contraception rate is highest. It is possible that this is a reason for use of emergency contraception. In Nepal, it is noted that "the extent of and patterns in knowledge of a modern method of family planning among currently married and never-married women are similar, except that never-married women are slightly less knowledgeable than currently married women about contraceptive methods other than emergency contraception."[58] It is also interesting to note that in India and Nepal, this knowledge is higher amongst men than in women.

In the ever-use of emergency contraception, all countries for which the data exists, a low usage of emergency contraception is noted. This could probably be attributed to the ongoing controversy around possible interference of EC pills with a fertilised egg, when taken later in the 72 hour grace period.[59] EC, if endorsed as a reproductive health service package, can tremendously reduce unmet need for contraception, reduce unintended/unwanted pregnancies as well as give women more control over their fertility.

Table 13:
Knowledge of Emergency Contraception and Ever-use of Emergency Contraception

Name of the country	Knowledge - All Women/ ever married women	Knowledge- All Men	Ever use of Emergency Contraception All Women/ever married women
East Asia			
China	-	-	-
South Asia			
Afghanistan	13.2	-	-
Bangladesh	-	-	-
Bhutan			
India	10.8	20.3	0.6
Maldives	28.9	-	0.6
Nepal	28.8	38.7	
Pakistan	17.8	-	0.9
Sri Lanka	-	-	-
South-East Asia			
Myanmar	-	-	-
Cambodia	11.3	-	-
Indonesia	6.3	-	0.3
Lao PDR	-	-	-
Malaysia	-	-	-
Philippines	9.7	-	0.3
Thailand	-	-	-
Vietnam	-	-	-
Pacific			
Fiji	-	-	-
Kiribati	26.4	21.0	0.5
PNG	-	-	-
Samoa	5.8	3.7	0.2

Source: Country Demographic & Health Survey(s).

SUMMARY

In all countries, women with lower or no education, poor women, as well as women who lived in remote and hard-to-reach areas had less access to contraception and hence, less control over their fertility in comparison to their educated and wealthier urban counterparts. Socio-economic inequities are closely inter-linked with higher rates of unintended births and it is important to ensure access to contraception to all groups of women.

Progress on contraception still seems to be driven by population policies. Ensuring access to a full-range of contraceptive methods will help shift this to focus more on women's needs.

Informed choice on contraception methods and side effects have not been emphasised in service provision and hence, have been very poorly provided in all countries. However, this is most probably the one factor that would be able to address the causes of unmet need such as concerns about side effects, health consequences and inconvenience of methods of contraception as well as non-use of contraception due to opposition.

Across 21 countries, it is important to consider the effect that migration has on fertility reduction, although it has not been extensively documented within the DHS. In Nepal, it has been documented that "[f]ertility reduction [is] also influenced by internal and external displacement of people due to political insurgency as well as migration...."[60] This is probably applicable to many countries in the region, which are experiencing low TFRs and low CPRs, simultaneously.

Across all the countries, the low numbers of both male sterilisation and of condom use reflect the gender power imbalance in negotiating the responsibility of bearing the burden of both pregnancy prevention and disease prevention. Cultural and gender norms about roles and values of men and women in sexual relationships and perceptions about male and female sexuality all play a key role in these low rates.

It may also be important to remember that the DHS deals with married women, and condom use within a marriage may also signify a lack of trust between partners, and hence, has a different value associated with it in the responses that women may have given to their surveyors. Male involvement, as equal partners, in decision-making on reproduction – male sterilisation and male contraception – needs to be encouraged.

The use of emergency contraception (EC) is not currently captured in the Contraceptive Prevalence Rates (CPR), however, it is an essential method for women. EC, if endorsed as a reproductive health service package, can tremendously reduce unmet need for contraception, reduce unintended/unwanted pregnancies as well as give women more control over their fertility.

3.2 PREGNANCY & CHILDBIRTH -RELATED MORTALITY AND MORBIDITY

Countries in the region are making progress in reducing mortality and increasing coverage of effective health interventions. Complications relating to pregnancy and childbirth, however, continue to remain as leading causes of mortality for women of reproductive age in many countries in the region, especially in countries such as India, Pakistan, Indonesia, Bangladesh, Afghanistan and Lao PDR, which are continuing to report high numbers of maternal deaths.[61]

The irony of these premature maternal deaths and disabilities is that most maternal deaths are avoidable, as the health care solutions to prevent and manage these complications are well known.[62,63]

The International Conference on Population and Development (ICPD) Programme of Action (PoA) urges countries to strive to affect significant reduction in maternal mortality by the year 2015: *A reduction of maternal mortality by one half of 1990 levels by the year 2000 and a further one half by the year 2015. Further to this the PoA notes that countries with intermediate levels of mortality should aim to achieve a maternal mortality rate below 60 per 100,000 live births by the year 2015, and countries with highest levels of mortality should aim to achieve by 2015, a maternal mortality rate below 75 per 100,000 live births.*[64]

Based on the maternal mortality estimates developed by WHO, UNICEF, UNFPA, and the World Bank in 2010, only seven of the twenty one Asia-Pacific countries are on track to achieving this target.[65]

The ICPD PoA further calls upon countries to:

- achieve a rapid and substantial reduction in maternal morbidity and mortality (ICPD PoA para 8.20);
- reduce the differences observed between developing and developed countries and disparities within countries, between geographic regions, socio-economic and ethnic groups should be narrowed (ICPD PoA para 8.20 and para 8.22);
- reduce greatly the number of deaths and morbidity from unsafe abortion (ICPD PoA para 8.20);
- improve health and nutritional status of women, especially of pregnant and nursing women (ICPD PoA para 8.20);
- expand the provision of maternal health services in the context of primary health care, based on the concept of informed choice, should include education on safe motherhood, effective prenatal care, maternal nutrition programmes, adequate delivery assistance, provide for obstetric emergencies, referral services for pregnancy, childbirth and abortion complications, post-natal care and family planning and assist all births by trained persons (ICPD PoA para 8.22);

- take measures to prevent, detect and manage high-risk pregnancies and births, particularly adolescents and late parity women (ICPD PoA para 8.23).

The above paragraphs underpin a range of human rights directly implicated by maternal mortality and morbidity, namely, the "right to life, to be equal in dignity, to education, to be free to seek receive and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health."[66]

Based on the International Statistical Classification of Diseases and Related Health Problems, 10th revision, WHO defines maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."[67]

This section will first look at current measurements of maternal mortality and prevention of maternal deaths, and the promotion of maternal health by monitoring the following key indicators:

The indicators, **maternal mortality ratio (MMR)** and **the lifetime risk of maternal death,** provide a measure of the extent of maternal deaths and the risk associated with childbirth for women of reproductive age in respective countries. These indicators will help assess the magnitude of maternal deaths in the region. At the same time, causes of maternal deaths are also discussed.

The indicators relating to preventing maternal deaths such as **emergency obstetric care (EmOC)**, **skilled attendants at birth**, as well as **post-partum care**, will help assess the extent to which these critical interventions are available in the countries under review and their access and utilisation in the ARROW ICPD+20 countries.

The indicator relating to the promotion of maternal health, which is **utilisation of antenatal care at least one visit and 4 visits**, is another key maternal health and well-being indicator will help assess the availability of antenatal care services for pregnant women in the ARROW ICPD+20 countries under review.
The situation of **maternal morbidities** will be assessed using indicators relating to maternal morbidity conditions such as obstetric fistula and uterine prolapse.

Finally, this section also looks at **adolescent pregnancies** in the region. Overall, the above set of key maternal health indicators aim to provide an assessment of the extent of improvements in the reduction of maternal deaths in the respective countries, as well as the availability and access to critical interventions that can prevent maternal deaths and promote maternal health.
There is a need to distinguish between maternal death and maternal health because a woman's health status does not a guarantee that she will have a risk-free delivery. This distinction between preventing maternal deaths and promoting maternal health has significant implications on setting priorities, framing strategies, designing programs, and on choosing indicators to use for monitoring and evaluation of the reduction in maternal mortality.[68]

While improvements in maternal health and well-being of a pregnant woman, including the overall physical, mental, and emotional health during and before pregnancy, is very important, further efforts are needed in terms of interventions such as universal access to emergency obstetric care (EmOC) during childbirth, access to skilled birth attendance and post-partum care which will guarantee reduction in maternal mortality. All pregnant women are at risk of developing complications at any time during pregnancy, at delivery, or in the post-partum period. At the same time, adequate allocation of financial, technological and human resources to these maternal health interventions need to be in place.

i. Measurements of maternal mortality.

"The ICPD PoA urges countries to strive to effect significant reductions in maternal mortality by 2015: Countries with intermediate levels of mortality should aim to achieve by the year 2015, MMR of below 60 per 100,000 live births. Countries with highest levels of mortality should aim to achieve by 2015, a maternal mortality of below 75 per 100,000 live births. However all countries should reduce maternal morbidity and mortality to levels which no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed (ICPD PoA para. 8.21)."

In the May 2011 report, the high-level Commission on Information and Accountability for Women's and Children's Health, formed as part of the UN Secretary General's Global Strategy for Women's and Children's Health, recommended institutional arrangements for effective reporting on the health women and children. The report suggests that effective reporting requires an established and efficient system for registration of births, deaths and causes of deaths, combining data from facilities, administrative sources and surveys.[69]

a. Maternal Mortality Ratio (MMR)

Globally, the MMR declined between 1990 and 2010 with the highest reduction in East Asia (69%), while in other sub-regions of Asia-Pacific it declined by 64% in South Asia and 38% in the Oceania (the Pacific) and 35% in Central Asia.[70,71] While the number of women dying due to pregnancy and childbirth related complications has nearly halved (47%) in the last two decades from 543,000 in 1990 to 287,000 in 2010, it needs to be noted that a significant 287,000 women still die from prevenTable

Table 14:

Comparison of 1990, 1995, 2000, 2005, and 2010 estimates of maternal mortality ratio (MMR, deaths per 100 000 live births) by country based on the estimates developed by WHO, UNICEF, UNFPA, and World Bank; most recent national estimates and lifetime risk of maternal death 2010; whether on track to meet ICPD target in 2015

Country	1990	1995	2000	2005	2010	Range of MMR uncertainty	Maternal deaths per 100,000 live births (national estimates) **	Lifetime risk of maternal death: 1 in	ICPD targets for 2015 met?
East Asia									
China	120	84	61	45	37	(23 - 58)	31.9 (China MDG Progress Report 2010)	1700	Yes
South Asia									
Afghanistan	1300	1300	1000	710	460	(250 - 850)	327 (AMS 2010)	32	No
Bangladesh	800	560	400	330	240	(140 - 410)	194 (BMMS 2010)	170	No
Bhutan	1000	670	430	270	180	(95 - 320)	255 (BNHS 2000)	210	No
India	600	480	390	280	200	(140 - 310)	254 (RGI,SRS 2004/06)	170	No
Maldives	830	390	190	94	60	(35 - 99)	-	870	Yes
Nepal	770	550	360	250	170	(100 - 290)	281 (Nepal DHS 2011)	190	No
Pakistan	490	440	380	310	260	(150 - 500)	276 (PDHS 2006-07)	110	No
Sri Lanka	85	74	58	44	35	(25 - 49)	14.2 (DRAFT DHS 2006/7)	1200	Yes
South-East Asia									
Myanmar	520	380	300	230	200	(120 - 330)		250	No
Cambodia	830	750	510	340	250	(160 - 390)	206(CDHS 2010)	150	No
Laos PDR	1600	1200	870	650	470	(260 - 840)	405 (Lao pop census 2005)	74	No
Malaysia	53	44	39	34	29	(12 - 64)	30 (2000 MOH AR 2004)	1300	Yes
Indonesia	600	420	340	270	220	(130 - 350)	228 (IDHS 2004-07)	210	No
Philippines	170	140	120	110	99	(66 - 140)	-	300	No
Thailand	54	54	66	54	48	(33 - 70)	49.9 (MDG Report 2009)	1400	Yes
Vietnam	240	160	100	74	59	(27 - 130)	165 (MOH 2003)	870	Yes
Pacific									
Fiji	32	33	31	29	26	(15 - 48)	31.8 (MDG Report 2009)	1400	Yes
Kiribati	-	-	-	-	-	-	-	-	
PNG	390	330	310	270	230	(100 - 510)	-	110	No
Samoa	-	-	-	-	-	-	-	-	

Source: World Health Organization. (2012). Trends in Maternal Mortality: 1990 to 2010. WHO, UNICEF, UNFPA and the World Bank estimates.

maternal mortality. The South Asia region alone contributed to 29%, which translates to 83,230 maternal deaths in 2010.

According to the recent report, *Trends in Maternal Mortality: 1990 to 2010, which presents estimated figures* by WHO, UNICEF, UNFPA and the World Bank, of the ten countries that contribute to 60% of maternal deaths, 5 countries are from the Asian region. These include India (56,000), Pakistan (12,000), Indonesia (9,600), Bangladesh (7,200) and Afghanistan (6,400). Assessing the maternal mortality rates against the ICPD target of reducing maternal mortality by 75/100,000 live births by 2015 in countries with highest levels of maternal mortality and 60/100,000 live births by 2015 in countries with intermediate levels of maternal mortality, it is noted that **only 7 of the 21 countries will be able to meet the ICPD target on maternal mortality reduction**. Details can be found in Table 14.China, Fiji, Malaysia, Maldives, Sri Lanka, Thailand and Vietnam are on track to achieving the MMR target of the ICPD by 2015. Among the countries under review, Lao PDR and Afghanistan have recorded a very high mortality of 470 and 460 maternal deaths per 100,000 live births in 2010. These MMR figures have to assessed keeping in mind the high confidence intervals.

*Negative values indicate a decreasing MMR from 1990 to 2008, while positive values indicate an increasing MMR. Given that the uncertainty intervals are wide for some countries, these will have to be interpreted with caution.
**Data retrieved from national surveys where available.

b. Adult Lifetime risk of maternal death

The adult lifetime risk of maternal mortality is a synthetic estimate which corresponds to the probability of a 15 year old eventually dying from a maternal cause, assuming she is subjected throughout her lifetime to the age-specific risk of maternal deaths observed for a given population in a given year.[72]

One in 32 women in Afghanistan face a lifetime risk of maternal death, and one in 74 women face this risk in Laos PDR. This risk is observed to be the lowest in China, Fiji, Thailand, Malaysia and Sri Lanka as shown in Table 15.

Although there has been a reduction in maternal deaths in the region in the last two decades as a result of some improvements in maternal health service provision,[73] much needs to be done to reach the target set in the ICPD PoA by 2014.

ii. Causes of maternal deaths in the Asia-Pacific region

According to WHO, the leading causes of maternal deaths are haemorrhage, hypertension and abortion related causes.[74] Details can be found in Table 15. Based on the recent estimates, the direct causes of maternal deaths worldwide include haemorrhage, and hypertension, which account for more than half of maternal deaths. This is also true for the South Asia region. Indirect causes include deaths due to malaria, HIV and AIDS, and cardiac disease which account for one-fifth of maternal deaths. The causes of maternal deaths for the Asia sub-regions are presented below.

Table 15:
Causes of maternal deaths for the Asia-Pacific region

Causes of maternal deaths for the Asia-Pacific region	South Asia	East Asia	South East Asia	Pacific
Haemorrhage	35%	33%	32%	33%
Hypertension	17%	10%	17%	15%
Abortion	10%	12%	9%	9%
Sepsis	7%	2%	8%	8%
Embolism	1%	12%	2%	1%
Other Direct	11%	15%	10%	10%
Indirect	19%	14%	22%	25%

Source: World Health Organization (WHO) & United Nations Children's Fund (UNICEF). (2012). *Building a Future for Women and Children. The 2012 Report.* Geneva, Switzerland: WHO & UNICEF.[75]

Deaths attributed to unsafe abortion are predominantly caused by severe infections or bleeding that resulted from the unsafe abortion procedure, or due to organ damage. Some women suffer long-term health consequences including infertility, while many more have short-term illness.[76]

An examination of the causes of death in Bangladesh (29%), Nepal (24%) and Fiji point to haemorrhage as the major cause of maternal death in line with the regional trend where haemorrhage is the major cause of maternal death.[77,78,79] It is also noted that most maternal deaths occur in the third trimester up to the first week after birth, at which point the mortality risks are higher, especially during the first two days after birth. This observation does not include deaths due to complications of abortion.[80]

Gender-based violence, domestic violence and intimate partner violence are also contributing factors to maternal deaths and morbidities in the region. According to an ARROW study in 2010, maternal deaths due to gender-based violence is equal to that of deaths from unsafe abortion.[81] In developing countries, it is estimated that the prevalence of violence a woman experiences during pregnancy is 4% to 32%.[82]

Maternal anaemia contributes to the indirect causes of maternal deaths. Maternal anaemia affects about half of all pregnant women and severe anaemia contributes to risk of maternal death

due to haemorrhage.[83] Two thirds of the estimated 56 million women, globally, are affected by anaemia.[84] In a study monitoring nutritional anaemia, it brings to mind India's commitments to ICPD Programme of Action 15 years on, in which anaemia has been noted as a major contributing cause to maternal mortality and a major public health problem in India. The case fatality rate varies from less than 1% to 50% depending on the availability of obstetric care and the severity of anaemia. Cardiac failure is the most important cause of maternal mortality in cases of severe anaemia. According to this study, anaemia contributes to 17% of maternal deaths. Obstetric complications associated or aggravated by anaemia include pre-eclampsia and antepartum, aggravation in cases of puerperal sepsis and thromboembolic complications, and other complications.[85]

iii. Interventions to prevent maternal deaths

a. Emergency Obstetric Care (EmOC)

Emergency Obstetric Care (EmOC) services include improving the availability, accessibility, quality and use of services for the treatment of complications that arise during pregnancy and childbirth, and is a way to reduce maternal mortality.[86] According to the EmOC guidelines published by WHO in 2009, facilities providing EmOC must: exist and function; be geographically and equitably distributed; be used by pregnant women; be used by women with complications; provide sufficient life-saving services; and provide good-quality care.[87]

There are two levels of EmOC services: Basic EmOC that includes administration of antibiotics, uterotonic drugs (used to prevent postpartum haemorrhage), and anticonvulsants, manual removal of placenta or other retained products of pregnancy, and an assisted vaginal delivery, and perform basic neonatal resuscitation; and a Comprehensive EmOC facility should include all the six interventions of the Basic EmOC, and a caesarean section and safe blood transfusion facilities.[88]

According to the revised guideline, the total of eight indicators on which countries are evaluated for EmOC services are shown in Table 16. Access to Emergency Obstetric Care (EmOC) services plays a pivotal role in saving the lives of women with obstetric complications during pregnancy. Access, availability and use of quality EmOC services go a long way in preventing maternal deaths arising out of obstetric complications. Universal availability and accessibility of EmOC interventions can prevent up to 60% of maternal deaths.[89]

The availability, utilisation and quality of emergency obstetric care services was evaluated using the UN process indicators in more than 40 countries between 1999 and 2003. The results showed 63-87% of designated Basic emergency obstetric care services were not fully functional in countries surveyed in South Asia.[90]

In a cross-sectional survey of 378 health facilities conducted in 4 African countries and 2 Asian countries of Bangladesh and India, between 2009-2011, results illustrated the lack of availability of EmOC life saving interventions across all the six countries in both the regions. Even where the number of facilities expected to provide comprehensive EmOC per 500,000 populations was more than sufficient, the quality of services offered in these facilities were inadequate, with many of the health facilities unable to provide EmOC functions and services.

The survey also pointed that the least available services included the lack of services such as assisted vaginal delivery (vacuum extraction) and removal of retained products of conception (by MVA or D&C). Even the functions which require relatively little skills, such as parenteral administration of anti-convulsant, anti-biotic and oxytocin, are not universally available at these health facilities. The estimated met need for EmOC was less than 35% in most of the settings in the survey pointing to the fact that many women with obstetric complications do not currently access a health facility (ref).

Further to this, the Ministry of Health and Family Welfare of India (along with the Federation Of Obstetric Societies of India (FOGSI) and Indian College of Obstetrics and Gynecology (ICOG) embarked upon implementing the Comprehensive Emergency Obstetric (EmOC) Certificate Program in 20 states of India in order to achieve the goals set as per National Rural Health Missions (NRHM) and the MDG.

The programme noted that there is a need for about 6000 competent doctors in providing Comprehensive EmOC care, and this initiative is working towards developing the capacity of doctors in the country in order to provide high quality emergency obstetric care services in underserved areas to prevent maternal mortality and morbidity.[91]

Other factors contributing to lack of utilisation of EmOC facilities include out-of-pocket expenditure for women and their families, non-functional referral system and distance, and non-equiTable distribution of health facilities.[92] In addition, limited human resources, lack of transportation facilities, and lack of blood transfusion facilities further impede the effective functioning of EmOC services.

The above studies illustrate the state of affairs with regards to universal access and availability of emergency obstetric care facilities e in the region, especially in South Asia. In South-East Asia, in Lao PDR where an assessment of EmOC services was carried out across three provinces, results indicated that only 14 out of 30 hospitals were providing EmOC services. Nine out of these were basic and the other five were comprehensive.[93] These services rank below the UN recommended EmOC facilities.
In Kiribati, new health and nursing stations have been established around the country. Radio telephones have been set up to allow communication between these health and nursing stations and

Table 16:
The UN Process Indicators

Indicator	AccepTable level
1. Availability of emergency obstetric care: basic and comprehensive care facilities	There are at least five emergency obstetric care facilities (including at least one comprehensive facility for every 500,000 population)
2. Geographic distribution of emergency obstetric care facilities	All sub-national areas have at least five emergency obstetric care facilities (including at least one comprehensive facility) for every 500 000 population.
3. Proportion of all births in emergency obstetric facilities	(Minimum accepTable level to be set locally)
4. Met need for emergency obstetric care: proportion of women with major direct obstetric complications who are treated in such facilities	100% of women estimated to have major direct obstetric complications are treated in emergency obstetric care facilities
5. Caesarean sections as proportion of all births	The estimated proportion of births by caesarean section in the population is not less than 5% or more than 15%
6. Direct obstetric case fatality rate	The care fatality rate among women with direct obstetric complications in emergency obstetric care facilities is less than 1%
New indicators for emergency obstetric care	
7. Intrapartum and very early neonatal death rate	Standards to be determined
8. Proportion of maternal deaths due to indirect causes in emergency obstetric care facilities	No standard can be set

Source: Monitoring EMOC: A handbook (2009) http://whqlibdoc.who.int/publications/2009/9789241547734_eng.pdf

the main hospital in Tarawa, which hosts the country's specialist medical staff who are responsible for women's health (including comprehensive obstetric care).[94]

While this shows the government's increasing priority towards maternal health in the country, it needs to be noted that there are only two transport options for women from the outer island who require emergency transfer for ANC or postnatal care (or for those women in labour) – by ship or the country's only airplane.[95] This is a deterrent for women seeking emergency obstetric care, causing them to deliver at home or at marginally equipped facilities.[96]

Universal access to emergency obstetric care services also needs to take into account the need to strengthen procurement and distribution chains for basic drugs and equipment, and improvement in the skills of health service providers to provide EmOC services. There are efforts around task shifting which can be seriously considered in designing effective functional EmOC interventions. Legal barriers also need to be addressed to allow trained midwives to perform MVA, and other procedures given the shortage of skilled medical professionals especially in remote geographical settings. Maternal death audits have to be institutionalised and all efforts should be geared to provide universal access to quality EmoC services at all levels to all women who need them.

b. Skilled Attendants at Birth

According to the World Health Organisation (WHO), a skilled birth attendant is *"an accredited health professional-such as a midwife, doctor or nurse- who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns."*[97] Traditional Birth attendants (TBA) either trained or untrained are excluded from the category of skilled health workers. It was agreed at the ICPD, that all births should be assisted by trained persons, preferably nurses and midwives, but at least trained

Table 17:
Skilled health attendants at birth from 2005-2011

Country	% of births attended by skilled health personnel (doctors, nurses, midwives and other cadres of health workers)	ICPD targets for 2015 met? (by 2010, 90% of births should be assisted by skilled attendants)
East Asia		
China	99.3 (2009)	Yes
South Asia		
Afghanistan	34	No
Bangladesh	26.5	No
Bhutan	64.5	No
India	52.7 (2007)	No
Sri Lanka	98.6 (2006)	Yes
Maldives	94.8 (2009)	Yes
Nepal	36	No
Pakistan	38.8 (2006)	No
South East Asia		
Cambodia	71	No
Myanmar	63.9 (2007)	No
Lao PDR	20.3 (2006)	No
Malaysia	98.6 (2007)	Yes
Philippines	62.2 (2008)	No
Indonesia	79.4 (2007)	No
Thailand	99.5 (2009)	Yes
Vietnam	87.7 (2006)	Yes
Pacific		
Fiji	99 (2002)	Yes
Kiribati	64 (2004)	No
Papua New Guinea	53.0 (2006)	No
Samoa	80.8	No

Source: United Nations' Millennium Development Goal Indicators

birth attendants. Action 64 of the Key Actions for the further Implementation of the ICPD PoA states that by 2010, where maternal mortality is very high, at least 50% of births should be assisted by skilled attendants and by 2015, at least 60%.[98]

The PoA also calls on all governments or countries to make concentrated efforts to achieve the target of 85% of births attended by skilled birth attendants by 2010, and 90% by 2015.[99] In this regard, as shown in Table 17 only seven countries out of the 21 surveyed in the region, have met the targets for 2010. These countries are China (96%) in East Asia; Kiribati (98%) and Fiji (99%) in the Pacific; Maldives (95%) and Sri Lanka (99%) in South Asia; and Malaysia (99%) and Thailand (99%) in South-East Asia. Afghanistan (34%), Bangladesh (27%), Bhutan (64.5%), Myanmar(63.9%), Cambodia (71%), India (52.7%), Indonesia (79.4%), Kiribati (64%), Lao PDR (20.3%), Nepal (36%), Pakistan (38.8%), Papua New Guinea (53.0 %), the Philippines (62.2%), and Samoa (80.8%) are below the set target.

While Afghanistan is far below the target, it is making a concentrated effort to improve the situation. In 2003, the Ministry of Public Health (MoPH) reported that the country had a severe shortage of SBAs and midwives. With support from international donors, two programmes to train and graduate new midwives were established - Institutes of Health Sciences (IHS)

program designed to train midwives to practise at the provincial, regional and national/specialty hospitals; and the Community Midwifery Education (CME) outreach program for community-based care. 34 schools across 31 provinces were established in nine years, with an increased number of trained midwives (from 467 in 2002 to 3,275 in 2011).[100]

In the 2011 State of the World's Midwifery (SOWM) report, it was noted that there were 2,331 midwives, nurse/midwives and nurses with midwifery competencies and an additional 254 auxiliary midwives and auxiliary nurse/midwives in the labour force in 2008.[101] According to the recent Demographic and Health Survey, the MMR in Nepal has decreased substantially as a result of improved maternal health services in the country.[102] The country's National Safe Motherhood Programme coupled with the recent policy on skilled birth attendants (SBA) can be credited for this.[103]

In India, a strategy under the National Rural Health Mission (NRHM) known as 'JananiSurakshaYojna' (JSY) is being implemented to provide cash incentives to pregnant women, who attend antenatal clinics and opt for institutional deliveries. The aim of this scheme is to reduce maternal and neonatal mortalities by promoting institutional deliveries. Pakistan and Bangladesh have also been experimenting with similar voucher and cash transfer schemes.[104] These schemes have to be investigated further for their positive and intended impact. In Fiji, there are a number of challenges faced by the health sector. The Ministry of National Planning has noted that if the shortage of specialist medical officers continues, this will lead to a deteriorating quality of health services in the country.[105]

Another find that is cause for alarm is that "surgery, including caesarean sections, and other specialist medical services were no longer available at sub-divisional hospitals even though the hospitals may still have a functioning operating theatre and have provided these services to their communities in the past."[106] This problem is aggravated by the loss of key health personnel due to migration, leaving key medical and specialist positions vacant in the country. For example, between 2003 and 2007, Fiji lost a total of 160 medical officers, 5455 nurses and 81 paramedic staff due to emigration to developed countries.[107] Kiribati and PNG, has shown regressing or no progress in the skilled attendance among the countries under review.

In Bangladesh, in an effort to reduce maternal deaths by improving the number of skilled birth attendants at the community level, an initiative was introduced by the government of Bangladesh, to increase the availability of skilled birth attendants at community level. A six-month theoretical and 12 month practical training (nine months supervised work experience, and three months additional training) in midwifery skills, including selected basic emergency obstetric care (EmOC) services was provided to the eligible people.[108]

In addition, in Bangladesh, Gonoshasthaya Kendra (GK), a non-governmental organisation which provides health services including reproductive health and family planning services at village and community levels, has also worked to improve the skilled attendance at birth in their intervention areas. GK has involved existing traditional birth attendants by giving them training in the scientific basis of pregnancy and handling of normal delivery. This training is periodically repeated, reinforced and updated.[109]

Equity in access to skilled birth attendants has been an issue across many countries. In a study by Countdown 2015, coverage of skilled birth attendants was the least equiTable of the 12 interventions monitored. Mean national coverage for the 54 countries was 54%, but the mean coverage in the poorest quintile was only 32%, compared with 84% in the richest quintile.[110]

c. Postpartum Care

Postpartum period here refers to care within the two days of delivery, and this indicator has been chosen as a large proportion of maternal deaths occur in the first 48 hours after delivery.[111] Key elements of postpartum care in this period for the mother include monitoring for blood loss, pain, blood pressure and other warning signs that can lead to maternal death. The single most common cause of maternal mortality continues to be obstetric haemorrhage, as demonstrated by the latest causes of maternal deaths data presented in this report by sub-region.

The rate of death due to postpartum haemorrhage (PPH) varies widely in the developing world. PPH-related mortality rates based on hospital studies are estimated to be 25% to 30% in India, and 43% in Indonesia. Because haemorrhage is more apt to occur and more difficult to treat in the community, studies have suggested higher rates of PPH-related mortality in these areas, but there is comparatively little data available outside of a hospital setting.[112]

Despite the realisation of the importance of postpartum care in the overall picture of maternal health, it is neither an indicator of the MDG5 target, nor is it highlighted in the ICPD PoA. However, it is important to analyse it in this report. Data is only available for thirteen out of the 21 countries surveyed and this is shown in Table 18. Of these, six countries have a below 50% rate of women being treated for post-natal care within two days of delivery. These countries include Afghanistan, Bangladesh, India, Nepal, Pakistan and Fiji.

With the data reported in Fiji, it shows that only 5% of women received postnatal care. It is to be noted that this data only represents "women who gave birth in a setting other than a health facility."[114] However, in September 2010, the Ministry of National Planning of Fiji stated in its MDG progress report

Table 18:
Post natal care visit within two days of childbirth % (2005-2010)

Country	Post-natal[113] care visit within two days of childbirth % (2005 - 2010)
East Asia	
China	-
South Asia	
Afghanistan	23
Bangladesh	23
Bhutan	-
India	48
Sri Lanka	71
Maldives	67
Nepal	31
Pakistan	39
South-East Asia	
Cambodia	70
Myanmar	-
Lao PDR	40
Malaysia	-
Philippines	77
Indonesia	70
Thailand	-
Vietnam	-
Pacific	
Fiji	5
Kiribati	-
Papua New Guinea	-
Samoa	66

Source: Demographic and Health Surveys of respective countries

that "...adequate care is given to the pregnant women in Fiji. The statistics show that almost 99% of pregnant women are getting proper prenatal, intra-natal and post-natal care."[115]

In Afghanistan, a majority of pregnancy-related deaths were reported to have occurred during the postpartum period.[116] According to the Afghanistan Mortality Survey of 2010, 28% of women received post-natal care for their last birth. Almost one in five women received post-natal care within four hours of delivery, about 22% received care within the first 24 hours of delivery, and only 2% of women were seen two days after delivery.[117]

In Kiribati, 22% of women are seen for their post-natal check-up within the first four hours of delivery, and 26% are seen within the first 24 hours of delivery. 50% of women are seen for their first post-natal check-up within two days of delivery. It is noted however, that almost 40% of mothers do not receive any form of post-natal check-up, and this is a cause for concern in the country.[118] In Bangladesh, only 21% of women receive any form of postpartum care within 2 days.[119]

Overall, post-natal visits have improved across the countries in the region, although it needs to be noted that it is crucial to ensure the quality of the care provided, as well as accessibility, especially for the small island countries in the Pacific, are addressed to achieve higher levels of maternal health.

iv. Promotion of maternal health

This section examines maternal health promotion with regards to antenatal care.

a. Antenatal Care

WHO recommends a minimum of four antenatal visits based on a review of the effectiveness of different models of antenatal care This takes into account important services like the treatment of hypertension to prevent eclampsia, tetanus immunisation and micronutrient supplementation. The antenatal care coverage (at least four visits) is defined as the percentage of women aged 15-49 with a live birth in a given time period who received antenatal care four or more times with any provider (whether skilled or unskilled).[120]

Table 19 shows that 13 countries out of the 21 surveyed have above 75% antenatal care coverage for at least one visit, which means that above 75% of women have made at least one visit for antenatal care service after delivery. These countries are Myanmar (83%), Cambodia (89%), Indonesia (93%), Malaysia (83%), Philippines (91%), Vietnam (88%), and Thailand in South-East Asia; China (94%) in East Asia, India (75%), Sri Lanka (99%), and Maldives (99%) in South Asia; and Kiribati (100%) and Samoa (93%) in the Pacific.
Antenatal care coverage for at least one visit is not a very effective indicator, and hence, we look at antenatal care coverage for at least 4 visits. Six of the 21 countries have reported at least 75% antenatal care coverage for at least 4 visits. These countries include Bhutan, Indonesia, Philippines, Thailand, Maldives and Sri Lanka.

Lao PDR has the lowest antenatal care coverage in South-East Asia and Bangladesh has the lowest in South Asia, followed by Afghanistan.

Table 19:
Antenatal care coverage in 21 countries from 2005-2011

Country	Antenatal care coverage (%) at least 1 visit	Antenatal care coverage (%) at least 4 visit
East Asia		
China	94	-
South Asia		
Afghanistan	60	16
Bangladesh	54	23
Bhutan	74	77
India	75	50
Sri Lanka	99	93
Maldives	99	85
Nepal	58	29
Pakistan	64	28
South-East Asia		
Cambodia	89	59
Myanmar	83	43
Lao PDR	37	-
Malaysia	83	-
Philippines	91	78
Indonesia	93	82
Thailand	99	80
Vietnam	88	-
Pacific		
Fiji	34	12
Kiribati	100	-
Papua New Guinea	60	29
Samoa	93	58

Source: World Health Organization's (WHO) World Health Statistics 2012

The Afghanistan Mortality Survey in 2010 reported progress, stating that "*more than six in ten women in Afghanistan are now receiving ANC, which is more than three times the proportion of women reported to have had ANC at the time of the 2003 MICS.*"[121]

It is interesting to note that Afghanistan, Bangladesh and Lao PDR have the highest MMR and lowest antenatal coverage in the region. There is little evidence, however, that points to the correlation between MMR and antenatal care. Researchers have found "that the majority of antenatal admissions to the hospital – other than for delivery – were for conditions that had arisen despite routine antenatal care. Antenatal visits had neither detected nor prevented the complications from occurring. Several studies have shown that antenatal care's screening and predictive values are poor and have no direct value in the prevention of maternal deaths."[122]

Although it has been proven that antenatal care doesn't necessarily save women from dying as a result of complications during or after childbirth,[123] it still remains an important indicator of universal reproductive health service coverage.
Antenatal care services can be the avenue for other reproductive health related services, such as screening for hypertension and gestational diabetes, screening for anaemia, provision of information on the danger signs of pregnancy and the benefits of birth preparedness, provision of information on post-partum contraception .[124] The progressive figures in 13 countries in the region is an opportunity for policy makers to strengthen overall reproductive health programmes towards achieving universal coverage.

v. Prevention of maternal morbidity

Maternal morbidity is an overarching term that refers to any physical or mental illness or disability directly related to pregnancy and /or childbirth. Though not necessarily life threatening, these illnesses and disabilities can have a significant impact on the quality of life.[125] For every woman who dies, some twenty face serious and long lasting consequences such as injuries, infections, and disabilities such as obstetric fistulae etc.[126]

Maternal morbidity arises from many of the same factors as maternal deaths. As a result, pregnancy-and childbirth-related death, and disability are the second leading source, after HIV/AIDS, for lost years of healthy life among women of reproductive age in developing countries. This accounts for nearly 31 million disability-adjusted life years lost annually.[127]
While we acknowledge various maternal morbidity conditions, this review is concerned primarily with obstetric fistula and uterine prolapse.

a. Obstetric Fistula

Obstetric fistula is a hole in the tissue wall between the vagina and the bladder or rectum, or between them both, that results in incontinence of urine and/or faeces. The cause of fistula is variable. It may result from prolonged obstructed labour that occurs when the baby is too large to pass through the birth canal or because the mother's pelvis is too small or immature, perhaps due to youth, or to malnutrition which stunts normal growth.[128]
Additionally, poorly performed forceps during the delivery for obstructed labour can also result in fistula.

BOX 7
Maternal Health

Case 1
Death during delivery of twin babies
Ani, 38, died one hour after delivering her twin babies in may 2008. Her husband came from a poor peasant family and their house is located very deep in a valley and far from the main road. For several years, she relied on the FP pills which she bought from a health cadre, but once she forgot to take it and subsequently became pregnant. During her pregnancy, she only experienced antenatal care once at the public health centre – at about 12 weeks – but nobody told her that she was carrying twins.

When the process of labour started, her husband asked a TBA from the same ward to help her. After several hours of labour, she was moved using a truck and, after almost 40 minutes of driving on a damaged road, she reached a midwife practice. Though she could have reached a nearer midwife practice (which was also a private practice), the family decided not to do so because of high tariffs. Though the midwife tried hard to help Ani, she died one hour after delivering a pair of healthy twins**.**

Source: Atashendartini Habsjah. (2010) Decentralisation and its impact on contraception access in Indonesia : a study from Bogor. Reclaiming & Redefining Rights - thematic studies series 3: Reproductive Autonomy and Rights in Asia.2010.ARROW pp 75

Case 2
Experience of two deliveries at Public Health Centres
My name is d..., I am 18 years old and I got married two and half years ago. My first child is one and half years old, and my second child was born just 23 days ago. We belong to the adi-dravida community. I studied till the 9th standard. I take care of the household chores and I do not carry out any work outside my house. My husband's is a construction worker, he goes to places like Coimbatore and Bangalore. He should be 23 years old and he also studied till the 9th standard. This house we stay in is our only property (mud house with thatched roof).Both of my children were born in the primary health centre in our village. As I conceived soon after the birth of my first child, the nurse informed me that it is enough if I had an immunisation. So, I had the injection once, she gave me medicines but I did not take it regularly. I might have had 10 – 15 iron Tablets but I did not like having the medicines.I would have gone 3 – 4 times for check-up. The nurse came to my home and took care of me. Compared to my first delivery, the services in the health centre have improved and they take good care [of women] now. Earlier in the hospital in our village, (phc) deliveries would happen very rarely but now one or two deliveries happen per day. The nurse stays close to the hospital (phc) and the doctor also stays in the next village.

On one Saturday night around 1 am, I felt the pain. They made me walk to the health centre, which is half a kilometre from my place. By 3 pm, they gave me an injection and by 8 o'clock in the morning I had a normal delivery. Half an hour after the child was born they asked me to breast feed my child. The staff in the PHC got me food in the afternoon, night and the next day. The food was also good, I felt as if the delivery had taken place at home. On Monday, the doctor came and checked me and then asked me to go back home. I reached home by 12 noon. For the first delivery, they asked for rs.100 – 200 And we gave the money but now they informed us not to give even a single rupee for sure. This should be appreciated; I did not spend any money for the second delivery before my delivery, a neighbour 'akka' (sister) had her delivery in a private hospital in dharmapuri and they spent rs.15, 000. My family cannot afford to spend that much. If there are no government hospitals where can poor girls like me go for delivery? They provided good care and if the same kind of care is provided in all the hospitals why will people go to private doctors?

Source: P. Balasubramanian & TK. Sundari ravindran.(2010) Utilsation of health facilities for reproductive health services : a case study from rural Tamil Nadu, India. Reclaiming & Redefining Rights - thematic studies series 4: Maternal Mortality and Morbidity in Asia. 2010 ARROW

The lack of data on this condition in the 21 countries, in many ways, reflects the extent to which it is neglected. Fistula persists particularly in areas where the rates of maternal mortality are highest, which includes areas with poor emergency obstetric care, referral systems, and infrastructure.[129] Maternal morbidity in Asia is a critical issue and in South Asia, where the maternal mortality ratio is 220, there are many incidents of maternal morbidity.

The estimated incidence of fistula in Pakistan ranges between 3000 and 5000 cases each year.[130] Three percent of ever-married women in Pakistan who have ever given birth have experienced the most common symptom of fistula, involuntary urination.[131] Less than half a percent of ever-married women reported leaking stool from the vagina. There are no significant differences by background characteristics.

The reproductive morbidity survey of more than 2,700 patients in two district hospitals in western Nepal revealed that 1% of women reported fistula. In another review, Kathmandu of Patan Hospital recorded 293 fistula patients, the majority of which were women age 25-34, and records showed that 41% of the patients had suffered their condition for 1-5 years, 10% for 6-10 years and 6% for 11-20 years. The vast majority (91%) of fistula were of obstetric origin, while 7% were due to gynaecological surgery (hysterectomy).

In India, between 1998 and 2003, three hospital based studies on the prevalence, nature and causes of obstetric fistula were conducted: two in New Delhi and one in the state of Tamil Nadu. The findings are based on small samples of less than 40 patients. The majority were below 30 years of age and a third of them developed the condition during their first delivery. 93% developed urinary leakage within two weeks and the patients had suffered from their condition for up to 15 years.[132]

In a 2012 community-based study on early post-partum maternal morbidity, results showed no cases of fistula in roughly 5,000 deliveries in rural Rajasthan, India, but the most common maternal morbidity problems were postpartum anaemia, sepsis, and breast and perineal infections.[133] Meanwhile, in another study, it was found that obstructed labour caused nearly 97% of genital fistulae, while pelvic surgery and accidental trauma contributed to 1.5% cases, each.[134] A 2003 study based on the community surveys conducted in six unions in six randomly chosen districts in Bangladesh found 1.69 cases of fistula per 1000 ever-married women, or potentially, an estimated country total of 70,199. These figures do not represent the actual prevalence of fistula in the country.[135]

Fistula is devastating to the lives of women who survive and endure them as the affected women are frequently driven from their marriages, families, and communities to the point where they become socially invisible. Denied family support, their poverty and malnutrition are aggravated, and they may be forced to depend (when able) on earnings from begging, prostitution and other comparably stigmatising employment. This condition often occurs in first pregnancies of young wives in early marriages who lack education and training.[136]

While overall upgrading of prenatal care and emergency obstetric services would go a long way to reduce the incidence of fistula, remedial care also needs to be targeted to meet or reduce needs. Health care systems should address patients' social and psychological support pending surgical repair, and as necessary afterwards, since not all surgery will succeed. Counselling may also be required in the event of post-repair pregnancy, particularly on the option of caesarean or vaginal delivery.[137] Counselling and advice on family planning services, especially for young wives, is very critical to avoid the risks associated with early childbearing.

b. Uterine Prolapse

The global prevalence of uterine prolapse is estimated to be 2%-20% in women under the age of 45.[138] Uterine prolapse occurs when a weakened pelvic musculature can no longer support the proper positioning of the vagina and the uterus. Uterine prolapse is defined as the "herniation of the uterus through the vagina, below it normal anatomic position."[139] The principal cause of uterine prolapse is obstetric trauma and post-menopausal atrophy, and thus, the condition is most common in multiparous (many births) or post-menopausal women.

Prevalence data for prolapse are available from a number of studies. In a 1997 study in southern India, 440 women under the age of 35 were evaluated for gynaecological morbidity, and cases of prolapse were noted in 3.4%.[140] In a 2000 study of 2,990 married women in northern India, 7.6% were diagnosed with cases of prolapse.[141]

Another study carried out in Dhaka, from November 1993-May 1995, showed that 10% women with obstetric complications had uterine prolapse. Higher parous women were significantly more likely to have uterine prolapse.[142] In 1997, data collected in a health camp in mid-western Nepal showed that 17% of 720 gynaecological patients were diagnosed with prolapse.[143] A 1997 hospital-based study from the maternity hospital in Kathmandu showed that of the 1,147 gynaecological patients attending the hospital during the study period, 110 (9.6%) were found to have prolapse.[144] The great majority (72.7%) of women developed prolapse before menopause and 23.7% were 15-25 years old at onset. Another "qualitative study among female agricultural wage labourers with self-reported uterine prolapse, found that most had uncomplicated deliveries, but many ascribed their condition to heavy manual labour within a week or fortnight following delivery, possibly explaining why the mean age for developing symptoms at 26 years was much younger than usual. Many had been suffering for over 10 years."[145]

A recent study held focus groups with 71 women in six villages of the eastern districts of Siraha and Saptari, and 14 qualitative interviews with health professionals from the local to central level and found that although all knew of the causes and risks for uterine prolapse, which are "patriarchy, gender discrimination, and cultural traditions such as early marriage and pregnancy make it difficult for people to discontinue uterine prolapse risk behaviours."

The ICPD PoA envisages women who are able to lead a healthy reproductive and sexual life and remain free from morbidity, disability fear and pain. Reproductive health information, in this case around care during pregnancy and awareness around delivery practices, and RH services (antenatal, during delivery and post natal), and including access to safe affordable facilities for surgical correction and related treatment, are critical to improving the quality of life of women suffering from prolapse. Information on the efforts of governments, to address uterine prolapse in Nepal showed that the Ministry of Health and Population of the government of Nepal plans to support services to address Uterine Prolapse (UP) cases and has declared UP as a priority program. In 2008/9 with External Development Partners (EDPs) including the World Bank, a budget was pooled to support 12,000 UP cases for surgical service. The government took six months to develop guidelines focusing on processes, policies and stakeholders to provide services to women with UP diagnosed in screening camps or in hospitals waiting for surgical treatment. Government guidelines are focused on the screening of UP, the use of pessary rings, and referral services for primary health workers working in public health facilities located in Village Development Committees.[146]

Currently, much of the intervention around morbidity is focused on dealing with the physical well-being of the body. There is still a long way to go to create a holistic perspective within service interventions, which cater for the mental health well-being of women. Sufferers of uterine prolapse, fistula and infertility need support services beyond the medical treatment of the actual condition. Counselling and support services for these groups of women, including those who may also experience stillbirth, miscarriages and post-natal depression, as well as second trimester abortions for foetal anomalies[147] also require appropriate attention, treatment and care.

Table 20:
Adolescent birth rates across the region

Name of the country	Adolescent birth rate per 1000 girls aged 15-19
East Asia	
China	6.2
South Asia	
Afghanistan	90.0 (2008)
Bangladesh	133.4
Bhutan	59.0
India	38.5
Maldives	15
Nepal	81.0
Pakistan	16.1
Sri Lanka	24.3
South-East Asia	
Myanmar	17.4
Cambodia	48.0
Indonesia	52.3
Lao PDR	110
Malaysia	14.0
Philippines	53
Thailand	46.7
Vietnam	35.0
Pacific	
Fiji	31.1
Kiribati	39
Papua New Guinea	70.0
Samoa	28.6

Source: Latest UN statistics, Millenium Development Goals Indicators , the official UN site for MDG indicators Adolescent Birth Rate

vi. Adolescent Pregnancies

Objective 7.44 (b) of the ICPD PoA is to "substantially reduce all adolescent pregnancies."[148] Adolescent birth rate is the annual number of births to women aged 15-19 years per 1,000 women in that age group that represents the risk of childbearing and the related complications among adolescent women between 15-19 years of age. In the Asia and the Pacific region, about 176 million adolescent girls (aged 15-19) are vulnerable to early pregnancies. While the adolescent birth rates, between 1990 and 2008, declined in South Asia and the Pacific, these sub-regions continue to have high adolescent birth rates in the region. Bangladesh (133.4), Lao PDR (110), Afghanistan (90.8), Nepal (81.0) and PNG (70.0) report high adolescent birth rates[149] as seen in Table 20.

Early childbearing entails an increased risk of maternal deaths or physical impairment. Almost 10% of the girls become pregnant by age 16 in South and South-East Asia.[150]

In the case of South Asia, Pakistan and Myanmar report lower adolescent birth rates at 16.1 and 17.4, respectively.

In Bangladesh, one-third of adolescents aged 15-19 have begun childbearing, 27% of these teenagers in Bangladesh have given birth, and another 6% are pregnant with their first child.[151] Early childbearing among teenagers in Bangladesh is more prominent in rural areas, compared with urban areas.[152]

In Nepal, 17% of adolescent women age 15-19 are already mothers or pregnant with their first child,[153] while in Afghanistan, 12% of women between 15-19 years of age have started childbearing, with 8% having had a live birth, and 4% pregnant with her first child.[154]

The 2010 Afghanistan Adult Mortality Survey notes that early childbearing is higher among women in rural areas,[155] and the government has introduced a National Child and Adolescent Health Strategy (2009-2013).[156]

Whereas in Nepal, the teenage pregnancy rates have dropped by 10%.[157] China, Myanmar, Malaysia, Sri Lanka and the Maldives have comparatively lower adolescent rates of adolescents births. Adolescent births is a concern across many countries in the region. While there have been policies and programmes to address the issue, much more needs to be done especially with regards to access to information and services which are catered for them.

SUMMARY

The right to the highest attainable standard of sexual and reproductive health is enshrined in the ICPD PoA and safe pregnancy is essential to every woman's right to life and dignified well-being. Governments in the region have to be accounTable to women to ensure that pregnant women do not die or experience poor quality of life resulting from the complications of pregnancy. It must be reinforced that the political will of the state is crucial to prevent maternal mortality and morbidity, which violate a woman's right to life. Simple medical interventions can save women's lives: for example, the treatment of eclampsia and severe pre-eclampsia with magnesium sulphate, and "the ability to control post-partum haemorrhage through active management of the third stage of labour, including with prophylactic misoprostol."[158] An estimated extra cost to the health budgets of US$0.22 to US$1.18 per capita, will ensure the improvement of skilled care delivery.[159]

In all the 21 countries surveyed, only Malaysia has a comprehensive reporting system for maternal deaths, including confidential enquiries into maternal deaths, which has enabled the government to refine its interventions, services and systems, and in the long run, reduce maternal deaths. Maternal Death Reviews (MDR) are necessary in improving the quality of maternal health services.

They form a key element of accountability and look critically at the causes and avoidable factors behind each maternal death leading to actions to improve quality of care. MDR should not be seen as a blame and punishment instrument but as a positive process to avert maternal deaths. It is very critical that policies, guidelines and tools for conducting MDR are scaled up, institutionalised and acted upon, and this is only possible through strong political will, resource allocation and integration of maternal death reviews within the maternal and child health programmes in respective countries.[160]

From what we have already discussed, 14 of the 21 countries (except for China, Fiji, Malaysia, Maldives, Sri Lanka, Thailand and Vietnam) have not been able to achieve the ICPD targets of maternal mortality ratio set for 2014. The Asia and the Pacific region is diverse with the East Asia sub-region reporting the lowest MMR at 37 maternal deaths per 100,000 live births and on the other end of the spectrum, we have South Asia with the second highest MMR across regions at 220/100,000 live births closely followed by the Oceania region at 200 maternal deaths per 100,000 live births. Among the Global South ARROW ICPD+20 countries, China, Malaysia and Thailand had lower maternal mortality rates even prior to ICPD. Nevertheless, Vietnam has made significant progress in reducing their maternal mortality in the region. India contributes 19% of all maternal deaths in 2010, with 56,000 maternal deaths.

EmOC is a critical intervention for addressing high maternal deaths. Many countries, especially in South Asia, have shown poor compliance to the UN process indicators on EmOC. While the ICPD PoA notes that every birth should be attended by a skilled attendant, and the ICPD+5 target reiterates that at least 90% of births should be assisted by skilled attendants by 2015, this goal will likely be led only by China, Malaysia, Thailand and Vietnam. Postpartum care coverage has shown some improvements, however, there needs to be more progress on this front as this can result in preventing maternal deaths, and due to the fact that postpartum haemorrhage (PPH) complications in which this condition remains a major cause of maternal death in the countries under review. Access to emergency obstetric care also goes a long way in reducing maternal morbidities.

Antenatal care coverage for at least four visits, which is seen as a better indicator than at least one antenatal care visit, shows a bleak picture with the lowest coverage in Maldives (7.3%), Afghanistan (16.1%), Bangladesh (20.6%), Cambodia (27%), Pakistan (28.4%), Nepal (29.4%), and Vietnam (29.3%). Antenatal care coverage is highest in Indonesia (81.5%), Thailand (79.6%), Philippines (77.8%), Myanmar (73.4%) and Kiribati (71%).

Adolescent births also remain a major challenge in many countries in the region, and this group is more susceptible to maternal mortality and morbidity conditions.

3.3 ABORTION

Although abortion is one of the most contentious issues within the ICPD PoA, it is regarded as an integral component of reproductive health services.

Paragraph 8.25 speaks of the need to reduce the recourse to abortion through contraception, pre- and post-abortion counselling, ensuring that abortion is not against the law, making certain that abortion should be safe; and that at the very least, all countries should have access to services for the management of complications arising from abortion.

As the ICPD PoA was negotiated between the countries, some compromises with regards to abortion appear within the ICPD PoA itself. The compromises can be located in the following paragraphs on abortion:

- 7.24, which does not recognise the role of abortion in limiting births;
- 7.6, which limits service provision to the prevention and management of abortion complications;
- 8.19, which talks of abortion prevention but not of provision of safe abortion services;
- 8.22, which again talks only of service provision to treat abortion complications.

One year later, however, the women's movement was able to take it one step further in the 4th World Conference on Women in Beijing in 1995 where in the Beijing Platform for Action, Paragraph 107 (j) and (k) adopted Paragraph 8.25 in full with the addition of "consider[ing] reviewing laws containing punitive measures against women who have undergone illegal abortions." This also enabled the shift in framing abortion from a public health perspective, to a human rights perspective and gave women's groups an opening to frame abortion within a rights perspective on international platforms.

One of the biggest challenges for many women across the globe is access to safe, legal abortion. This is one of the shortcomings of the ICPD PoA: "access to safe, legal abortion [is] not recognised as part of reproductive health and rights; [in] deference to national laws; where illegal, [requiring] treatment of complications only."[57]

Despite Cairo and Beijing, a benchmark has yet to be set that establishes the right to safe and legal abortion as a good indicator of the status of women within the country; of their autonomy and their agency; and of respect for their bodily integrity.[58] Legality in the context of each country indicates public acceptance of fertility control, of women's need for abortion, of the limitations of contraception and contraceptive use, and of women's right to decide the number and spacing of their children, as well as public respect for and acknowledgement of women's responsibility as mothers.[59]

The deference to national laws has two different aspects. One, in countries where access to abortion is difficult, this deference puts many women and women's organisations in a bind: it is difficult to advocate and fight for something that is considered 'illegal,' especially when laws governing abortion may be covered under different sections; may be difficult to interpret; may be contradictory; and may be obfuscatory.

Furthermore, there is an absence of an international standard of a universal right to abortion which provides credence to this issue. Two, in countries where abortion is legal and available upon request, most national laws usually stipulate a time frame, i.e. within 12 weeks or 16 weeks. This deference to these 'legal' time-limits make it difficult to advocate for second trimester abortion services and for the provision of services for second trimester abortions.

In both situations, access to abortion should be viewed primarily as a human right. The Centre for Reproductive Rights defines restrictions on access to abortion as discrimination: "Freedom from discrimination is enshrined in every international human rights document. Since only women need abortion services, restriction of access to abortion services is viewed as discrimination against women."[60]

While contraceptive use increases in the region, abortion is a woman's only means of exercising her right to decide on the number and spacing of her children and governments have to make these services safe, legal and accessible to women. In fact, the WHO notes that there have been huge reductions in the total fertility rates in our region despite only a modest improvement in contraceptive use, "showing a reliance on abortion for fertility control."[161] It is important at the +20 review of ICPD, to recognise abortion both as a public health issue and a human rights issue. It is important to view access to abortion in a humane and just way as possible: "women have abortions for only one reason – because they cannot cope with a particular pregnancy at a particular time. This can never be said enough. They may regret the reasons, but this does not alter the fact that abortion is the correct decision for them and necessary in the circumstances of their lives."[61] Moreover, it is important to create policies, laws and procedures, which enable and empower women to enact these choices.

Since 1994, 26 countries across the globe have removed legal restrictions on abortion, making it a total of 73 countries where abortion is permitted without restrictions of reason.[162] This indicates a slow shift towards public acceptance of a woman's control over her fertility, of her right to abortion when needed, the limitations of contraception and contraceptive use, as well as acknowledging the role and responsibility of women as mothers.[163]

A breakthrough in the abortion debate is the introduction of medication abortion. Medication abortion is just as safe as

BOX 8
ABORTION

Case 1
Mrs. Murni is 42, married, the mother of five children, and whose husband does not have a permanent job. When she first came to the clinic, her menstruation was nine weeks overdue. Eight months earlier, she had delivered a baby by way of a caesarean section, after which, she used 3-monthly injectable contraceptives. When she could not pay for an injection, her husband reverted to using condoms. However, on one occasion, when mrs. Murni could not afford an injection and had intercourse with her husband without any protection, she became pregnant.

Some weeks later, she experienced slight bleeding and began to feel unwell. This incident made her think about her unwanted pregnancy and thus, she decided to terminate the pregnancy:"i know abortion is a sin according to Islam, but i don't think we can afford to have another child since my husband's job is uncertain. I am also too tired now... i believe god will understand my problem and will forgive me..." she tried consuming five packs of traditional herbs (jamu) with the trademark "kates" (papaya), and 1 pack with the trademark "nanas" (pineapple). Later on, she supplemented her initial effort with another 5 packs of jamu/traditional herbs, "wayang" (puppet) and ate two pineapples. However, her attempts at abortion failed, and she developed severe headaches, became very stressed and ncreasingly worried that the ongoing development of the foetus would result in it being impaired. Finally, following the advice from her friends and a recommendation of a doctor from a public health centre, she went to the clinic. After the abortion procedure, mrs. Murni no longer felt the acute stress symptoms and as a result of post-abortion counselling session, she decided to be sterilised. She hopes that through sterilisation her family would have a brighter future, and she will not haveto worry about another pregnancy. However, before this could be achieved, she would have to somehow obtain the money for sterilisation services.

Source: Ninuk Widyantoro & Anita Rahman (2010). Unsafe abortion in Indonesia: The urgent need to reform policies. Reclaiming & Redefining Rights - thematic studies series 3: Reproductive autonomy and Rights in Asia.2010. ARROW pp 90

clinical procedures and can be performed at home.[164] Medication abortion is the termination of pregnancy by the use of drug or a combination of drugs.[165] The procedure works best until the 9th week of pregnancy and uses two medicines called Mifepristone and Misoprostol. Misoprostol is already widely available in almost all countries since it is registered for the treatment of gastric ulcers. Registering mifepristone is an important step towards making medication abortion more widely available to women. As women can perform the procedure at home, medication abortion circumvents many of the issues of access, affordability and confidentiality of abortion.

Medication abortion is available in countries such as India, China, Vietnam and Nepal.[166] In a study mapping the availability of medical abortion products in Cambodia, it was found that medical abortion products were available in 14% to 24% (surgical abortion) of all rural and urban sites of Cambodia.[167] These are countries which already have liberal abortion laws. While the uptake is high in those countries - the sale of misoprostol-only drug has increased by 69% in China and 64% in India from the year 2002 – there is greater potential for medication abortion where abortion laws are more restrictive – the sale of misoprostol-only drug increased by 128% in Bangladesh and 116% in Indonesia in the same time period.[168]

Availability of medication abortion has helped reduce the incidence of unsafe abortions, and made safe abortion more accessible. In Asia-Pacific, there is a 244% increase in the use of medication abortion from 2010 to 2011.[169] It is noted that "the greatest absolute rise was in South Asia, with over 380,000 more services provided in 2011 than 2010. Most of the growth was in Asia, where mifepristone and/or misoprostol are provided outside clinic settings, for home-based care.'[170]

In this section, we examine the status of abortion in 21 countries by monitoring indicators such as the legal status of abortion, the changes in laws since the ICPD in 1994, the extent of the knowledge of abortion laws, the incidence of unsafe abortion, and percentages of maternal deaths attributed to it in different countries.

i. Legal Status of Abortion in the Region

There are different levels of permissibility with regards to abortion in the 21 countries studied as shown inTable 21. National laws create or restrict legal access to abortion. The grounds upon which abortion is legally permitted are usually 'additive' – when abortion is permitted for a more liberal condition, it is generally also permitted for the more restrictive conditions as the Table

Table 21:
Status of abortion laws in the selected 21 countries in Asia-Pacific

COUNTRY	To save woman's life	To preserve physical health of the woman	To preserve mental health of the woman	Rape or Incest	Foetal impairment	Economic or Social Reasons	On request
East Asia							
China	×	×	×	×	×	×	×
South Asia							
Afghanistan	×	-	-	-	-	-	-
Bangladesh	×	-	-	-	-	-	-
Bhutan	x	X	×	×	-	-	-
India	×	×	×	×	×	×	-
Sri Lanka	×	-	-	-	-	-	-
Maldives	×	×	-	-	-	-	-
Nepal	×	×	×	×	×	×	×
Pakistan	×	×	×	-	-	-	-
South-East Asia							
Cambodia	×	×	×	×	×	×	×
Myanmar	×	-	-	-	-	-	-
Lao Pdr	×	×	-	-	-	-	-
Malaysia	×	×	×	-	-	-	-
Philippines	×	-	-	-	-	-	-
Indonesia	×	-	-	-	-	-	-
Thailand	×	×	×	×	×	-	-
Vietnam	×	×	×	×	×	×	×
Pacific							
Fiji	×	×	×	×	×	-	-
Kiribati	×	-	-	-	-	-	-
Papua New Guinea	×	×	×	-	-	-	-
Samoa	×	×	×	-	-	-	-

Source: The World Abortion Laws 2012

below shows. There is adequate evidence to show that restrictive legislation on access to abortion is associated with a high incidence of unsafe abortion. There may also be discrepancies between the wording of the law and its application.[171]
The aspects of abortion being legal and safe are intertwined: "Making abortion legal is an essential component of making abortion safe.... Legal changes need to take place if safety is to be sustained for all women. Safety is not only a question of safe medical procedures being used by individual providers. It is also about removing the risk of exposure and the fear of imprisonment and other punitive measures for both women and providers, even where illegal abortion is tolerated."[172] Furthermore, these aspects apply both in situations where abortion is unavailable or partly available, and also with regards to second trimester abortions in countries where abortion is already legal within certain time frames.

Government commitment to making abortion accessible to women must also be followed up with programme implementation through the provision of service, facilities and personnel trained on procedures. In some Asian countries — notably Cambodia, India and Nepal — abortion laws are liberal, but many pregnancy terminations are performed in sub-standard conditions.[173]

Table 21 maps the grounds on which abortion is permitted in the 21 countries. In the Asia-Pacific region, there are countries which occupy the different extremes with regards to women's access to safe abortion services - Cambodia, China, Nepal and Vietnam have legalised abortion while Afghanistan, Myanmar, Papua New Guinea, the Philippines, Kiribati and Sri Lanka are most restrictive. In the Pacific countries, it is noted that as abortion is legal only under certain circumstances (it is not legal to perform abortions on request), unplanned and unwanted pregnancies lead to unsafe abortions which are either self-induced, or induced by untrained practitioners, leading to complications that can lead to maternal deaths.[174]

It is interesting to note that in Samoa, abortion is only allowed to preserve a woman's mental health without inclusion of other grounds such as to save a woman's life. On the other hand, in Bhutan, abortion is permitted to save a woman's life and in cases of rape or incest. It is also permitted on "additional enumerated grounds relating to such factors like the woman's age or capacity to care for child."[175] These laws exist in accordance with a social environment of high socio-economic inequalities and of stigma against women seeking abortion based on religious and cultural perceptions of womanhood.[176] In all countries, there are qualifying and or limiting clauses on the access and availability of abortion to women. For example, although Cambodia, China and Nepal have legalised abortion across the board, Cambodia and Nepal have set gestational limits of 14 weeks[177] and 12 weeks,[178] respectively. While in China and Nepal, it is illegal to have an abortion for sex-selection purposes.[179]

In reality, there are huge variances in practice with regards to the law. These variances are due to the fact that practices such as 'menstrual regulation' fall outside the purview of laws on abortion; the law may be interpreted differently by different parties; providers who are not willing to perform abortion based on a lack of the understanding of the law or for personal, religious reasons; or hospital administrative policies which are not based on the understanding of the law.

In Bangladesh, although 'abortion' is only available to save the life of the woman, in the mid-70s, the government slowly started introducing menstrual regulation (MR) services as an option for early termination of pregnancy. "Menstrual regulation refers to the use of a syringe and cannula to extract the contents of the uterus up to 10 weeks gestation in order to restore menstruation. During the last 20 years, menstrual regulation services have been extended throughout Bangladesh and the government has trained over 10,000 physicians and other health care providers, primarily family welfare visitors, to provide menstrual regulation services."[180]

In Nepal, there are prohibitions on abortions done without the consent of pregnant women, sex selective abortions and abortions performed outside the legally permissible criteria.[181] Although the abortion law allows for a range of grounds including risk to the mother's health, abortion is usually perceived as illegal. The law on abortion is derived from the Islamic Qisas and Diyat Ordinance. Physicians are most often left with the discretion of performing abortions and they are usually reluctant to interpret the law liberally. Sometimes, the doctors resort to second opinions or verify their decisions with medical boards consisting of three experts.[182]

In Malaysia, the Penal Code Amendment Act (1989) allows a medical practitioner registered under the 1971 Medical Act "to terminate the pregnancy of a woman if such medical practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to the mental and physical health of the pregnant woman greater than if the pregnancy were terminated."[183] This is according to Section 312, of the Malaysian Penal Code. However, government hospitals generally do not provide access to abortion services except for two hospitals which offer services in cases of severe foetal malformation which indicate that the baby would not survive on delivery.

Women also face policy barriers such as mandatory spousal authorisation for abortion services in Indonesia and Maldives.[184] In Pakistan, although the law allows abortion on a number of grounds, it is usually perceived as illegal. This is mainly because the law on abortion is derived from the Ordinance based in Islamic Sharia and most physicians when granted the discretion of performing abortions are usually "reluctant to interpret the law liberally'."[185] In Maldives, one of the coalition partners of the Democratic Party even "mooted for execution of women who

have aborted their foetuses—a sin as per the prevailing Sharia law."[186]

It is also important to understand the risk that both women and service providers take in seeking and providing abortion services. In almost all countries, there are penalties.
Even among the countries which have legalised abortion, there are penalties. In China, "unapproved" abortions result in admonishment, fines, revocation or denial of future birth permits and possible sterilisation for the woman.[187] In Nepal, the law punishes anyone who "tricks" or "provides incentives" to a pregnant woman to have a sex-selective abortion with imprisonment of up to one year.[188]

In Thailand, "a woman who induces her own abortion or allows another person to do so is liable to imprisonment up to three years or is fined up to USD 146;" a provider is liable to imprisonment to of up to five years or fined USD 244.[189]
In countries where the abortion law is restrictive such as Bangladesh[190] and Pakistan,[191] both the women who seek abortion and the service providers can be imprisoned for up to three years and fined. The sentence increases for second trimester abortions. In Sri Lanka, any person who voluntarily causes a pregnant woman to miscarry may be punished with up to three years of prison, a fine or both, unless the miscarriage was caused in good faith in order to save the woman's life. Under these penal code provisions, a woman who causes her own miscarriage is liable for the same punishment as a provider or other individual who causes her to miscarry.[192]

In the Philippines, the penal code prescribes penalties of imprisonment from 30 months to six years for any woman who causes or consents to her own abortion and imprisonment of two to six years for any person who intentionally causes an abortion with the consent of the woman.[193]

Surprisingly enough, in India, the penal code prescribes penalties for both woman and provider of up to seven years of imprisonment and fines.[194] The similar is true in Malaysia.[195] This is in contradiction to the legal status of abortion itself.
In Bangladesh, India and Pakistan the penalties are more severe for second trimester abortions.

In all countries, penalties are more severe for abortion performed without the consent of the woman and abortions which result in the death of the woman. Both of these target service providers.

ii. Changes in law/ policy on abortion since ICPD.

Many countries, only in recent years, have been addressing abortion in laws and policies. Since the ICPD in 1994, five countries in the Asia Pacific region have liberalised their abortion related laws. These countries include: Bhutan, Cambodia, Fiji, Indonesia and Nepal.

In Cambodia, in 1997, concerned with the high MMR brought about by the unsafe conditions in which illegal abortions were generally being performed, the government decided to introduce abortion legislation to regulate the procedure formally. It hoped that the legislation would reduce the MMR by one half by 2010. Moreover, it depicted its proposed legislation as a measure designed to improve the social welfare of the population. Despite some opposition from those who argued that the country's Buddhist traditions do not allow the legalisation of abortion, the proposed legislation was enacted early October 1997.[196]
In Vietnam, abortion and menstrual regulation have been officially allowed by the Vietnamese Government since 1989 when it approved the Law on Protection of People's Health. Women's rights to gynaecological checks-up and treatment and abortion and menstrual regulation as stipulated in Chapter 8 (Family Planning and Mother and Child Health) Item 1, Article 44 reads: "Women have the right to abortion and menstrual regulation at their will and to gynaecological checks-up and treatment and health checks up during pregnancy and child delivery services at health facilities."[197]

In 2002, India adopted legislation aimed at improving access to safe abortion facilities by moving authorities to approve facilities from the state level to the district level. The law, which is intended to simplify the approval process for new facilities, also increases criminal penalties for providers and facility owners who operate without approval.

In Nepal, it was only in 2002 that "abortion [was made] legal without restriction as to reason during the first 12 weeks of pregnancy, and thereafter on specific grounds. Under the [previous] law, abortion was prohibited altogether."[198] In 2009, the Supreme Court of Nepal ordered the government "to secure women's access to safe and affordable abortion services through a comprehensive abortion law and the creation of a government fund that would cover the cost of abortions for those unable to pay." This came as the result of a court case of *Lakshmi Dhikta v. Nepal,* where Dhikta was reported to have been denied abortion, as she could not afford to pay the fee charged for abortion at the government hospital.

In Bhutan, previous abortion laws were unclear but assumed to only allow the procedure to save a woman's life. These were changed in 2004[199] when the grounds on which women can have abortions were expanded to include cases of rape or incest as well as cases where women are mentally unsound.
In Thailand, it was only in 2005, that the Medical Council amended a regulation governing the medical profession's conduct with regard to abortion. "The regulation provides a standard interpretation of the criminal law provision on abortion, which permits the procedure when a woman's life or health is in danger and in cases of rape. According to the new regulation, "health" is defined to include mental health as well as physical health. The regulation clarifies that abortion may be performed in public or private health facilities not only to protect a woman's

life and physical health and in cases of rape, but also when a pregnancy causes harm to a woman's mental health and in cases of foetal impairment."[200]

In Indonesia, it was only in September 2008 that the law was amended again recently, and stipulates that only women whose lives are in danger or those that have been raped can have an abortion.[201]

In 2009 Fiji, like Bhutan, expanded the grounds on which abortion was permitted and went further by explicitly mentioning so in its Penal Code, which was not done before.[202] The Penal Code of 1945 (article 172 – 174, 221 and 234) now permits abortion in cases of rape, incest or foetal impairment as well as on socio-economic grounds.[203]

iii. Extent to which abortion law is known, accepted and acted upon by health providers and the public

Lack of knowledge about abortion laws – among women and among service providers –continues to be an issue in Nepal, Pakistan and India.

In Nepal, although the law stipulates that abortion services should be available on demand for the duration of the first 12 weeks in general, and in cases of rape until 18 weeks and any duration if the life of the mother is under threat - only one in three women is aware that abortion is legal.[204] Just over one in two women mentioned that they know of a place where abortions are carried out.[205]

In Pakistan, inadequate awareness of the law, including on the part of doctors and the conservative social milieu, has proved to be a strong barrier to abortion. There is confusion and reluctance to carry out induced abortion. There are no established guidelines for the medical profession mandating such permission. Physicians are cautious in their application of the abortion law, particularly in their reading of the term "necessary treatment," and will provide abortions only when the pregnant woman suffers from a serious medical ailment, even though the statute itself does not state that the "treatment" must be related to physical health.[206]

In India, only 29% of informal providers know abortion is legal.[207] Lack of service facilities and staff trained in abortion methods is an issue in Cambodia, although the law is liberal. Health services in Cambodia are not highly developed and much of the population lacks adequate access to these, particularly at the in-patient level. Additional health personnel who have the proper training to perform abortions safely are also needed. With such obstacles to overcome, it is likely that, at least in the short run, many abortions will still be performed in unsafe conditions by unskilled persons.[208]

Service provider attitudes to unmarried adolescents undergoing induced abortions and the quality of care afforded to them is an issue in China where a study by "SIPPR on 1,927 family planning providers in eight provinces endeavoured to learn about the attitudes of family planning providers towards sexual behaviour and induced abortion among unmarried adolescents. The survey showed that 60.7% and 88% of service providers disagreed with pre-marital sexual behaviour and induced abortion, respectively."[209]

Lack of knowledge about the abortion law is an issue which has led to a burgeoning of abortion services in the private sector in Malaysia. Anecdotal evidence suggests that abortion services are easily available in the private sector for a cost, where physicians are more likely to form opinions to the advantage of women. All forms of abortion services are available. These services are for the most part, safe. This may explain the low number of maternal deaths due to abortion (one to five deaths a year) – a number which is quite trustworthy as Malaysia is one of the rare countries which investigates each and every maternal death. However, abortion services are not available even for victims of rape and incest and cases of foetal malformation in the government hospital system which has almost universal coverage for the country's population.

In Indonesia, the awareness amongst key policy implementers about abortion laws is poor where many of them think that abortion is completely illegal in the country, while others had no information on the stipulations under the law.[210] This has also affected the implementation of the existing law in the country where abortion is permitted on the grounds of saving women's lives and in cases of rape/incest or foetal impairment, but majority of the abortions are still carried out by traditional healers in clandestine settings.[211]

In Sri Lanka, the knowledge about abortion prevalence in the country is common among the law makers/implementers, however, the reasons that they think women seek abortion, which include economic constraints, rape, and contraceptive failure, are not reflective of the real situation in the country.[212] There has been a reported increase in the rates of abortion among young unmarried women between the ages of 18 and 25.[213]

iv. Unsafe abortion and percentage of maternal deaths attributed to unsafe abortion

The ICPD Programme of Action locates abortion and strategises about it in the context of public health.[214] Similarly, the Beijing Platform for Action brought focus on the impact unsafe abortion has on the lives of women, and urged governments to review the measures taken against women who have had unsafe abortions and further emphasises on the need for women's access to quality post-abortion care.[215]

Unsafe abortion, which is one of the top five leading causes of maternal mortality,[216] is defined as "a procedure for terminating

Table 22:
Estimates of incidence of and mortality due to unsafe abortion, 2008

Region	Unsafe abortion-related mortality				
	Number of unsafe abortions (rounded)	Number of maternal deaths due to unsafe abortion (rounded)	Unsafe abortion mortality ratio (per 100,000 live births rounded)	% of maternal deaths due to unsafe abotion	Unsafe abortion care-fatality (deaths per 100000 unsafe abortions rounded)
Asia	10 780 000	17 000	20	12	160
East Asia(excluding Japan, Australia and New Zealand)	*	*	*	*	*
South-Central Asia	6 820 000	14 000	30	13	200
South-East Asia	3 130 000	2300	20	13	70
Western Asia	830 000	600	10	16	70

* No estimates are shown for regions where the incidence is negligible.
Source: World Health Organization. (2012). *Information Sheet: Unsafe abortion incidence and mortality. Global and regional levels in 2008 and trends during 1990-2008.*

an unintended pregnancy performed by persons lacking the necessary skills, in an environment that does not conform to minimal medical standards, or both."[217] About 40% of unsafe abortions that were performed in Asia in 2008 were unsafe abortions.[218]

The rates, ratios and percentages show the relative health burden of unsafe abortion in the specified regions. Unsafe abortion is negligible in East Asia and in some developing countries of other regions where abortion is legal and relatively accessible, for example, Vietnam. Hence, in these countries all procedures are safe.[219] The incidence of unsafe abortion still continues to be a pressing problem in the region. Unsafe abortion is a major factor contributing to maternal mortality.

Unsafe abortion continues to be a major factor in maternal deaths in the region. Mortality due to unsafe abortion is estimated at 13% of all maternal deaths, for South Asia and South-East Asia, at 13% as shown in Table 22.

In Bangladesh, abortion contributes 8% of maternal deaths.[220] However, another study has found that between 1996-1997, nearly 26% of all maternal deaths were estimated to be a result of abortion-related complications. At this time, almost half of the reported abortions resulting in complications were performed by untrained birth attendants through the insertion of a foreign object into the uterus, most commonly a root or stick. If services had been available for women to obtain a medically approved abortion from a trained provider, nearly 84% of the deaths would probably have been prevented.[221]

The impact of menstrual regulation services on reducing maternal mortality and abortion-related deaths has been significant in Bangladesh, although determining and understanding the extent of this impact has been difficult due to the scarcity of data on abortions. Despite the safety and increased availability of MR procedures, women in Bangladesh still lack access to these services based on differences such as location and financial status, and many women, despite access, still seek a traditional provider because of the convenience. Additionally, as many as 33% of women seeking MR are rejected—most often the result of a late gestational age. Most of these rejected women will still obtain an abortion even if the abortion is not achieved through a medically approved procedure. These women are at a greater risk of complications that could result in death; yet, the magnitude of this risk remains undocumented.[222]

The Pakistan Demographic Health Survey 2006-07 notes that 6% of maternal deaths are attributed to complications of abortion (either sepsis or haemorrhage); however, very few deaths were reported to follow an induced abortion, and from the verbal autopsy history, it was quite difficult to make a distinction between induced abortion and miscarriage.[223] Another national study estimated that 890,000 induced abortions occur annually, with the estimated annual abortion rate of 29 per 1000 women aged 15-49. "If women of reproductive age were to experience

this rate over their lifetime, the average Pakistani woman would experience about one abortion in her lifetime."[224] Additionally, this study also estimated that 197,000 women were admitted annually to public medical facilities and private teaching hospitals for the treatment of complications of induced abortion.[225]

In India, abortion was legalised in 1972; however, legalisation has not ensured access to safe abortion services for Indian women. Eight percent of all maternal deaths are attributed to abortions, translating to 11,000-15,000 deaths due to unsafe abortion annually. There are no established national level mechanisms for the monitoring and evaluation of maternal mortality and morbidity resulting from unsafe abortion.[226] In Nepal, abortion complications and ante-partum haemorrhage account for five percent of maternal deaths.[227]

In Indonesia, complications from abortion are believed to be responsible for 15% of maternal deaths in Indonesia.[228] Another survey quoted that "of the 750,000 to one million abortions each year in Indonesia, 89[%] were among married women and 11[%] were among single women. It is estimated that 70[%] of women who have had an abortion were trying to abort using traditional herbs (jamu), traditional massage, or an object, or sought an abortion from a traditional healer (dukun) before going to the clinic. This is a cause for concern because these attempts can be life threatening and dangerous for women's health.

Another 1997 study in Indramayu-West Java showed that 40 [%] of village women who sought abortion services (mostly unsafe abortions) were unmarried adolescents."[229] A base line survey, conducted by the Demography Institute, for 15-19 year-olds in four provinces of Indonesia (East Java, Central Java, West Java and Lampung) in 1999 indicates that 61% have unwanted pregnancies, with 12% of them undergoing abortion and 70% of these performing the abortion themselves, while 10% are assisted by traditional helpers to perform the abortion. Only 7 % make use of professional medical assistance.[230]

In the Philippines, pregnancy with abortive outcome contributed to nine percent of maternal deaths in 2000.[231] In Malaysia, annually, unsafe abortion accounts for one to five deaths in the last 10 years according to the Confidential Enquiry into Maternal Deaths by the Ministry of Health.[232] Common unsafe abortion methods used include inserting sticks, herbs, roots, and foreign bodies into the uterus. Other vaginal methods include pins, laminaria tents and fetex paste. Rural Medical Providers sell medicines for oral use to induce abortion. ANMs use intra-amniotic saline and intra-amniotic glycerine with iodine. Orally ingested abortificants include, indigenous and homeopathic medicines, chloroquine Tablets, prostaglandins, high dose progesterone and estrogens, liquor before distillation, seeds of custard apples and carrots. Invasive or surgical methods are tried by a minority of informal providers. The common instrument used is a curette, and occasionally a syringe, catheter or copper T.[233]

SUMMARY

Estimates of the incidence of unsafe abortion continue to be high in the region as does the percentage of maternal deaths attributed to unsafe abortion. Although access to safe abortion services has been proven to be linked to a lower incidence of unsafe abortion (and lower percentages of maternal deaths due to unsafe abortion), progress on amending laws seems slow. Five countries in the region provide abortion on many grounds: China, Nepal, Vietnam, Cambodia and India. Where abortion laws are restrictive, it is important to look at how women's NGOs are working to amend these laws as clearly mentioned in the Beijing Platform for Action.

It is also useful to note that abortion services for women are being provided safely through the private sector (as in Malaysia and Thailand), through the family-planning methods of menstrual regulation (as in Bangladesh) and through private provision of medical abortion (as in South-East Asia). In countries such as Lao PDR, the Philippines, Indonesia, Bangladesh and Pakistan, legal barriers continue to curb women's access to abortion, simply because there can be no services without laws.

In countries such as Malaysia, there are non-legal barriers such as hospital administration policies which continue to curb women's access.

There is still a challenge in shifting the paradigm to provide abortion upon request, within the public health system in the countries with restrictive laws, although most countries have made some provisions for post-abortion care after ICPD. In countries where abortion is legal, this is mainly for the duration of the first trimester with the exception of China, where the government permits abortion to be performed up till six months of gestation.[234]

In these countries, second trimester abortions still prove to be a challenge in terms of legality, political support, the balancing between women's rights and pregnancy advancement, as well as empathy for both women and service providers. [235] In countries with liberal policies on abortion, such as Cambodia, India and Nepal, there are service barriers to accessing safe abortion. In these countries, many abortions are performed in sub-standard conditions, and governments must follow through on their efforts to provide safe abortion services.

3.4 REPRODUCTIVE CANCERS

Paragraph 7.2 of the ICPD Programme of Action states that "reproductive health is a state of complete physical, mental and social well-being...in all matters relating to the reproductive system and its functions and processes."[236] In this context, the resolution on cancer prevention and control (adopted in May 2005) recognises that there is an urgent need for member states to develop and reinforce existing cancer control policies and programmes. It also recognises that *among all cancer sites cervical cancer, among women in developing countries, has one of the greatest potential for early detection and cure, that cost effective interventions for early detection are available and not yet widely used, and that the control of cervical cancer will contribute to the attainment of international development goals and targets related to reproductive health.*[237]

In addition, in 2008, WHO initiated the Non-Communicable diseases action plan which includes interventions around cancer for respective countries. Nevertheless, effective country level action on the prevention, screening, treatment and palliative care are yet to be implemented.

In this section, we will look at cancers of reproductive system among women. These include cervical cancer, breast cancer and ovarian cancer. The section will look at the incidence and mortality due to these cancers and prevention, and treatment measures in place in the region.

In 2008, 7.6 million people (13% of all deaths), globally, have died from cancer.[238] It also needs to be noted here that the most frequent cancers differ for women and men. According to the latest Globocan 2008 report, of the 7.6 million deaths, breast cancers accounted for 458,000 deaths and cervical cancers accounted for 275,000 deaths in 2008. 70% of these deaths occur in low and middle income countries.[239] The Asia-Pacific region contributes to 51.6% of the world burden of cervical cancer.[240]

National cancer registries produce regular reports that present data on cancer incidence in the countries as well as provide cancer mortality data. Unfortunately, only 6 countries out of the 21 surveyed in the region have national cancer registries. These countries are China, India, Indonesia, Malaysia, Pakistan, Philippines and Thailand.[241] In this review, we look at cancers that mostly affect women, including cervical cancer, breast cancer and ovarian cancer.

i. Cervical Cancer

Cervical cancer is the third most common cancer for women, and the seventh most common cancer in the world. In 2008 alone, there was an estimated 530,000 new cases of cervical cancer globally, out of which 275,000 resulted in the death of the patient.[242] In Asia, there were 159,800 deaths caused by cervical cancer in 2008.[243] It needs to be noted here that more than 85% of incidences of cervical cancer occur in developing countries, accounting for 13% of all female cancers.[244]

As shown in the Table 23, the highest incidence of cervical cancer is in India, China, Bangladesh, Indonesia and Pakistan. It is lowest in Samoa, Maldives and Bhutan. Cervical cancer is the most frequent cancer among women in Bhutan,[245] Cambodia,[246] India,[247] Lao PDR,[248] Nepal,[249] and Papua New Guinea.[250] In Bangladesh,[251] Myanmar,[252] Fiji,[253] Malaysia,[254] Pakistan,[255] the Philippines,[256] Samoa,[257] Sri Lanka[258] and Thailand,[259] cervical cancer ranks as the second most frequent cancer among women. In Indonesia,[260] cervical cancer ranks as the third most frequent cancer among women, while it ranks fourth and fifth highest, respectively, in both Afghanistan[261] and Vietnam.[262] In China, cervical cancer ranks as the eighth most frequent cancer among women.[263]

In Malaysia, cervical cancer is the second most common cancer affecting women, causing a total of 766 deaths a year in the country.[264] As recourse, a screening process is carried out by the National Population and Family Development Board (LPPKN), which has a wide network of about 56 Nur Sejahtera clinics throughout Peninsular Malaysia providing reproductive health services, of which one of the crucial services given to clients is the early detection of cancer among women. Furthermore, in 2011 the government of Malaysia announced that an allocation of USD 20 million was to be used for the HPV immunisation programme to protect women against cervical cancer, targeting at least 350,000 women in the nation.[265]

India, Vietnam and China use cytology as a method to screen for cervical cancer and different levels of coverage. Sri Lanka has taken the cytology method a step further, establishing laboratories in every district with trained cyto-technicians and providers.[266] In the urban areas of Bhutan, the screening is done by using the Pap smear method.[267]

Thailand uses the cytology method as well, although it is noted that there are some challenges of screening in terms of lower coverage due to a lack of trained pathologists and cytologists, and expensive or unreliable laboratory equipment. Another challenge for Thailand is the difficulty in tracking patients which leads to inadequate follow-up and it is also noted that the clinical capabilities, especially in rural areas, is limited.[268] Thailand has also initiated a cervical cancer prevention programme using a single visit with visual inspection approach with acetic acid (VIA) with cryotherapy for pre-cancerous lesions. This service was provided by trained personnel and integrated into the existing reproductive health services of the country. The initial pilot project has transitioned into a national programme, with strong support from the government. [269]

It is important that the countries need to have a strong health service delivery system in order to increase coverage as well as to ensure that client management is effective and efficient,

Table 23:
Cervical cancer incidence and mortality in 21 countries

	Incidence* Incidence is the number of new cases arising in a given period in a specified population. This information is collected routinely by cancer registries. It can be expressed as an absolute number of cases per year or as a rate per 100,000 persons per year. The rate provides an approximation of the average risk of developing a cancer.		**Mortality*** Mortality is the number of deaths occurring in a given period in a specified population. It can be expressed as an absolute number of deaths per year or as a rate per 100,000 persons per year.	
	Number	**%**	**Number**	**%**
East Asia				
China	75434	6.3	33914	4.6
South Asia				
Afghanistan	468	6.3	319	5.7
Bangladesh	17686	21.8	10364	19.0
Bhutan	50	16.7	27	9.0
India	134420	25.9	72825	23.3
Sri Lanka	1395	10.4	814	9.6
Maldives	13	13.0	6	6.0
Nepal	3504	21.5	1872	16.9
Pakistan	11688	15.7	7311	14.6
South-East Asia				
Cambodia	1578	22.5	867	20.2
Myanmar	6434	16.6	3536	14.7
Lao PDR	491	16.4	270	13.5
Malaysia	2126	12.6	631	6.9
Philippines	4544	11.1	1856	8.4
Indonesia	13762	8.8	7493	7.2
Thailand	9999	16.0	5216	14.9
Vietnam	5174	9.2	2472	6.5
Pacific				
Fiji	120	20.0	66	16.5
Kiribati	-	-	-	-
Papua New Guinea	540	20.8	364	20.2
Samoa	13	13.0	3	-

* Incidence and mortality data are for all ages.
**Proportions per 100,000
Source: Globocan Report 2008

when using the cytology method of screening. Data on cancer screening, treatment and palliative care is not available uniformly for all the ARROW ICPD+20 countries under review in the Asia and the Pacific region.

The previous ARROW study noted that although HPV vaccination can prevent the transmission of HPV, there is a financial burden placed on the women. The study also recognised that aside from the cost, "it is important to have a functional health system, including trained health professionals, to deal with prevention, treatment and care of reproductive cancers."[270] In the 21 countries surveyed, only Malaysia has made a commitment to provide doses of HPV vaccine to the women in the country, to prevent cervical cancer, effective from 2010.[271]

Cytology Screening, basically pap smear screening, has the potential to reduce cervical cancer incidence by as much as 80%, however, this pap smear screening is sparsely implemented in developing countries with less developed health systems due to lack of infrastructure for testing, trained personnel for reading and quality assurance, and poor coverage of women at risk. The use of alternative low cost methods to pap smear such as visual inspection with acetic acid (VIA) and/or Lugol's Iodine Solution are seen as effective methods in preventing cancer in low resource settings. Research in the area of cost effective and simple HPV testing for screening and preventing cancer is especially necessary in low resource settings. These screening procedures have to be mainstreamed as part of health service delivery package at the national level.[272]

ii. Breast Cancer

Breast cancer is the most frequent form of cancer among women, and accounts for one in five new cancer cases in women worldwide. It is estimated that in 2008, there were approximately 1.38 million new cases diagnosed, being the most common cancer in both developed and developing regions in the world with a projection of 690,000 new cases reported each year.[273]
Data on the incidence, mortality and prevalence in the 21 countries is shown in Table 25. The incidence of breast cancer is the highest among women in China and India. This is followed by Indonesia, Pakistan and Bangladesh, with Samoa, Bhutan and Maldives reporting the lowest incidences of breast cancer.

Although breast cancer is ranked as the most frequent cancer among women, there is not much data available in the 21 countries surveyed. This could be attributed to the lack of awareness about the seriousness of this issue as well as the low priority it has in public health schemes for most countries, although it has to be noted that health awareness improved socio-economic conditions, and the provision of breast cancer screening in more of the developed countries provides better and more favourable outcomes.[274] Organised population-based screening programmes for breast cancers can go a long way in reducing the mortality among women.[275]

iii. Ovarian Cancer

Data on the incidence, mortality and prevalence of ovarian cancer in the 21 countries is shown in the Table 24. Incidences of ovarian cancer is highest in China and India (although again, this could be attributed to the high population in these countries), followed by Indonesia, Pakistan and Thailand. The lowest incidences reported are in Samoa, Maldives and Bhutan.

Very little data is available on ovarian cancer, although it is one of the more aggressive forms of reproductive cancer. It accounts for about 3% of the types of cancers that affect women, and is the fifth leading cause of death among women. Often times, women who suffer from ovarian cancer die without knowing the cause of their illness,[276] and this can be a contributing factor to the low numbers of ovarian cancer when compared to cervical and breast cancer. At present, there are no established methods for early detection of ovarian cancer.[277]

SUMMARY

In the coming years, more women will die from reproductive deaths than from maternal deaths. Countries should be planning programmes in order to anticipate this challenge adequately. As the interventions are considered more costly than those for contraception or maternal health, there is a greater struggle in establishing women's rights to access preventive and curative services. Additinally, unequal socio-economic situations coupled with socio-cultural barriers and poor or inadequate health care infrastructures impede the "prevention, treatment and care of reproductive cancers."[278] Although a number of countries are showing commitments towards screening and the prevention of cervical cancer, it needs to be emphasised that the scarcity of data and low level of priority towards breast cancer and ovarian cancer is worrying. There needs to be a more systematic and in-depth data collection on these two cancers in order to raise awareness and provide health care which includes screening, treatment and cure.

Most of the countries under review in the ARROW ICPD+20 monitoring, are countries in low resource settings. Early screening can go a long way in reducing the incidence and mortality from cervical and breast cancers and health systems in respective countries in the region have to be geared to put in place effective prevention strategies, early detection, which comprises of diagnosis, screening including cervical cancer screening, HPV testing, mammography screening, treatment and palliative care.[279] Therefore, population-based data on cancer incidence and mortality become the starting point for any intervention and countries need to start collecting this information.

Table 24

Breast Cancer: Incidence and Mortality

	Incidence* Incidence is the number of new cases arising in a given period in a specified population. This information is collected routinely by cancer registries. It can be expressed as an absolute number of cases per year or as a rate per 100,000 persons per year. The rate provides an approximation of the average risk of developing a cancer.		**Mortality*** Mortality is the number of deaths occurring in a given period in a specified population. It can be expressed as an absolute number of deaths per year or as a rate per 100,000 persons per year.	
	Number	**%**	**Number**	**%**
East Asia				
China	169452	14.2	44908	6.1
South Asia				
Afghanistan	1509	20.4	853	15.2
Bangladesh	17781	21.9	8396	15.4
Bhutan	20	6.7	11	3.7
India	115251	22.2	53592	17.2
Sri Lanka	3436	25.6	1624	19.1
Maldives	53	53.0	22	22.0
Nepal	2574	15.8	1248	11.2
Pakistan	19271	25.9	10376	20.7
South-East Asia				
Cambodia	1213	17.3	448	10.4
Myanmar	7911	20.4	2926	12.2
Lao PDR	391	13.0	144	7.2
Malaysia	4485	26.5	1716	18.7
Philippines	11524	28.2	4085	18.4
Indonesia	39831	25.5	20052	19.2
Thailand	12566	20.2	4427	12.7
Vietnam	6830	12.1	2423	6.3
Pacific				
Fiji	121	20.2	60	15.0
Kiribati	-	-	-	-
Papua New Guinea	393	15.1	220	12.2
Samoa	16	16.0	1	-

* Incidence and mortality data are for all ages.
**Proportions per 100,000
Source: Globocan Report 2008

Table 25:
Ovarian Cancer: Incidence and Mortality

Country	Incidence*		Mortality*	
	Number	%	Number	%
East Asia				
China	28739	2.4	11419	1.6
South Asia				
Afghanistan	162	2.2	122	2.2
Bangladesh	2518	3.1	1786	3.3
Bhutan	22	7.3	15	5.0
Bangladesh	2518	3.1	1786	3.3
India	28080	5.4	19558	6.3
Sri Lanka	1095	8.2	771	9.1
Maldives	6	6.0	5	5.0
Nepal	1078	6.6	774	7.0
Pakistan	3568	4.8	2650	5.3
South-East Asia				
Cambodia	266	3.8	156	3.6
Myanmar	1690	4.4	997	4.2
Lao PDR	131	4.4	76	3.8
Malaysia	916	5.4	616	6.7
Philippines	2031	5.0	949	4.3
Indonesia	9664	6.2	7031	6.7
Thailand	2748	4.4	1555	4.5
Vietnam	845	1.5	359	0.9
Pacific				
Fiji	35	5.8	27	6.8
Kiribati	-	-	-	-
Papua New Guinea	104	4.0	77	4.3
Samoa	1	1.0	0	-

* Incidence and mortality data are for all ages.
**Proportions per 100,000
Source: International Agency for Research on Cancer (IARC), Globocan 2008

CONCLUSIONS

From a review of the reproductive health and reproductive rights indicators across the 21 countries, the following conclusions can be made.

REPRODUCTIVE HEALTH AND RIGHTS

1. **Progress across the region is uneven and slow with regards to reproductive health and reproductive rights**

- No one country has made progress in every single indicator of RH and RR.
- Contraceptive prevalence rates are still low in many countries, but are high in countries which have strictly implemented population policies. The burden of contraception falls on women. The fertility rates in some countries in the region are also affected by migration. Access to emergency contraception is still low in the region.
- Maternal deaths remain a challenge in South Asia and Lao PDR in South-East Asia. Haemorrhage and hypertension remain major causes of maternal deaths in the region and these can be prevented with effective interventions. Lack of access to EmOC services, skilled attendants, strengthened procurement and distribution chains for essential drugs and equipment to prevent maternal deaths, and legal barriers to maternity care contribute to high maternal deaths in these countries. Systems to audit maternal deaths at community and facility level are scarce. Few countries in the region have made progress in providing at least 4 antenatal check-ups during the course of delivery. Issues of equity largely loom on the access to EmOC, skilled birth attendance, and antenatal and postnatal care. Adolescent births are also a cause of concern in the region. Though the maternal mortality ratios are showing some improvements in the region, progress on the essential interventions to prevent maternal deaths and promote maternal health such as skilled attendance, EmOC services, antenatal and postnatal care is painstakingly poor.
- Abortion policies take a long time to change. Progressive laws need to be backed up with service provision and quality of care.
- Reproductive cancers are yet to be addressed in a cohesive and comprehensive manner within health systems.

2. **Political will of governments is crucial in making laws, allocating resources, and deploying trained staff**

- Political will of governments is a key factor for the achievement of reproductive health and reproductive rights outcomes. When governments decide to reduce fertility, as seen in China, India and Indonesia, it is done. When governments decide to reduce maternal deaths in Malaysia and Thailand, it is done. When governments decide to provide access to safe abortion services, as in Vietnam and China, it is done. When governments decide to address reproductive cancers in a concrete manner, as in Malaysia, it is done.

- Once the RH issue is seen as a prime importance, governments create policies and programmes, deploy budgets and trained personnel, and provide facilities and access.

3. **Access for marginalised groups is a concern across all countries**

- In all countries, women who are poor, less educated, live in remote areas and/or rural areas and hard to reach areas face greater difficulties in accessing services and realising the autonomy of their bodies. Tribal women, women from ethnic minorities, women from lower castes, and younger women are also marginalised. This happens regardless of whether the service they require access to is contraception, maternal health services, safe abortion services, and the prevention and treatment of reproductive cancers. Reproductive health and reproductive rights are an issue of socio-economic equity as well as gender equity.

ENDNOTES

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9 These [wanted] fertility rates are [generally calculated in the same manner across all the country DH Surveys:] calculated in the same way as the total fertility rates, but unwanted births are excluded from the numerator. For this purpose, unwanted births are defined as those that exceed the number considered ideal by the respondent. Women who did not report a numeric ideal family size were assumed to want all of their births.

10 The figures for Wanted Fertility Rates are only available where the country's latest DHS is available. No other sources of data can be relied upon for this indicator.

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chapter 4

sexual health and sexual rights

4. SEXUAL HEALTH & SEXUAL RIGHTS

4.1 INTRODUCTION

In this section, we deal with sexual health and sexual rights. Under sexual health, we will look at sexually transmitted infections (STIs) and HIV and AIDS. Within STIs, we will focus on STI prevalence and intervention programmes. Within HIV and AIDS, we will focus on HIV prevalence and incidence rates, vulnerability of women to HIV and AIDS, laws and policies for people living with HIV and AIDS, programmes for access to voluntary counselling and testing and anti-retroviral therapy, and integration of sexual and reproductive health services with HIV and AIDS services.

Last, but not least, we will tackle sexual rights in this section, although it is a highly contested term in international arenas. Detractors often dismiss 'sexual rights' as terminology which has not been agreed upon by governments within the UN system. Sexual rights issues are seen by many governments as being synonymous with the legalisation of homosexuality and same-sex marriage.

This is a highly limited perspective on sexual rights because the majority of women, who live in patriarchal societies, still continue to struggle for sexual rights. The concept of sexual rights is also so closely intertwined and interlinked with that of reproductive rights so much so that, in some aspects, it is difficult to separate both.

In order to achieve desirable SRH outcomes, it is crucial to empower men and women with rights which enable them to be equals[1] in the public and in the most private spheres of life. It is also important to empower women to exercise their decision making with regards to sexuality and reproduction.[2] It is also imperative to establish rights for women, in which those rights may not currently exist, in order to enable women's decision-making capacities.[3]

But what are sexual rights? Are they really so contested? "Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of health in relation to sexuality, including access to SRH care services;
- seek, receive and impart information in relation to sexuality;
- sexuality education;
- respect for bodily integrity;
- choice of partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when to have children; and
- pursue a satisfying, safe and pleasurable sexual life." [4]

This WHO working definition is wholly consistent with and does not deviate from the principles of the ICPD PoA. It is useful to enunciate and enumerate the separate and different components of sexual rights in order to build the discourse and create support for the language among governments and civil society. This review attempts to do exactly this.

We will ascribe, what we feel to be, important indicators of sexual rights. In order to determine the rights around choice of partner, decision to be sexually active or not, and consensual sexual relations and consensual marriage, we will choose to look at the laws and implementation of the legal age of marriage and the existence of arranged marriages and forced marriages. As for indicators of bodily integrity, we will look at traditional practices harmful to women and laws on sexual violence and trafficking. Concerning indicators of the rights to the highest attainable standard of health in relation to sexuality, in choice of partner, in consensual sexual relations and to pursue a satisfying, safe and pleasurable sexual life, we will look at laws around sex work, same-sex sexual relations and transgendered people.

All of these, we hope, will continue the work we started in 2009 to demystify the notion of sexual rights through the use of the following indicators, and show issues of sexual rights that need to be addressed by governments: legal age of marriage and the enforcement thereof; arranged/forced/child marriage; traditional practices harmful to women; laws against sexual violence - marital rape, rape, and sexual harassment; laws on the trafficking of women; laws on sex work; laws on same-sex sexual preference/relations/unions; and transgenderism.

We agree that "[t]he creation of the concept of sexual rights is something we should value as a platform for conversation that may help drive coalition building.... While the definition of sexual rights in Cairo has limitations, we need to value it. It was the feminist community working at the UN level that crafted this incredible concept of sexual rights that goes beyond identity politics, allowing us to address issues of violence, race and disease prevention and at the same time issues of pleasure, autonomy and self-determination."[5]

We also feel strongly that 20 years after ICPD, we need to realise and recognise the value that sexual rights brings to facilitate the achievement of the ICPD PoA and the SRHR community.

4.2 SEXUAL RIGHTS OF ADOLESCENTS TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH IN RELATION TO SEXUALITY

In order to determine the indicators of the rights to the highest attainable standard of health in relation to sexuality, in choice of partner, in consensual sexual relations and to pursue a satisfying, safe and pleasurable sexual life, we will look at adolescent sexual rights. In this review, we will focus on unmarried adolescents, as access to information, education and services is especially problematic for this group.

Theoretically, contraception and abortion are considered core reproductive health components, but for unmarried adolescents, they not only ensure sexual autonomy but also sexual health. Within this area, the indicators we will examine are availability of sex and sexuality education as well as service provision for adolescents as their rights to the highest attainable standard of health in relation to sexuality, including access to SRH care services; to seek, receive and impart information in relation to sexuality; access to sex and sexuality education; and to decide to be sexually active or not.

The World Health Organization (WHO) defines adolescents as the 10-19 age group, and in general terms, this period is considered a time of transition from childhood to adulthood, during which young people experience changes following puberty, but do not immediately assume the roles, privileges and responsibilities of adulthood.

The ICPD PoA acknowledges that this population group has sexual and reproductive health (SRH) needs that must be addressed. It urges the governments to address adolescent SRH issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, as well as HIV and AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suiTable for that age group.[6]

There are two clear strains of thinking about adolescents in the 21 countries surveyed. In South Asia, where the age of marriage is rather low, adolescents are very often married and their rights to services are recognised within this framework. In South-East Asia, where the age of marriage is comparatively higher, adolescent sexual activity is often perceived as being outside the framework of marriage. As SRH services have been so often subsumed within the framework of reproduction, access to these services and to information becomes problematic for adolescents. In this review, we will focus mainly on unmarried adolescents simply because, for this group, access to contraception and abortion, in theory, core reproductive health components, helps ensure sexual autonomy. We will focus on their access to information, education, and services.

i. Sex Education and Sexuality Education within the National Education Curriculum

Sex education is defined as the basic education about reproductive processes, puberty and sexual behaviour. Sex education may include other information, for example, about contraception, protection from sexually transmitted infections and parenthood.[7] Sexuality education is defined as education about all matters relating to sexuality and its expression. Sexuality education covers the same topics as sex education but also includes issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and the social pressures to be sexually active, and it provides information about SRH services. It may also include training in communication and decision-making skills.[8]

Progress in providing sex education, in the 21 countries, is uneven. In fact, there are vast differences in the interpretation of what constitutes sex/ sexuality education among and within countries. Some governments have already begun to address incorporating sex education into the education curriculum. In addition to this, the scope and coverage of sex education curriculums differ significantly within the countries. The current emphasis seems to be on biology rather than health and rights. In the 21 countries, NGOs have been working on creating awareness about the demand for sex/sexuality education and this has created an atmosphere of acceptance of sex/sexuality education in the countries.

Five out of the 21 countries (Afghanistan, Bangladesh, Indonesia, Nepal and Thailand) have national population and reproductive health strategies or plans that made direct reference to the education sector, and there are also other population and reproductive health strategies and/or plans that include activities that are related to education. For example, Indonesia has a National Strategy for Adolescent Health (2004) which includes sex education, focusing on the "improvement of skills of health personnel in adolescent counselling, life skills education, prevention and detection as well as HIV/AIDS management," but the activities are not being implemented by the education sector and there is no direct link with education. [9]

It is also worth noting that in these five countries, while the focus is on working with the Ministry of Education in order to include the relevant contents into the education curriculum, this is often done with other ministries such as the health or social affairs, and only a few of these plans/strategies have defined at which level of education (primary, secondary) the integration should take place and whether this intervention covers the education environment (formal, non-formal).[10]

Cambodia, China, Indonesia, Nepal, Papua New Guinea and Vietnam have included a detailed discussion of sexuality education in national HIV laws and/or policies, while the documentation on the strategies and/or plans on the education

sector in Bangladesh, Bhutan, Malaysia, Samoa, and Thailand do not include a specific reference to sexuality education.[11] Indonesia, Malaysia, Pakistan, Bangladesh, Bhutan, the Philippines and Samoa have not started providing sex education in schools as part of the school curriculum. Indonesia has a policy to extend information and reproductive health education to adolescents, to be implemented by the National Family Planning Coordinating Board and the Department of Education. Controversies persist on whether SRH education and services need to be extended to adolescents in the country and this has implications on the implementation of the policy. Training modules for parents and adolescents were also developed, however their integration into the school curriculum is limited.[12] Similarly, in Malaysia and Pakistan, sex education has not been integrated into the school curriculum, although the demand for sex education among adolescents has been documented by NGOs.

In Bangladesh, sex education is not taught by teachers in schools although some basic reproductive health topics are included in the school curriculum.

In the Philippines, adolescent reproductive health (ARH) education is mostly community- based. Some are school-based, and a few are implemented in the workplace. Information and education interventions include lectures, workshops, discussions, trainings, and media-based activities. Most of these programmes are focused on ARH, sexuality and fertility issues, in which counselling is provided.[13] In 1997, the Population Commission of the Philippines, with the assistance of the national and local governments and NGOs, launched "Hearts and Minds," a nationwide information, education and communication (IEC) campaign that teaches young Filipinos about sexual health, responsible adulthood, and parenthood.[14]

In Vietnam, Afghanistan, India and Nepal, there are attempts to introduce sex education but there are limitations. In Vietnam, from 1995-96 onwards, the Ministry of Education and Training decided to integrate education on HIV/AIDS prevention into the official curriculum of secondary schools throughout the whole country. This move consisted of incorporating lessons on reproductive health and HIV/AIDS.[15] From 2002 to the present, after the issuance of the decision 40/2000/QH10 regarding school reformation, and with the support of UNFPA, the Population and RH curriculum in upper-secondary schools has been developed and is in the process of being piloted. It has been integrated into the school text books for Biology, Civics Education, Geography, Language and into extracurricular activities for Grades 10 to 12 in some provinces. In the final evaluation, UNFPA noted that most of the information on adolescent RH mainly focuses on pathological aspects of RH and contains poorly clarified/confusing/wrong concepts and statements; information which is sometimes insufficient or even incorrect; the use of outdated statistics; and poorly written Vietnamese. Yet, the integration of adolescent RH in upper-secondary schools has shown increased knowledge among students. Rapid assessment confirmed that more than 60% of students in all schools are aware of basic adolescent RH issues such as STDs/HIV/AIDS, condoms, oral contraceptive pills and emergency contraception.

In Afghanistan, the National Reproductive Health Strategy (2003-2005) specifically foresees a pilot on family life education and life skills in schools which will be "tested sensitively in the first phase in the appropriate age group of secondary students."[16] As for India, the sex education curriculum is called the Adolescence Education Programme (AEP). The curriculum was developed by the National AIDS Control Programme, and was rejected by several state governments including Madhya Pradesh, Chhattisgarh, Rajasthan, Uttar Pradesh, Kerala and Karnataka, with the chief ministers writing to the Ministry of Human Resources Development accusing it of corrupting the morals of the young.

The module was revised but, in turn, was rejected by 33 NGOs from across the country, including youth groups, sexual rights groups, women's groups and groups working with child sexual abuse. In a joint statement, they declared: "The thrust of the... curriculum is abstinence. It is silent even about the biological aspects of reproduction. The lesson on conception, whilst addressing internal biological mechanisms, omits any description of intercourse. Sexual intercourse is shrouded in the euphemism 'intimate physical relationships.' Without the knowledge of what does cause conception, the curriculum will fail in one of its own objectives - that of addressing teenage pregnancy."[17]

In Nepal, the National Adolescent Health and Development Strategy (2000) considers adolescents a key target group for information and services. Nevertheless, the extent to which sex education is being provided in schools has received little attention. At higher secondary level, students are supposed to be taught basic sex education using a chapter in a textbook called *Health, Population and Environment.* Little is known about how or how well this material is covered. A study in 2002 found that adolescents in these schools did not appear to be getting the information they needed. Most of the teachers did not want to deal with sensitive topics and feared censure by their colleagues and society. Some lacked the skills to give such instruction. Many students also felt uncomforTable with the topics. The challenge is to strengthen sex education, make it more appropriate for the students and ensure that teachers are more comforTable and able to give instruction on the topic.[18]

Papua New Guinea shows consistent mainstreaming of sexuality and HIV and AIDS education in policy documents, according to a recent study done by UNESCO.[19]

In Thailand, there has been progress on sex education, with the boundaries being pushed forward with each revision of the curriculum. Thailand has already introduced sexuality education.

The first national policy on sexuality education in schools was announced in 1938, but sex education was not taught in schools until 1978. In the past, it was called "Life and Family Studies," and its content consisted of issues related to the reproductive system and personal hygiene. The education curriculum has been revised several times, involving efforts from both government and non-government sectors, and sex education has been accepted as a problem solving tool for adolescent SRH issues. This has been a consequence of educational reform following the National Education Act B.E. 2542, increasing awareness of problems related to adolescents' sexual practices, and the emergence of women's sexuality, and queer movements. The most remarkable new approach in sexuality education curricula in Thailand has been the Teenpath Project developed by PATH, Thailand. PATH has also succeeded in institutionalising sexuality education curricula in schools since 2003.[20]

Sexuality education seems to be an area where intellectual theory and perspectives have far surpassed the ability of governments in the Region to deliver. Both sex education and sexuality education are contentious issues for voters, especially in the countries where conservative/religious fundamentalist parties hold considerable power in parliament. In the countries where sex education has been initiated, challenges with regards the comprehensiveness of the curriculum still remain. The increased acceptance in the countries for sex education is attributed to combating the HIV epidemic rather than providing sex education to adolescents. Recent developments have also contributed to re-conceptualising sex education as sexuality education, mostly in NGO-led programmes in Thailand and Vietnam, to include dimensions such as sexual expression, negotiation and communication.

ii. Access to Services within the Public Health System

In the Asia-Pacific region, there is a need for realisation of the fact that adolescents and young people need to be well equipped with information about their sexuality and that access to sexual and reproductive health services is an important aspect to ensure that they live healthy and productive lives. The higher proportion of youth in the population in the region is a cause for concern given the lack of such services and at the same time, it is an opportunity that needs to be invested into to solve economic deprivation in most of the countries in the region.
As far as the access to sexual and reproductive health services is considered, there is great demarcation between those married and young people who are not married but are seeking such services in the region. Such demarcations exist even within countries.

In a study conducted by WHO in 2004 in the South East Asia Region, adolescent and young respondents from Bangladesh, Myanmar, Bhutan, Nepal, Maldives and Thailand identified 'sexual and reproductive health' of adolescents and the lack of such services was highlighted.[21]

Due to the ever-growing youth movement and the increased awareness of young people's sexual and reproductive health needs, there have been many interventions introduced by different stakeholders, including the governments in different countries of the region. However, it has been reported that barriers are mostly related to cultural unacceptability of young people's sexual rights rather than the laws around it.[22]

The Government of Nepal has a National Adolescent Health and Development Strategy and the Young People Development Programme that caters to "adolescent and young people as a key target group for integrated sexual and reproductive health services, with interventions planned to increase knowledge on sexual and reproductive health issues and availability of services."[23] However, the lack of quality services and the stigma attached to young women and girls accessing sexual health services stop young people from reaching out to such facilities and the situation does not change despite the programmes in place.

Similar barriers exist in other countries in the region. In Vietnam, there are no legal restrictions against youth's access to SRH services within the public health system. The National Strategy on Reproductive Health Care for the 2001-2010 Period identified ARH as one of the major problems. The strategy focuses on improving ARH through education, counselling, and provision of reproductive health services.[24] However, barriers of stigma and discrimination related to pre-marital sex impede access to SRH services.

In Cambodia, the National Reproductive Health Programme / Ministry of Health (MoH) recognises the importance of providing services for young people who constitute around 36.5% of the population amidst the changing patterns of premarital sexual relationships in the country.[25]

The Chinese government has taken steps to improve availability and accessibility of reproductive health care for adolescents. In 2002, a government hospital in Beijing opened the country's first clinic for adolescent psychological and sexual healthcare services. The clinic provides adolescents with free or low-cost gynaecology, maternity, urology, paediatrics, and psychological counselling services. Similar facilities have since opened in several cities. These government-funded adolescent health-care facilities offer free abortion services for pregnant girls under 18 years of age, and some permit anonymous abortions without parental notification.[26]

In Lao PDR, a study noted that services are, in theory, accessible to all irrespective of age or marital status. However, services tend to be of limited quality and are not readily accessible to the unmarried. Providers, considered as the Family Planning Unit, at such government health facilities are responsible for the provision of contraceptive services. However, the unit is attached to the Maternal and Child Health section and is not widely used

by the unmarried.[27] The same study also notes that unmarried youth have difficulties accessing services and this may be related to negative attitudes of the providers and poor quality of services. In India, there is limited access for youth to SRH services and socio-cultural norms constrain unmarried adolescents from seeking these services. Thus, contraceptives remain out of their reach. Social stigma prevents unmarried girls and their family members from seeking services related to abortion. Providers are often judgmental and lack counselling skills.[28] However, the National Youth Policy articulates the inclusion of information on reproductive health as part of the curriculum and of setting up clinics in rural areas to address the health needs of adolescents, and of access to antenatal, postnatal and natal health services.[29]

In the Pacific, there is also a growing realisations and mobilisation of governments to address adolescent sexual and reproductive health needs through introducing youth-friendly policies. In June 2012, New Zealand Parliamentarians Group on Population and Development brought together ministers and parliamentarians from Papua New Guinea, Solomon Islands, Marshall Islands, Tuvalu, Vanuatu, Kiribati and Samoa to push for policies revision and more, in this regard.[30] However, concerted efforts are still needed to establish youth-friendly services that they will be able to access without the fear of stigma and discrimination, and breaching of their confidentiality.

A gender-sensitive rights-based approach to CSE can help young people, and young women and girls, in particular, acquire the necessary skills and knowledge to negotiate safe sexual practices. It is essential to put in place broad-based strategies for CSE that address the needs of young people, especially young women and girls.[31] CSE is necessary for all women, including unmarried girls, to prevent unwanted pregnancies.[32] The positive impacts of CSE on young women and girls include: an increase in the use of contraception, a decrease in the onset of sexual activity and in the number of sexual partners, as well as a drop in the frequency of sexual activity. [33]

SUMMARY

Progress on imparting sex education and sexuality education to adolescents in the 21 countries is staggered and uneven. In all countries, unmarried young people still face many barriers, some legal and some socially discriminatory, to accessing SRH services. It is clear from the lack of provision of education, information, and services to young people who are in dire need of these, that governments in the region are hesitant to recognise the role of sexuality beyond its function in reproduction.

BOX 9

Reproductive Tract Infections (RTIs) - Less attended to in current centres

I was hospitalized for three days for RTI problems, though it is a government hospital and we need to spend for food and travel expenses, those expenses were heavy burdens to my poor family. Doctor asked to come for follow-up visits once in 15 days but i was unable to go. – RTI 4

Source: P. Balasubramanian & TK. Sundari Ravindran.(2010) Utilsation of health facilities for reproductive health services : a case study from rural Tamil Nadu, India. Reclaiming & Redefining Rights - thematic studies series 4: Maternal mortality and morbidity in Asia. Pp 88

4.3 SEXUAL HEALTH

i. Sexually Transmitted Infections (STIs)

The ICPD PoA urges the governments "*to prevent, reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women.*"[34] At ICPD+5, governments were called to ensure that prevention of and services for sexually transmitted diseases and HIV/AIDS are an integral component of reproductive and sexual health programmes at the primary health-care level.[35]

"Sexually transmitted infections (STIs) are infections that are spread through sexual contact. There are more than 30 different sexually transmissible bacteria, viruses and parasites. They may produce no symptoms at all or produce symptoms that are mild and transient. However, many STIs can have severe long-term consequences. Some (gonorrhoea, chancroid, herpes simplex) produce acute symptoms. In adults, chlamydia and gonorrhoea may lead to complications such as infertility and potentially fatal ectopic pregnancy or chronic illness. In newborn children, chlamydia, gonorrhoea and syphilis can produce serious and often life-threatening conditions, such as congenital syphilis, pneumonia and low birth weight. STIs amplify the risk of HIV transmission, and infection with the human papillomavirus (HPV) is a proven precondition for the development of carcinoma of the cervix, which is the second leading cause of female cancer mortality worldwide."[36][37]

The World Health Organization estimates that in 2005 there were 7.39 million cases of *Chlamydia trachomatis* in South-East Asia (SEA). Estimates for gonorrhoea were 8.37 million cases, for syphilis were 11.77 cases, and for trichomoniasis were 26.91 million cases.[38] The corresponding 2005 incidence rates for chlamydia related infections were 6.6 and 41.6 million, for

gonorrhoea were 22.7 and 26.9 million, for syphilis were 2.9 and 1.1 million, and for trichomoniasis were 38.6 and 39.1 million, respectively. The total for these four infections was 70.8 million for the SEA region and 108.7 million for the Western Pacific region giving an overall total of 179.5 million.[39] The Asia and Pacific region had by far the greatest number of curable bacterial STIs of all the global regions.[40]

In South Asia and South-East Asia, HIV epidemics have largely followed the trend of STI. In countries where STI control is strong, HIV epidemics are slow to develop. Where STI control measures have been scaled-up, rapidly growing HIV epidemics have been halted and even reversed. Thus, an effective STI control programme reduces the burden of both HIV infection as well as other STIs.[41] Based on the available data of the 21 countries monitored, it is apparent that most of the STI interventions are being carried out through the HIV/AIDS programmes and are targeted at the most-at-risk behaviours, although there are some countries, like Malaysia, that also target STI/HIV prevention for young men and women.

Between 2006 to 2010, Afghanistan implemented the Afghanistan National HIV and AIDS Strategic Framework (ANASF), which was designed to guide Afghanistan's response to HIV/AIDS. The Guiding Principles of the ANASF include the right to protection from HIV and STI; cultural, social and language sensitivity; supportive of vulnerable populations, particularly women; confidentiality and informed consent; and full community participation (including PLWHA) in prevention as well as care.[42] Bangladesh, in 1997, endorsed the National Policy on HIV/AIDS and STD Related Issues (NASP), and became the first among the South Asian countries to adopt such a policy. The government of Bangladesh also developed National STI management guidelines in the year 2006.[43]

Nepal's national programme is targeted at most-at-risk populations, and in the Nepalese context, there has been a noTable expansion in the numbers of clinics treating STIs, offering services for key target groups such as FSW and clients, MSW, MSM, IDUs and migrant workers as well as for PLHAs.[44] In Pakistan, the government's response to the HIV epidemic during the period 2003-2007 emphasised the interventions on prevention and management of STI.[45] The Government of India's National Policy for the Prevention and Control of AIDS places emphasis on targeted intervention for the control of STI and RTI. STI prevalence in the country varies markedly between different states in India ranging from 1% to 26%.[46]

In Indonesia, the National Strategy and Action Plan 2006-2010 (NSAP) sets clear priorities and targets, and serves as the overall framework for interventions on HIV/AIDS/STI. STI treatment services were expanded with a focus on sex workers and clients, and behaviour change interventions targeting mobile groups were implemented in many provinces.[47]

In Malaysia, one of the interventions for the prevention of STI/HIV/AIDS is through implementation agencies like the Federation of Family Planning Associations, Malaysia (FFPAM). The programme aims to improve the capability of young men and women in respective project areas in protecting themselves from HIV and STIs as well as improving the capacity of educators, including young people, in effecting behavioural change towards HIV and STI prevention among young people.[48]

In the Philippines, prevention programmes include mass media, condom social marketing, counselling and testing, improving management of STIs, interventions for vulnerable populations, and programmes for sex workers among others.[49]

In Vietnam, STI management and treatment has been approved as part of prevention programmes in Vietnam. Various activities have been implemented to reduce STI prevalence such as: conducting IEC activities around STI prevention for both the general population as well as key populations at higher risk; building capacity for health staff working with STI management systems; strengthening STI sentinel surveillance and expanding it to 20 provinces; as well as providing equipment, test kits and STI drugs. However, the STI management programme still faces challenges in Vietnam and the majority of people diagnosed with an STI visit private clinics for treatment. There is a lack of drugs provided for patients at public health facilities and there is a need to further invest in building the capacity of health staff.[50]

In Fiji, a STI treatment guidelines and surveillance system review took place in 2009, as well as a roll out of training of STI treatment to health care centres and Training of Trainers (ToT) for further roll out of treatment of STIs to PHC level.[51] Almost all the countries monitored do have antenatal screening for syphilis, with the exception of Cambodia, India, Lao PDR, Nepal, Pakistan and Samoa. Data was not available for Bhutan, Myanmar and Kiribati.

SUMMARY

The prevention and treatment of STI in the countries under review have largely been driven by the HIV intervention efforts. HIV intervention focuses on high-risk behaviour groups. As a result, the larger population, who are at risk of STI but do not fall under the high risk categories, are not prioritised for prevention and treatment programmes. In countries, such as Malaysia, however, a concentrated effort has been made to target young men and women in prevention against HIV and STIs.

ii. HIV/AIDS

Paragraph 8.29 of the ICPD PoA objective on HIV/AIDS calls upon the governments *"to prevent, reduce the spread of and minimize the impact of HIV infection; to increase awareness of the disastrous consequences of HIV infection and AIDS and associated fatal diseases, at the individual, community and*

BOX 10

HIV and AIDS

Stigma And Discrimination And Other Forms Of Violence Among People Of Diverse Sexual Orientation And Gender Identity

Jyoti, medical supervisor of a hospice in kathmandu shared: "in tuberculosis treatment centres, staff do not understand how to deal with transgender people and are hesitant to examine them. Once, a pregnant nurse refused to touch a HIV+ patient for fear of infection. There is lack of knowledge about HIV among health personnel and even less about sexuality. There are laws for people living with HIV, including directives that they be referred to as sankramit (infected) and not rogi (diseased). These laws contain clauses about confidentiality and rights to a proper death certificate, documents and rituals. There remains a large gap in the implementation of these laws."

Source: Neha Sood . Redefining identity: transgenderism and sexual citizenship – conversations across India, Nepal, and Thailand. Reclaiming & redefining rights - thematic studies series 1: Sexuality and Rights in Asia. ARROW pp 80

national levels, and of the ways of preventing it; to address the social, economic, gender and racial inequities that increase vulnerability to the disease."

Further to this, the Millennium Development Goal (MDG), reiterated in its target 6A, "*to have halted by 2015 and reverse the spread of HIV/AIDS.*" The 2006 political declaration urged for universal access to HIV prevention, Care and Treatment by 2015, and in 2011 as part of the United Nations Political Declaration on HIV and AIDS, governments had committed to intensifying efforts to eliminate HIV and AIDS, countries had pledged to take specific steps in the lead up to 2015. The 2011 Political Declaration set key targets including, reducing sexual transmission by 50%, reducing HIV transmission among people who inject drugs by 50%, substantially reducing the number of mothers dying from AIDS related causes, providing antiretroviral therapy to at least 15 million people, closing the global AIDS resource gaps, eliminating gender inequalities and gender-based violence and abuse, eliminating stigma and discrimination, and strengthening the integration of AIDS response in global health and development efforts.

The following are indicators under review for section on HIV and AIDS, shown in Table 26:

- The indicators of HIV Prevalence and incidence data will provide the magnitude of the epidemic and the epidemic pattern prevalent in the respective countries in the region.
- The indicators on women and HIV will provide estimates of the epidemic and prevalence among women, and their vulnerability to HIV and AIDS.
- The indicators on higher risk and vulnerable groups, will help assess the vulnerability of the HIV and AIDS among men having sex with men, injecting drug users, and sex workers.
- The indicators on stigma and discrimination will assess the status of the policies in this regard, and protecting the rights of individuals from stigma and discrimination.
- Laws and policies pertaining to people living with HIV
- Voluntary counselling and testing (VCT) and anti-retroviral therapy (ART)

iii. HIV Prevalence and Incidence (New Infections) in the 21 Countries

In the Asia and the Pacific region, an estimated 4.9 million people were living with HIV in 2011.[52] In 2011, in South and South-East Asia, an estimated 4 million (3.1 million-4.6 million) people were living with HIV, in East Asia an estimated 830,000 (590,000-1.2 million) people were living with HIV, and in the Pacific an estimated 53,000 (47,000-60,000) people were living with HIV. The number of people living with HIV is more for all the sub-regions in comparison to 2001.[53]

New infections accounted for 370,000 in the Asia and the Pacific region, with Pacific and South and South-East Asia having made progress in reducing new HIV infections and AIDS-related deaths. In East Asia, however, new HIV infections and AIDS-related deaths are increasing.[54]

National HIV prevalence among adults is highest in South-East Asia, with a wide variation in epidemic trends between different countries. While the prevalence is declining in Cambodia, Myanmar and Thailand, HIV prevalence in Indonesia (especially in the Papua province), and Vietnam is on the rise. In South Asia, the epidemic is showing an increasing trend in Bhutan (see Table 26).

In terms of the epidemic pattern, recent data published in 2012 suggests a declining epidemic with new infection and people living with HIV declining, and deaths remaining sTable in India and Nepal in South Asia, and Thailand, Myanmar and Cambodia in South-East Asia. The epidemic is showing a maturing pattern, with new infections declining, people living with HIV still increasing or stabilizing , and deaths trends varying in China in East Asia, Vietnam and Malaysia in South-East Asia, and Papua New Guinea (PNG) in the Pacific.

The epidemic is showing an expanding pattern with new infections and people living with HIV, and deaths increasing in Indonesia and the Philippines in South-East Asia and Pakistan in South Asia. The epidemic pattern is latent with new infections increasing or sTable at around 1000 per year, people living with HIV increasing not more than 10,000, and deaths not more than

Table 26:
HIV and AIDS Estimates and Data, 2009 and 2001

Name of the country	Estimated HIV prevalence adult (15-49)		Number of HIV Infected female adults		People living with HIV 15+	
	2011	2001	2011	2001	2011	2001
East Asia						
China	<0.1	-			771000	
South Asia						
Afghanistan	<0.1	-<0.1	1300	<1000	5600	2000
Bangladesh	<0.1	<0.1	<1000	<500	7700	2100
Bhutan	0.30	<0.1	<500	<100	1200	<100
Sri Lanka	<0.1	<0.1	1400	<500		
Maldives	<0.1	<0.1	<100	<100	<100	<100
Nepal	0.30	0.5	10000	7800	47000	42000
Pakistan	0.1	0.1	28 000	2500	130000	12000
India		0.4			4100	1900
South-East Asia						
Cambodia	0.6	1.2	31000	40000	56000	77000
Myanmar	0.6	0.8	77000	58000	210000	220000
Lao PDR	0.30	<0.1	4700	1200	9700	3100
Malaysia	0.40	0.4	84-00	5800	80000	57000
The Philippines	<0.1	<0.1	3500	<1000	19000	2400
Indonesia	0.30	<0.1	110000	3300	370000	11000
Thailand	1.20	1.7	200000	200000	480000	620000
Vietnam	0.50	0.3	48000	12000	240000	110000
Pacific						
Fiji	0.20	<0.1			<500	<100
Kiribati	-	-	-	-		
Papua New Guinea	0.70	0.5	12000	10000	24000	22000
Samoa	-	-	-	-		

Source: 2012 UNAIDS Global Report

500 in Afghanistan, Bangladesh and Sri Lanka in South Asia, and Lao PDR in South-East Asia. The epidemic pattern is at a low prevalence with low levels of HIV infections detected and risk factors existing in Bhutan and Maldives in South Asia, and Fiji in the Pacific region.[55]

Country-level progress in reducing new HIV infections varies throughout the Asia-Pacific region, according to a regional fact sheet by UNAIDS. In Cambodia, India, Malaysia, Myanmar, Nepal, Papua New Guinea and Thailand, the rate of new HIV infections fell by more than 25% between 2001 and 2011, while in Bangladesh, Indonesia, the Philippines and Sri Lanka, the rate of new HIV infections increased by more than 25% between 2001 and 2011.

iv. Women and HIV

The most recent estimates of people living with HIV/AIDS worldwide show half are women, about 1.6 million.[56] Women are vulnerable for many reasons including the biological and social contexts. Biologically, women are more vulnerable and susceptible to acquire HIV in comparison to men. Women have a larger mucosal surface exposed to abrasions during sex, and semen has higher concentration of HIV/AIDS than vaginal fluid does. Cultural norms of sexual ignorance and purity for women block their access to prevention information. Gendered power imbalances make it difficult for women to negotiate for safer sexual practices (including condom use) with their partners, and economic dependence and fear of violence can effectively force women to consent to unprotected sex. Women receive inadequate care and treatment both because it is being directly withheld from them, and because what is provided is inaccessible and unsuited to their health needs. [57]

Women are also vulnerable due to inequalities within the families, violence as well as lack of ability to negotiate safe sex and in some case, sex occurs without consent. Lack of power to negotiate or assert their rights because of societal norms, embedded cultural belief systems, lack of access to proper information, lack of access to health care, poverty, women's low status in the society, lower education levels, difficulty in negotiating condom use due to the association of condoms with sex work, gender inequity, limited knowledge about sexuality and HIV transmission, and taboos related to communication about sexuality. "In many societies, there are cultural dictates for women to play a passive role in sexual interactions, and strong social pressure for women and girls to remain ignorant about sexual matters."[58]

Gender inequity, limited knowledge about sexuality and HIV transmission, taboos related to communication about sexuality, and ambiguity about love and trust are putting married women in high risk of HIV transmission from their husbands and long-term partners.[59] All of these have been cited as main reasons for the increasing rate of women contracting HIV/AIDS in Vietnam.

In the Asia and the Pacific regions, the number of women living with HIV varies between and within countries. Women represent 35% of people living with HIV in Asia; this proportion has remained sTable over the past decade.[60] It is estimated that 90% of women living with HIV in Asia contract HIV through their husbands or long term partners.[25]

An overview of the spread of the epidemic among women in the region shows that women living with HIV in Asia and the Pacific are slowly increasing. The pattern of transmission shows the spread of HIV to the female partners of IDUs and the clients of sex workers and their other partners.[61] Male clients of sex workers are also key in the spread and magnitude of HIV epidemics in the region, as they have the potential to transmit HIV to their regular partners.[62]

v. Higher Risk Groups and Vulnerable Groups

a. Men having sex with men

Men having sex with men is seen as one of the prominent mode of HIV transmission in the region and it is projected that half of all new infections would be among men having sex with men in the region if effective strategies are not in place.[63] HIV prevalence among men having sex shows a rising trend. China has a comparatively low percentage of men who have sex with men and who are living with HIV at 6% in comparison to countries in South-East Asia as seen in Table 27.

Although not much data is available in South Asia, in South-East Asia, the percentage of men who have sex with men and who are living with HIV is in the range of 1% in Malaysia, 7.8% in Myanmar, 8.5% in Indonesia, 16.7% in Vietnam and 20% in Thailand in 2011 (see Table 28). One of the key factors for higher levels of HIV among MSM is the lack of consistent use of condoms among MSM and men with multiple male sex partners. In China, according to the sentinel surveillance study held in 2011, 85% of men had multiple male sex partners in the last six months. In Indonesia, 65% of 1450 MSM surveyed in six cities had multiple sex partners in 2007. In Thailand, 77% had more than 6 partners in a 2012 study, and in Vietnam, 63% had more than 2 partners in the last two months in a study conducted in 2009. 64 studies also point to high proportion of MSM having regular female partners which will influence onward HIV transmission.[65]

The cultural and legal barriers related to expression of sexualities in the region act as a barrier for men having sex with men, and this hinders prevention and treatment programmes. 18 of the 38 member states in the Asia-Pacific region criminalise same-sex sexual activities.[66] The annulment of Section 377 of the Penal Code of India which criminalises men having sex with men in July 2009, by the Delhi High Court, is seen as a step forward in India. Fiji also became the first Pacific country to formally decriminalise sex between men after passing the Fiji National Crimes Decree in February 2010. As of date, Afghanistan, Bangladesh, Bhutan,

Table 27:
High-risk and vulnerable groups

Countries	Percentage of men who have sex with men who are living with HIV(2011)	Percentage of people who inject drugs who are living with HIV(2011)	Percentage of Sex workers living with HIV
East Asia			
China	6%	6%	0%
South Asia			
Afghanistan		7%	0%
Bangladesh	0%	1%	0%
Bhutan	-	-	-
Sri Lanka	-	-	0%
Maldives	-	-	-
Nepal	4%	6%	-
Pakistan	-	27%	2%
India	-	-	-
South East Asia			
Cambodia	2%	24%	-
Myanmar	8%	22%	9%
Lao PDR	-	-	1%
Malaysia	1%	9%	-
The Philippines	2%	14%	0%
Indonesia	8%	36%	9%
Thailand	20%	22%	-
Vietnam	17%	13%	3%
Pacific			
Fiji	1%	-	-
Kiribati	-	-	-
Papua New Guinea	-	-	-
Samoa	-	-	-

Source: Global AIDS report 2012

Maldives, Pakistan, and Sri Lanka in South Asia, Malaysia, and Myanmar in South-East Asia, and Kiribati, Samoa and PNG in the Pacific, all of which are part of the ARROW ICPD+20 Countries under review, criminalise same-sex sexual activities between consenting adults.[67, 68]

b. Injecting Drug Users

This group of people is most severely affected with HIV in comparison to the general population in all countries. Data in the ARROW ICPD+20 countries under review shows that the percentage of people who inject drugs and are living with HIV in 2011, particularly in Pakistan is as high as 27%. In South-East Asia, the percentage of people who inject drugs and are living with HIV is higher in many countries in the sub-regions like Indonesia (36%), Cambodia (24%), and Myanmar and Thailand at 22%. Malaysia reports a comparatively lower percentage of people who inject drugs and living with HIV at 9%. Data for the pacific region is scarce (see Table 27).

Barriers include the accessibility to needles and syringes programmes and in most of the countries, this access remains particularly low for women compared to men.[69] Evidence also suggests that women who inject drugs are more vulnerable to violence from intimate partners, police and sex trade clients. Evidence also indicates that women, who inject drugs and living with HIV as well as became pregnant, have a substantially lower likelihood of accessing services to prevent children from acquiring HIV infection compared to other women living with HIV. Lower condom use, lack of access to HIV testing, lack of supply of opioid substitution therapy, and lower rates of needle distribution, continue to hamper HIV prevention, treatment and care for this group of people.[70]

c. Unprotected paid and unpaid sex work

The 2012 UNAIDS global report informs that more countries are reporting data pertaining to sex workers as compared to 2006. A review of available data from 50 countries estimated the Global HIV Prevalence among female sex workers is at 12% and found that female sex workers are 13.5 times more likely to be living with HIV than other women.[71] In the ARROW ICPD+20 countries under review, not many countries have reported on this and of the countries that have reported, for South Asia, Pakistan reported 2% of sex workers living with HIV. In South East Asia, Myanmar and Indonesia reported 9%, Vietnam 3%, and Lao PDR 1% and this is shown in Table 27. Data for the Pacific is not available.[72]

Overall, female sex workers are more vulnerable to contracting HIV/AIDS because of their livelihood, which places them at greater risk of acquiring HIV. This group faces stigma since they do not conform to the reproduction oriented sexual morality.[73] In China, it is estimated that sex workers and their clients account for just less than 20% of the total number of people living with HIV (Ministry of Health, People's Republic of China/ UNAIDS, 2005a). A study indicated that 22%-38% of young Nepalese women who were trafficked to India, especially Mumbai, and then, returned to Nepal were found to be HIV positive."[74] HIV prevalence among sex workers in Papua New Guinea is approximately 20%, and this is very high in comparison to the national HIV prevalence of about 1%. In Myanmar, about 10% of sex workers are living with HIV compared to a national prevalence of about 0.5%. These concentrated epidemic scenarios need focused interventions and while it is reported that China and Myanmar have HIV prevention programmes for sex workers, in Bangladesh, Indonesia and Pakistan, the overall coverage of programmes is less than 25%.

vii. Stigma and Discrimination

The ICPD PoA urges governments to develop policies and guidelines to protect the individual rights of and eliminate discrimination against people infected with HIV and their families.[75]

HIV related stigma and discrimination is seen as a barrier to universal access to HIV prevention treatment, care and support. The region has many countries which pose restrictions that are tainted by stigma, gender inequality and this is reflected in many HIV-related laws and policies in the region. Stigma and discrimination, especially against higher risk and vulnerable groups, will have an impact on the implementation of HIV programmes and impedes access to prevention, treatment and care and support.[76]

Based on the regional analysis of the stigma index carried out in nine countries - Bangladesh, Cambodia, China, Fiji, Myanmar, Pakistan, Philippines, Sri Lanka, and Thailand in the region - the analysis notes that HIV-related stigma is pervasive in the lives of people living with HIV in the region. Results from the same study pointed to almost a third of the respondents noting that they were not able to adequately access healthcare. Despite requiring care, a third of the respondents avoided going to clinics and hospitals. In terms of health care providers, while some health care providers did not discriminate, a significant 3%-29% were not supportive and many health care providers (37%-90%) did not have constructive discussions with health care professionals regarding HIV-related treatment options.[77]

Discrimination against PLHIV not only affects their livelihood, but also makes PLHIV less likely to seek care and treatment and adhere to treatment. Family members, caregivers and children of PLHIV are also subject to discrimination and shame. In China, a 2005 survey shows that almost 1 in 5 nurses in three provinces said patients with HIV should be isolated, while in another study, it records that almost "one in three health professionals...said they would not treat a HIV-positive person."[78]

viii. Laws and Policies Pertaining to People Living with HIV/AIDS (PLHIV)

Based on the People Living with HIV Stigma Index, in the Asia and the Pacific Regional Analysis 2011 publication, sex work is criminalised in at least 29 out of 38 countries in the Asia and the Pacific region. These countries include Afghanistan, Bhutan, China, Fiji, Lao PDR, Maldives, Myanmar, Pakistan, Papua New Guinea, Philippines and Vietnam in the among the ICPD+20 countries in the region.
Sex between men is criminalised in 19 out of 38 countries. Among the ARROW ICPD+20 countries, these countries include Afghanistan, Bangladesh, Bhutan, Maldives, Pakistan, and Sri Lanka in South Asia, and Indonesia, Malaysia and Myanmar in South-East Asia, as well as Papua New Guinea in the Pacific.[79]

All governments in Asia, and most in the Pacific, treat drug use as a criminal activity.[80] At the same time, eighteen countries in the region have laws meant to shield people with HIV against discrimination. India in South Asia, Indonesia and Thailand in South-East Asia, and Papua New Guinea in the Pacific have put in place programmes to ensure that law enforcement does not act as an obstacle to HIV treatment and prevention.[81]

India is noted to have drafted a legal framework to address stigma and discrimination, and Vietnam has a law on HIV that protects people living and affected by/with HIV. Fiji and Papua New Guinea have reported to have made progress, too. [82]
Specific national HIV legislations enacted in the ARROW ICPD+20 countries under review include:

- Cambodia – Law on the Prevention and Control of HIV/AIDS, 2002
- China – Regulations on AIDS Prevention and Treatment, 2006; Yunnan Provincial HIV/AIDS Prevention and Treatment Regulations, 2006; Responsive Measures for HIV/AIDS Prevention in Yunnan Province Law, 2004
- Papua New Guinea – HIV/AIDS Management and Prevention Act, 2003
- Philippines – AIDS Prevention and Control Act, 1998 (“Republic Act No. 8504”)
- Vietnam – Law on HIV/AIDS Prevention and Control, 2007; Decree No. 108/2007/ND

Among the 21 countries, “Cambodia, the Philippines and Vietnam have introduced laws that specifically seek to protect the rights of people living with HIV (PLHIV), and guard them against HIV related discrimination.

NoTable progress has been made by Cambodia in the area of legislation. The Law on the Prevention and Control of HIV/AIDS, enacted in 2002, is regarded as a “best practice” in Asia, particularly in relation to anti-discrimination, privacy and confidentiality, and protection offered to people attending voluntary counselling and testing.[83]

Nepal has amended its laws relating to HIV/AIDS. The Supreme Court has ordered the government to promulgate laws to ensure confidentiality in the judicial process for cases involving people living with HIV.[84]

Bangladesh, China, India, and the Lao PDR have announced policies that protect the rights of HIV-Positive People.”[85]

Papua New Guinea has developed a national HIV Prevention Strategy that specifically addresses the need for an enabling legal environment for HIV responses for MSM, transgender people and sex workers.[86]

ix. Voluntary Counselling and Testing (VCT), and Anti-Retroviral Therapy (ART)

The region has demonstrated many successful HIV prevention and treatment programmes in countries such as Thailand and Cambodia. In terms of commitment, HIV expenditure from domestic sources, Malaysia has shown the most commitment with 92% expenditure from domestic resources in the region. This is followed by China (89%) and Thailand (83%). Nepal (1%), Afghanistan (3%), Bangladesh (4%), Myanmar (9%) and India (10%) in South Asia, and Lao PDR (7%) in South East Asia have spent up to 10% in terms of HIV expenditure from domestic sources in the region.[87]

a. Access to counselling and testing

In the area of access to counselling and testing, in Asia and the Pacific, there is limited data to show coverage of HIV testing overall for women and other vulnerable groups. A few surveys have indicated that the proportion of the adult population who have been tested and counselled is as low as 0.5% in India (8.8 million tested out of 579 million adult population between 15 and 49 years of age), 0.5% in the Lao PDR and 0.1% in Malaysia. This leads to an estimate that, overall, only 0.1% of people in the region may have ever been tested and counselled. However, this does not indicate what proportion of the people most in need of testing is actually receiving this service.[88]

A review of the 2009 UNGASS country reports on voluntary counselling and testing (VCT) in Cambodia, China, Fiji, India, Indonesia, Maldives, Pakistan, Sri Lanka and Thailand, points to the following observations: With same day test results, response to VCT in Cambodia has been quite high with more than 200,000 people accessing VCT in 2006, with a 97.7% return for post-test counselling rate.

In China, VCT is provided free of charge and is voluntary.
In India, the cumulative number of people tested during 2002-2006 was 8.8 million. Excluding pregnant women, 55% of HIV testing was client-initiated and 25% provider-initiated in 2006.
In India, challenges remain in the quality of counselling services,

Table 28:
Estimated people receiving and needing anti-retroviral therapy and coverage

Countries	Estimated number of people needing anti retroviral therapy based on WHO 2010 guidelines	Reported number of people on ART
East Asia		
China		126448
South Asia		
Afghanistan	1700	111
Bangladesh	2200	681
Bhutan	<500	64
Sri Lanka	1500	311
Maldives	<100	3
Nepal	26000	6483
Pakistan	25000	2491
India	---	543000
South-East Asia		
Cambodia	46000 (39000-60000)	46473
Myanmar	120000	40128
Lao PDR	3800	1988
Malaysia	38000	14002
The Philippines	3900	1992
Indonesia	100000	24410
Thailand	320000	225272
Vietnam	110000	60924
Pacific		
Fiji	<100	74
Kiribati		
Papua New Guinea	14000	9435
Samoa		

Source : UNAIDS 2012 Data[91]

especially at sub-district level, and discrimination by health care providers is of particular concern in some areas.

In Indonesia, while there has been a large expansion of testing and counselling services, there has also been under-utilisation of testing and counselling services by the population.

In Maldives, out of 27,753 tested, only 374 (1.35%) came through VCTs in 2009.

In Thailand, HIV voluntary counselling and testing started in 1991 through anonymous clinics in government hospitals. Provider Initiated Testing and Counselling (PITC) was introduced in the late nineties with the PMTCT programme. PITC includes group pre-test information giving, and if requested, individual pre-test counselling is accompanied by informed consent and gives the option to opt out, depending on the type of health services. The PITC was a key to the success of the national PMTCT programme. Out of a total of 672,035 deliveries in 2005, 98% attended ANC and out of those, 99.7% were tested for HIV.

In Pakistan, the National HIV testing strategy states that HIV testing should be voluntary, confidential and accompanied by pre- and post-test counselling.[89]

Challenges with respect to voluntary counselling and testing in the region include instances of hospitals testing patients without their consent. Compulsory testing is practised in a number of settings, for instance, among IDUs and migrant workers. Similarly, the requirement of confidentiality is not strictly observed in the region. The understanding of consent and the legal requirements for informed consent vary in different countries. It is recognised that people may seek HIV testing only if they can see its benefits. In the region, discrimination against people infected with HIV and limited availability and accessibility of treatment services discourage people from seeking HIV testing and counselling. It is clear that any escalation of testing and counselling needs to be linked to improved provision of other services such as high quality treatment and treatment monitoring, positive prevention, and care and support for people living with HIV. Given the nature of the epidemic in the region, that is, several countries with concentrated high-risk groups, not all interventions will take place in health settings. Furthermore, marginalised most-at-risk populations may not have ready access to health services and may be better reached through community-based interventions and services.[90]

b. Access to anti-retroviral therapy

There has been an expansion in the coverage of anti-retroviral therapy, and more people were covered with ART in 2011 compared to earlier years. The 2011 Political Declaration commits to reaching 15 million people globally with HIV treatment. According to the UNAIDS factsheet, while the global average of access to ART is at 54% in 2011, 69% of people eligible for

antiretroviral therapy were accessing it in the Pacific region, that same year. The coverage is below the regional average in South and South-East Asia at 47%, and a further lower coverage of 18% in East Asia. In 2011, only one country in the Asia-Pacific region (Cambodia) reached more than 80% coverage of anti-retroviral therapy. In Thailand and Papua New Guinea, more than 60% of people eligible for antiretroviral therapy were receiving it. However countries like Pakistan reported less than 20% coverage of HIV treatment.[92]

Data from the ARROW ICPD+20 countries under review shows on the review of countries ARROW shoes the reported number of people having access to ART, as shown in Table 28, is not encouraging. Except for Cambodia, which has made significant strides in coverage of ART, other countries need to step up effort to improve coverage with regards to access to ART in the region.

One of the major barriers to access antiretroviral drugs is the high cost. Cheaper generic versions are being produced by pharmaceutical companies in Asia, it will be easier for governments to obtain and distribute the drugs. Yet even where drugs are available, the poor state of healthcare in many Asian countries, particularly a shortage of trained doctors, is hindering governments' abilities to organise life-long treatment programmes for millions of people living with HIV.[93,94]

x. Integration of SRH Services, including HIV and AIDS

The 2011 Political Declaration on HIV and AIDS calls for eliminating parallel systems for HIV related services, and the integration of AIDS response in the global health and development efforts. Most importantly, it is necessary that HIV services be integrated into SRH services in the region, as they will reduce the burden on the health system to deliver vertical services. Some countries have piloted this initiative.
While it is widely acknowledged that the intersections and interconnections between HIV/AIDS and SRHR are profound, HIV/AIDS and SRH services remain predominantly separate and parallel programmes, not only from the angle of bilateral and multilateral donor allocation of resources, but also from the national health systems point of view, which mostly have vertical AIDS control programmes, not integrated into the public health system.[95]

While sporadic attempts have been made to include STI prevention and treatment, as well as HIV testing and counselling into the family planning programmes, these attempts have not been sustained or fully integrated. Some progress has, however, been made in developing institutional linkages. Cambodia provides an unusual example of full integration, with the merging, in 1998, of the national AIDS control programme and National Clinic for STI and Dermatology and STD control (NCHADS). Cambodia has started links between NCHADS and the National Centre for Maternal and Child Health.

India is in the process of linking activities between its National AIDS Control Programme and its Reproductive and Child Health Programme. This moves forward the existing links for the prevention of mother-to-child transmission of HIV/AIDs (PMTCT) and antenatal screening for Syphilis.

In Papua New Guinea, the National AIDS Council Secretariat in 2009 developed the National HIV Strategy for PNG, which covers the period of 2011–2015 and followed by the National Strategic Plan (NSP) for HIV/AIDS (2006–2010) which guides the annual operational plans. While the number of infected HIV patients going for HIV counselling and testing (HCT) has grown exponentially, annually and is one the major successes in Papua New Guinea's HIV response, and with PNG almost achieving the 80% target of ART coverage, prevention of HIV transmission continues to be one of the bigger challenges in the national response to date. Although HIV awareness has increased, the response has been criticised for failing to address the broad-based structural and social factors that affect HIV transmission.[96]
Thailand has included PMTCT and syphilis screening in the ante-natal care settings, whereas China provides condoms to family planning clients. The addition of RTI/STI diagnosis and management to family planning settings have been attempted in Indonesia, although the clinical training proved to be challenging.[97]

If resources allocated for HIV and AIDS are integrated, this will enable better functioning health systems, and improve the delivery of other SHR services through the public health system. PLHIV need a broader range of SRH services apart from anti-retroviral treatment, including access to a range of contraception, abortion, maternal health services and STI/RTI management.

SUMMARY

Based on the data collected and presented, the status of HIV/AIDS prevention is mixed across the 21 countries in the region. The epidemic in the region is largely concentrated among higher risk groups such as men who have sex with men, sex workers and injecTable drug users. National HIV prevalence among adults is highest in South-East Asia, with wide variation in epidemic trends between different countries. While the prevalence is declining in Cambodia, Myanmar and Thailand, HIV prevalence in Indonesia (especially in the Papua province), and Vietnam is on the rise. In South Asia, the epidemic is showing an increasing trend in Bhutan. Compared to the rest of the 21 countries under review, Cambodia addresses the HIV/AIDS epidemic in a more comprehensive manner and it has made significant progress in bringing down the rates of HIV cases within its borders. Few governments in the region have addressed stigma and discrimination through laws, policies and programme. Stigma, especially for the vulnerable populations, hinders access to HIV treatment and care. There is a need to expand the reach awareness programmes, and make voluntary counselling and testing for HIV/AIDS widely available in the region. Access to

BOX 11
Sexual Rights
Stigma And Discrimination Faced By People Of Diverse Sexual Orientation And Gender Identities

Case 1
A few years ago, in my village, Naikap, people used to abuse and insult me. They didn't know about transgender people, that there are others like me. I used to think, why has god made me like this? People would say - there are organisations for hijras, chhakkas; go there. I thought - I am not a chhakka, why should i go ... Bhoomika Sreshtha, Kathmandu.

Source: Neha Sood . Redefining identity: transgenderism and sexual citizenship – conversations across India, Nepal, and Thailand. Reclaiming & redefining rights - thematic studies series 1: Sexuality and Rights in Asia. 2010. Arrow pp 75

Case 2
Family, society and institutions in nepal do not understand issues of gender and sexuality. They cannot understand why some men are gay, or why some people are transgender. They don't understand why men cannot behave like "real men." They ridicule these men. Devendra Sreshtha, Narayangarh

Source: Neha Sood . Redefining identity: transgenderism and sexual citizenship – conversations across India, Nepal, and Thailand. Reclaiming & redefining rights - thematic studies series 1: Sexuality and Rights in Asia. 2010. Arrow pp 75

Case 3
My family wants me to get married to a woman and have a kid so that i will have support in my old age and a companion. From the moment a boy is born to a family, the parents have dreams about their son growing up, bringing home a bride and giving them grandchildren. I tell them that i can provide every kind of happiness to them except a bride. Pinky Gurung, Kathmandu. *Source: Neha Sood. as above.*

Case 4
About a year ago, somewhere in eastern nepal, a man got to know that his teenage son is a homosexual. He gave his son poison and killed him. The bds branch office there filed a case with the police. The whole village collected money and gave it to the police to bury the case. Kumar vaidya, lalitpur.

Source: Neha Sood . Redefining identity: transgenderism and sexual citizenship – conversations across India, Nepal, and Thailand. Reclaiming & redefining rights - thematic studies series 1: Sexuality and Rights in Asia. 2010. Arrow pp 75

ART has improved in the region, however, there still exists gaps. In the 21 countries under review, coverage of ART remains a challenge in many countries in the region, except for Cambodia which has reached more than 80% average for anti-retroviral therapy, followed by Thailand and Papua New Guinea which have reached more than 60% of people eligible for ART.

As we reach the 2014 and 2015 timeline, it is important to step up efforts in the prevention, treatment and care around HIV and AID. For the region, since most of the epidemic is concentrated among high risk groups, it is essential to focus prevention and treatment programmes around these groups. At the same time, it is essential to step up prevention programmes for all people to raise awareness around this issue. Governments have to allocate domestic resources for the prevention, treatment and care aspects of the epidemic.

It is also imperative to take into account complex aspects of HIV transmission modes. While women are indeed biologically more at risk for HIV in any one act of heterosexual vaginal sex than their male partners, not all sex within heterosexual relationships involves vaginal penetration. It is also imperative to note that not all sex is heterosexual and vaginal, and these have to be considered in HIV and AIDS programme planning. Gender analysis also needs to take into account the role of sexuality and diversity as well as meanings of and within sexual relations.[98]

The most vulnerable groups that are easily identified, and become targets of testing, sometimes mandatory, and of the interventions have been pregnant women, female sex workers, and more recently, male sex workers. Yet, interventions that focus specifically on the male partners and clients of vulnerable women (and male sex workers) are insufficient and inadequate.
At the same time, laws and policies have to be supportive towards people and not discriminate and stigmatise people living with HIV and AIDS. Stigma and discrimination have to be addressed immediately and enabling legislations have to be put in place around HIV and AIDS.

Integration of health services is critical for the best use of limited financial, infrastructural and human resources. HIV prevention, treatment and care have to be integrated into the mainstream health system and should cease to operate as vertical programmes.

4.4 SEXUAL RIGHTS AROUND CHOICE OF PARTNER, CONSENSUAL SEXUAL RELATIONS AND CONSENSUAL MARRIAGE

Early marriage and child marriage are important issues in our region, which are slowly transitioning out of their earlier cultural and historical contexts. In order to ensure the health and well-being of women and girls, and access to equal opportunities in life for women and girls, it is important to ensure progress on the issues of early and child marriage.

Table 29:
Legal age and median age at marriage

Country	Women	Men	Median Age At Marriage For Women (Age Group 25-49)	Remarks
Afghanistan	16	18	17.7	
Bangladesh (2004)	18	21	15	
Bhutan	18	18		
Cambodia	18	20	20.1	If an under aged girl becomes pregnant, with the consent of parents/guardian, marriage can be requested
China	20	22		
Fiji	21	21		Requires parental consent
India	18	21	17.4	
Indonesia	16	19	19.8	
Kiribati	21	21	20	
Lao Pdr	18	18	19.2	In special and necessary cases, age less than eighteen years but no less than fifteen years of age.
Maldives	18	18	19.0	No minimum legal age for marriage. An individual can enter into marriage once puberty has been reached, however, government policy strictly discourages marriages under the age of 16
Malaysia	18	18		16 for women and 18 for men under Muslim law, Individuals aged 18-21: written parental consent.
Myanmar	20	20		
Nepal (2003)	20	20	17	18-requires parental consent
Pakistan (2007)	16	18	19.1	
Papua New Guinea	16	18		Under customary law, the emphasis is on physical maturity rather than on the chronological age, a girl of 14 years of age who has the attributes of a physically 'fit' person may enter into a valid customary marriage
Philippines	18	18	22	Individuals aged 18-21: written parental consent and must undergo marriage counselling; 21-25: parental "advice."
Samoa	19	21	-	Requires parental consent
Sri Lanka	18	18	22.4	Does not apply to Muslim population
Thailand	17	17		
Vietnam	18	20	21.1 (2002)	

Source: UN Data: A World of Information[99]; Median age at first marriage source: Measure DHS. (2009). *Demographic and Health Surveys* [100]

i. Legal age of marriage and the enforcement thereof

Table 29 shows the legal age of marriage in all 21 countries. In 11 of the 21 countries – Bhutan, Myanmar, Fiji, Kiribati, Laos PDR, Malaysia, Maldives, Nepal, Philippines, Thailand and Sri Lanka – the legal age of marriage is the same for both men and women. In other countries, the legal age of marriage of women tends to be lower than that of men.

Where legal age of marriage is below the age of 18, it is to be recollected that according to the definition of 'child' in Article 1 of the Convention on the Rights of the Child,[101] such marriages as allowed by the law can be termed as child marriages. It is alarming that five countries in the region, Afghanistan, Indonesia, Pakistan, Papua New Guinea and Thailand have a legal age of marriage under 18. In Pakistan, the legal age of marriage, according to the Child Marriage Restraint Act, 1929, is 16 for girls, and 18 for boys. This law is inadequately enforced. The religious lobby is of the view that a girl's puberty is indicative of her maturity, a perspective that carries weight in many instances; *jirgas* force little girls to be exchanged as 'compensation' between warring groups or tribes.[102] The Human Rights Commission of Pakistan in its 2006 annual report also noted a rise in the number of child marriages while the Global Gender Gap Report said that "21% of girls aged 15-19 were married, divorced or widowed."[103]

Different regulations may exist for different communities within one country: in Malaysia, and Indonesia under Muslim law, for example, the age of marriage is 16 for women and 18 for men. There have been cases in recent years, however, of underage marriages in Malaysia. For example in 2010, a 14 year old girl married her 23 year old teacher after being given permission by the Islamic Sharia court.[104,105] There are also special dispensation for girls from Muslim communities in countries such as Sri Lanka. This is an interesting situation to note, because in essence, such dispensation creates two classes of women and girls citizens in these countries, one class which is subject to civil law and entitled to rights under civil laws and another class which is subject to Sharia law and entitled to rights under Sharia laws. These systems are pre-determined at birth, and women and girls cannot opt for the legal system which affords them greater rights, especially with regards to Family Law.

There are also pre-conditions for parental approval in some countries. In Fiji, Malaysia and Samoa, for example, individuals aged 18-21 need written parental consent to get married. In the Philippines individuals aged 18-21 need written parental consent and must undergo marriage counselling, and individuals aged 21-25 need parental advice before getting married. In Nepal, individuals aged 18 -20 also need parental consent.
Despite the existence of a legal minimum age, girls may be getting married very early. This is evident in the country DHS data on median age at first marriage. In Bangladesh, India and Nepal, the median age at first marriage for women aged 25-49 is lower than the legal age of marriage.

In other countries, alternative sources of information indicate that marriages at young a age are not always consensual. In Cambodia, under special circumstances, for example, when a girl becomes pregnant, marriage can be requested with the consent of parents or guardians. In the context of Cambodian society and its culture of censuring children born outside marriage, it is very likely that young pregnant girls will be forced to get married.[106] In Papua New Guinea, while the legal age of marriage for women is 16, the emphasis is on physical maturity rather than on the chronological age, under customary law. This means that if a younger girl whose physical attributes are similar to those of a 16 year old, she would be eligible for marriage.

In Thailand, if a man "mistakenly has sexual relations with a girl over age 13 but under age 15, with the consent of the girl or her parents, the Criminal Law allows the Court to permit the couple to marry without the man being prosecuted."[107]

In the Philippines, under the Civil and Commercial Code, betrothal can occur only when both the man and the woman are at least 17 years of age; children must obtain the consent of their parents or guardians for the betrothal, and only men can initiate betrothal.[108]

As of now, most of the laws around the legal age of marriage are constructed within a hetero-normative framework. It would be interesting to look at Nepal in the coming years to see if similar age structures would apply to consent for same-sex marriages.[109] Raising women's legal age of marriage will enable women to spend time in education and labour, both of which have positive correlations on their SRH and their empowerment.[110]

ii. Non-consensual Marriage

a. Arranged and forced marriages

Arranged and forced marriages indicate the lack of control women and young girls have over their sexual rights and lives, from choosing their partners to consensual relationships. It needs to be noted here that not all arranged marriages are forced marriages, yet there is a limitation around the choice of partner or age of marriage put on the woman or young girl by her family or caretakers.

Arranged marriages in South-East Asia are not as prevalent in Malaysia, the Philippines and Vietnam, but more common in both Indonesia and Cambodia. Arranged marriages is part of the culture and tradition in Indonesia,[111] while in Cambodia, daughters live under a strict rule and have little or no right to refuse an arranged marriage. Her partner is chosen for her by her parents and in most cases, the woman has no say in the process.[112]

In an opposite tract, Article 9 of Vietnam's Family and Marriage Law states that "the marriage is voluntarily decided by the man and the woman; neither partner is allowed to force or deceive the other; nobody is allowed to force or obstruct their marriage."[113] Arranged and forced marriages are both quite common and deeply embedded in the cultures and traditions of South Asia. In Afghanistan, the Afghanistan Independent Human Rights Commission estimates that over 38% of women have been victims of forced marriage.[114]

Similarly, forced marriage is also common in Pakistan where a woman is often forced to marry a different person if she expresses her interest to marry someone of her choice.[115] Moreover, girls are often sold into marriages in exchange for money or settling disputes or to compensate for crimes committed by her male family members.[116] There is also a practice of marrying girls to the Quran, practised by a few feudal families. This is done primarily to keep property within the family, and these girls are then forced to lead lives of complete seclusion,[117] and numerous other discriminatory traditions.[118]

While the legal frameworks of the country does not allow or condone these practices, the court does little or nothing to address these injustices on young girls and women in the country.[119] The Chief Justice of Pakistan has declared that such practices are "un-Islamic and expressed concern over the rising number of these cases."[120] In addition to that, the Law and Justice Commission in 2004 stated that all individuals who contract a marriage by all such practices will be punished. However, this amendment has yet to be passed.[121]

A newspaper article notes that Commonwealth nations account for 12 of the worst 20 global offenders on forced marriage. There is also customary law in some Pacific countries such as Papua New Guinea, Solomon Islands and Vanuatu, allowing girls to be married at 12 or 13.[122] In Papua New Guinea, families traditionally sell girls into forced marriages to settle their debts, leaving them vulnerable to forced domestic service, and tribal leaders trade the exploitative labor and service of girls and women for guns and political advantage. Young girls sold into marriage are often forced into domestic servitude for the husband's extended family. [123]

b. Child marriage

It is recognised that "child marriage is a violation of many aspects of rights including of sexual rights."[124]

Countries in the region are rated amongst those having the highest number of child marriages, with the highest concentration in South Asia. However, a recent study in the Journal of the American Medical Association noted that the prevalence of child marriage in South Asia has declined over the past twenty years. This decline has reduced the number of girls under 14 getting married; the situation, however, remains the same for adolescent girls above 15.[125] The study noted that "the practice fell by 35% in India, 45% in Bangladesh, 57% in Nepal and 61% in Pakistan"[126] for girls under 14 years of age. [127] In Afghanistan, 54% of girls are victims of early marriage,[128] and in Bangladesh, there is a disturbing statistic of one in three adolescents already having begun child-bearing.[129]

In 1990, Pakistan ratified the UN Convention on the Rights of Child, which prohibits child marriages. Additionally, the Muslim Family Law Ordinance states that a girl and boy must be 16 and 18 years old, respectively, to marry, and both girl and boy must give their consent before the marriage can take place. [130]

In Kiribati, although the minimum age of marriage for a woman is 18 years of age, data shows that among women aged 20 to 49 years, 5% were married by the age of 15, while another 26% were married by the age of 18.[131]

iii. Traditional practices harmful for women

Analyzing traditional harmful practices prevailing in the region are important as such practices have tremendous implications for women's sexual and reproductive health and rights in the region. The most common practices observed in the region include female circumcision and others that are quite specific and unique to different cultures and communities in the region.

a. Female Circumcision

The practice of female circumcision or female genital mutilation is concentrated in different parts of the region. While it is concentrated in one community in a country such as those in Indonesia, it is totally non-existent in others such as in Bangladesh.[132] The practice of female circumcision is commonly attributed to Muslim communities in the region, although the Quran itself does not obligate female circumcision..

Due to the lack of comprehensive research done on the subject in the region, analysis of the prevalence of this practice in the region can only be drawn from news sources or alternative reports. This can also be attributed to the lack of agreement on the definition of the term itself and what is considered 'genital mutilation.' The practice is a common symbol of patriarchal systems in the region where "the meaning attached to it ranges from being a symbol of cleansing of primordial sin to a symbol of suppressing sexuality and desire of women."[133]

The practice of female circumcision in most prevalent in Indonesia where a study showed that it was practised in eight major ethnic groups.[134] The Government of Indonesia was called upon by the CEDAW Committee in 2007 "to speedily enact legislation prohibiting female genital mutilation and ensure that offenders are prosecuted and adequately punished" and urged them "to develop a plan of action and undertake efforts to eliminate the practice of female genital mutilation, including

implementing public awareness-raising campaigns to change the cultural perceptions connected with female genital mutilation, and provide education regarding the practice that has no basis in religion as a violation of the human rights of women and girls."[135] Female circumcision in Pakistan is usually practised among the Bohra Muslims, and is deeply rooted in their culture. The Bohra community is located in the southern regions of Pakistan and has a small population of only about 100,000 people. The practice of female circumcision has increased in the recent years due to strict religious compliance set by Bohra Muslims.[136] This community also exists in India.

b. Other Discriminatory Practices

Other forms of discrimination and violence against adolescent girls and young women are also found in different parts of the region. For example, in Nepal, the Hindu practices of *Deuki* and *Jhuma* are prevalent and widely accepted, "where young girls are offered to the temple and then forced into prostitution; *Badi* - a caste of traditional prostitutes; *Chhoupadi* - isolation outside the house during menstruation; and violence based on superstition, such as torture for alleged witchcraft."[137] Similar practices also exist in India.

The practice of *Deuki* is discouraged by the 1992 Children's Act and is punishable under law which could result in imprisonment for five years.[138] However, there are no other legislations to support this law and thus, the practices prevail and have great implications for young girls and women in the country. Moreover, practices such as vaginal repair and tightening exist in Cambodia, Vietnam, Lao PDR and Thailand, affecting women's sexual and reproductive health and rights.[139]
Between March 2010 and 2011, the Afghanistan Independent Human Rights Commission (AIHRC) in Herat recorded 14 cases of "honour killings" or "*Karo Kari*"[140] - the murder of women and girls committed by family members. This is a substantial increase when compared to the four known cases that occurred the year before. It must be noted, however, that the real number is likely to be much higher, but because of the culture and shame that surrounds such cases, they were most likely not reported.[141] According to the Human Rights Commission of Pakistan, at least 1,790 women were murdered in 2010. Out of these, 791 were killed in incidents of honour killings. The killers were often related to the victim.[142]

4.5 SEXUAL VIOLENCE AGAINST WOMEN

WHO defines sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work."[143] In this context, the section below will look at rape, marital rape and sexual harassment and the relate legislations across the 21 countries in the region.

i. Rape/ Sexual Violation/ Sexual Assault

Information on anti rape laws are given in Table 30. Out of all countries surveyed, 18 countries, with the exception of Myanmar, Maldives and Samoa, have laws against rape and these usually exist within the penal code or the criminal code. However, many barriers remain preventing justice for victim-survivors of rape. Consent is the fine line that divides rape from consensual sex, and legal definitions in all countries use non-consensual and forced vaginal penetration as definitions of rape. For example, in Nepal, rape as described in the *Muluki Ain* is an act of sexual intercourse with a woman without her consent or with the use of force, threats, fear, or immoral enticement.

The law does not further explain the scope or definition of rape. However, judicial interpretations have limited the definition of rape to vaginal penetration. Nepalese courts have strictly interpreted the non-consent requirement: if a woman is raped against her will but does not resist the sexual advances of the rapist, the act does not amount to rape.[148]

These two conditions of 'consent' and 'forced vaginal penetration' convey a 'patriarchal' interpretation of the crime. One, consent is generally difficult to establish. It is particularly more problematic with women who are perceived to be transgressing society's accepTable expressions of sexuality, for example, young women who have had consensual sexual relations, and sex workers. Two, the limiting of rape to vaginal penetrative sex fails to recognise that rape can also be a crime against children, men, including men with same-sex sexual preferences, and transgendered people. It is important to expand the definitions of rape to include all possible acts and groups that are affected.

In many countries, such as Afghanistan, China, Cambodia, India, Nepal, Malaysia and Indonesia, laws on rape have also been crafted around the age of consent. For girls below the age of consent, the crime is that of statutory rape and carries a heavier penalty. Some rapes are considered worse than others. For example in China, harsher penalties are imposed if rape occurs under several circumstances, including: the rape of a woman "before the public in a public place;" the rape of a woman by "one or more persons in succession;" and causing the victim serious injury, death, or other serious consequences. However, if a person between the ages of 14 to 18 commits rape, then the person is subject to a reduced sentence.[149]

In Afghanistan, that for the first time in the country, under the Law on the Elimination of Violence against Women (EVAW) enacted in August 2009, criminalises rape and 21 other acts of violence against women and specifies the punishment for the perpetrators.[150] This is a marked improvement from the 1976 Afghan Penal Code, that did not criminalise rape, instead the term *'zina'* is used when forced sexual intercourse occurs, which does not address the main issue of rape – consent. *'Zina'*, under chapter eight of the Penal Code which focuses on crimes of

Table 30:
Anti-Rape Laws in 21 countries in Asia and the Pacific

COUNTRY	ANTI-RAPE LAWS
Afghanistan	Rape is a crime under the Law on Elimination of Violence against Women 2009.
Bangladesh	The penal code and the Prevention of Oppression Against Women and Children Act (2000)provide the legal framework for prosecuting crimes of rape
Bhutan	Rape is a felony of the fourth degree under the 2004 Penal Code
Cambodia	Rape is a crime under the UNTAC Criminal Code (Art. 33) and also under the Law on Aggravating Circumstances of the Felonies (Art. 5). There is no specific government policy on rape in Cambodia.
China	Rape, whether committed by violence, coercion, or other forcible means, is punishable by a minimum of 3 years and a maximum of 10 years imprisonment.
Fiji	The Crimes Decree 2009 states that rape is a crime against humanity, under Article 88.
India	Indian Penal Code and the amendments in 1983 to rape provisions in the Indian Penal Code
Indonesia	Rape is a crime under the criminal code.
Kiribati	Rape is a crime under the Penal Code (1965), and punishment for rape is imprisonment for life, while an attempt at rape receives a punishment of imprisonment for 7 years.
Lao Pdr	Rape is crime under the Criminal Law 1992. 3-5 years imprisonment; if victims are 15-18 years - 5-10 years imprisonment; gang rapes, victims below 15 years and if rape disables victims 7- 15 years.
Malaysia	The penal code defines and prescribes the punishments for rape, while the Criminal Procedure Code and the Evidence Act 1950 provide the procedural and evidentiary rules for the prosecution of rape. In 2007, this was amended to include marital rape.
Maldives	---
Myanmar	---
Nepal	Rape is described in the Muliki Ain is an act of sexual intercourse with a woman without her consent or with the use of force, threats , fear or immoral enticement.
Pakistan	The offence of rape (Zina bil jabr)is dealt under the Offence of Zina (Enforcement of Hudood) ordinance, 1979
Papua New Guinea	The Criminal Code (Sexual Offences and Crimes against Children) Act (2002)
Philippines	Anti-Rape Law of 1997, which amended the Revised Penal Code
Samoa	---
Sri Lanka	Rape is a crime under the Penal Code
Thailand	Penal Code governs the crime of rape
Vietnam	The Penal Code provides the legal framework for prosecuting crimes of rape

Source: Women of the World: Laws and Policies Affecting Their Reproductive Lives (East and South-East Asia,[144] and South Asia[145]); For Cambodia: CEDAW shadow report; For Sri Lanka: Penal Code: An Ordinance to Provide a General Penal Code for Ceylon, 1885;[146] For the other countries: The UN Secretary-General Database on Violence Against Women[147]

adultery, pederasty, and violation of "honour", only refers to individuals engaged in sex outside of marriage.[151]

Research by the Office of the United Nations High Commissioner for Human Rights (OHCHR) and United Nations Assistance Mission in Afghanistan (UNAMA) found that while judicial officials in numerous parts of the country have begun to use law on EVAW, its use represents only a small percentage of how the government is addressing the cases of violence against women.[152] Under Article 17, the Law on EVAW states that if a person commits rape with an adult woman, the punishment is continued imprisonment in accordance with the provision in Article 426 of the Penal Code. If the victim dies as a result of rape, the perpetrator shall be sentenced to the death penalty.[153] The 2004 Penal Code in Bhutan repeals the Rape Act of 1996,[154] covering rape as a felony of the fourth degree, and is punishable by minimum prison of three years and maximum of less than five years. It stipulates that compensation should be paid where injury is the result of rape, covering 11 different categories of rape, of which all are felonies of the fourth degree or higher.[155]

In the Pacific countries, Fiji, Kiribati and Papua New Guinea have criminalised rape under the criminal code, the crimes decree and the Penal Code. There is no legal framework for rape in Samoa. In all countries, except Malaysia, the police station is the first point of entry for victim-survivors of rape.

The police culture, across all countries is problematic for rape victims. In India[156] and Cambodia,[157] it has been noted that the police very often ask difficult questions which demonstrate the discriminatory attitudes and perceptions about women. In India, the lack of female police officers is cited as one of the reasons India has a sexual violence problem, as male police officers frequently demean the women who report rapes.[158] In some cases, like in Malaysia, the police officers, however, provides the One-Stop-Crisis-Centre (OSCC) model for women victims of violence (including sexual violence) within the hospital's emergency department.

This was done as early as 1993 and a police desk is available at the hospital itself. The OSCC model was first fostered as a partnership with women's groups, namely the Women's Aid Organization (WAO) and the All Women's Action Society (AWAM), and then later with the police force and Welfare Services. Through the advocacy efforts of WAO and AWAM, the OSCC went from being a service offered at one hospital to being a policy of the Ministry of Health.

The women's groups lobbied for the ministry to include a budget for the OSCC and gender training, and for the service to be recognised as a right for women. By 2006, the OSCC had already been introduced at 104 out of the 134 hospitals in Malaysia. Currently, there are even plans to start the OSCC at government-run polyclinics which provide emergency medical services to rural communities. The services could also be strengthened through continuous gender-sensitisation of health personnel.[159] However, the coverage of the OSCC in Malaysia is limited to the public hospitals only and not replicated in the private hospitals. The hospital entry point may be easier for victims, but hospital staffs, too, are in need of gender-sensitisation and training to handle victim-survivors of rape.

Young women are particularly vulnerable to rape. For example, the Naripokkho Pilot Study on Violence against Women conducted in Bangladesh found that the majority of rape victims were young: 66% of total victims were below 25 years of age, and 39% were below 15 years of age indicating the extremely vulnerable position of girl children in Bangladesh.[160] In India, "8.9 % of the rape victims in 2004 were under 15 years of age, while 11.0% were teenage girls (15-18 years)."[161] Moreover, this is not an exact picture of the gravity of the situation as a large number of such cases simply go unreported because of the social stigma attached to the crime.[162]

More recently, a young woman was gang-raped in New Delhi after boarding a bus. She was beaten and raped, and then thrown out of the moving bus onto the street. She succumbed to her injuries and died thirteen days later. Her case made headline news around the world and brought violence against women back in the limelight as a key political issue.[163]

Incest is one form of sexual violence against girls and young women. In Malaysia, there has also been a slight increase in the reporting of incest - the number of cases rose from 213 in 2000 to 385 in 2005 - according to the Ministry of Women, Family and Community Development in 2010.[164] Knowledge, Attitudes, Behaviour and Practices (KABP) surveys done in Fiji and Samoa in 2006 showed that in Fiji, the children surveyed were aware of child sexual abuse happening in their society, affecting themselves or others. 22% of a Suva survey and 29% of school leavers had knowledge of child sexual abuse. As a result of been subjected to incestuous rape by the fathers, uncles and grandfathers, some 13-14 year old girls became pregnant.[165]

ii. Marital rape

Marital rape is a contested issue in almost all the countries in the region. Many countries in the region have no legal provisions to address this issue, as shown in Table 31, and the same debate of private/public spheres and of non-intervention of the state in private sphere is applied to this.

Unfortunately, there is little international pressure around the issue that further sustains the situation as is. For example, even when the ICPD PoA mentions in Para. 7.3 that it is the right of the individual and couples "to make decisions concerning reproduction free of discrimination, coercion and violence" it does not reflect the notion that not all sexual acts within the institution of marriage are related to matters of 'reproduction.' However, there are countries in the region that have

Table 31:
Anti-Marital Rape Laws in 21 countries in Asia

Country	Anti- Marital Rape
East Asia	
China	---
South Asia	
Afghanistan	---
Bangladesh	---
Bhutan	---
Sri Lanka	---
Maldives	---
Nepal	Act For Gender Equality 2006
Pakistan	---
India	Within The Domestic Violence Act (2005)
South-East Asia	
Cambodia	Law On The Prevention Of Domestic Violence And Protection Of Victims (2005)
Myanmar	Marital Rape Exemption, Where Under The Law, Spousal Rape Is Only Illegal If The Woman Is Under 12 Years Of Age.
Lao Pdr	---
Malaysia	Part Of Penal Code (Amended 2006)
Philippines	Anti-Rape Law 1997
Indonesia	Within Law No. 23/2004 Regarding Elimination Of Household Violence
Thailand	Criminal Code Amendment Act No 19 B.E. 2550 (2007)
Vietnam	Within Domestic Violence Law (2007)
Pacific	
Fiji	---
Kiribati	---
Papua New Guinea	The Criminal Code (Sexual Offences And Crimes Against Children) Act (2002)
Samoa	---

Source: The UN Secretary-General's database on violence against women.[166]

acknowledged and in some cases even addressed the issue in their legal frameworks. These countries include Myanmar, Cambodia, Indonesia, Philippines, Thailand, Vietnam, Malaysia, India, Nepal and Papua New Guinea.

In four of these countries, Cambodia, India, Indonesia and Vietnam, the marital rape legislations are part of the overall domestic violence laws. In the Philippines, it is covered under the anti-rape law which was passed in 1997. In Malaysia, the penal code was amended in 2007 criminalising marital rape. The Gender Equality Bill also includes marital rape and terms it as 'emotional violence' against women.

The way laws are formed and worded in some countries of the region are also problematic. In such cases, even if a marital rape law is introduced, there are usually contradictory legislations present to counteract it. For example, in India, while the legislations discourage marital rape, it states in section 375 of the Penal Code that "sexual intercourse by a man with his own wife, the wife not being under 15 years of age, is not rape."[167] The same is true in Myanmar, where the Marital Rape Exemption stipulates that under Myanmar's law, spousal rape is only illegal if the woman is under 12 years of age.[168]

Marital rape is not a crime in Sri Lanka unless a judge has ordered a spousal separation. The 2005 Prevention of Domestic Violence Act (PDVA) provides some protection. The PDVA allows victims of domestic violence (including rape and sexual assault) to request a protective order from a Magistrate's Court that would limit contact between the perpetrator and the victim.[169] In Papua New Guinea, The Criminal Code (Sexual Offences and Crimes against Children) Act 2002 introduced a series of new offences by extending penetration to include penetration of all orifices by the penis or any other object, graded according to the seriousness of the harm and by incorporating the ways in which women are sexually violated.

Marital immunity that had previously protected husbands from a charge of rape was removed, and the requirement for corroboration was removed.[170] The enforcement of such laws is also ensured in certain countries such as in Malaysia when a man was jailed for 5 years for forcing his wife to have sex with him, the first case treated "under a new provision in Malaysian Islamic family law introduced in 2007, making it an offence for husbands to hurt their wives or put [them] in fear of death in order to have sexual intercourse."[171]

iii. Sexual Harassment

Sexual harassment is one of the most common forms of violence against women. The vastness and complexities of the issue is such that it needs targeted policies and programmes that are usually missing in the legislative systems in countries of the region. However, there has been some progress made toward a specific form of sexual harassment that exists in workplace against women and this is shown in Table 32. Provisions for anti-sexual harassment in the workplace exist in Afghanistan, Bangladesh, Bhutan, Cambodia, Maldives, Nepal, Philippines, and Sri Lanka, and these provisions are part of the labour law in Bangladesh, Malaysia, Pakistan and Thailand. Only the Philippines has a separate anti-sexual harassment act. No such laws exist in China, India, Indonesia, Lao PDR, Vietnam and all four countries in the Pacific.

The Anti-Sexual Harassment Act of 1995, in the Philippines, prohibits all forms of sexual harassment in employment, education, and training environments; sexual harassment is committed when a person in a position of power, influence, or moral authority over another person in such an environment demands, requests, or requires any sexual favour from the other, regardless of whether that favour is accepted.[173]

In Malaysia, a total of 300 cases of sexual harassment at the workplace was reported from 1999 to 2011,[174] although that number was noted to have reduced from year 2000 to 2005.[175] In Thailand, "sexual harassment against women both physical and verbal also continues in offices, factories, public places and among domestic workers, most of whom have not been treated fairly by employers."[176]

In India, in 1998, the National Commission for Women (NCW) produced a Code of Conduct for the Workplace that clearly codified the requirements of the *Vishakha* judgment. The code expands the definition of sexual harassment laid out in *Vishakha,* and clarifies the employer's responsibility to address sexual harassment in the workplace.

In Nepal, there is no law addressing all forms of sexual harassment. However, some aspects of sexual harassment are dealt with in provisions of the *Muluki Ain.* Any man who touches the body of a woman other than his wife, or a girl above the age of 11, with the intention of having sexual intercourse is liable for up to one year of imprisonment, a fine of up to Rs 500 or both. Additionally, the seduction of a woman with the intention of sexual intercourse is punishable with six months to two years of imprisonment, a fine of Rs 500-6,000 or both. There is no specific law on sexual harassment in the workplace.[177]

Sexual harassment in Sri Lanka is very prevalent in public places, including at the workplace, and it is regarded as a norm. This could probably be a reason for the lack of comprehensive data available on this issue as women fear repercussions such as attacks of revenge as well as the social stigma of blame in which the victim is blamed instead of the perpetrator.[178]

iv. New and emerging forms of sexual violence

New emerging forms of violence include harassment of women via email and mobile phones, which include sending their nude photographs to the public in order to discredit and shame them.

Table 32:
Anti-Sexual Harassment Laws in 21 countries in Asia and the Pacific

Country	Anti-Sexual Harassment
East Asia	
China	---
South Asia	
Afghanistan	Law on Elimination of Violence against Women (2009)
Bangladesh	Labor Code 2006
Bhutan	Constitution (2008) Labor and Employment Act (2007 National Action Plan on Gender (2008-2013)
Sri Lanka	Act No. 22 amending the Penal Code in 1995 (1995)
Maldives	National Gender Equality Policy (2009)
Nepal	Constitutional Provision (2007) Act For Gender Equality 2006
Pakistan	Protection against Harassment of Women at the Workplace Act 2010
India	---
South-East Asia	
Cambodia	Article 172 Of The Labor Law 1997 (Law)
Myanmar	
Lao Pdr	---
Malaysia	Code Of Practice On Prevention Of Sexual Harassment At Workplace (1999)
Philippines	Anti-sexual Harassment Act (1995)
Indonesia	---
Thailand	Labor Protection Act (Amended 2008)
Vietnam	---
Pacific	
Fiji	---
Kiribati	---
Papua New Guinea	---
Samoa	---

Source: The UN Secretary-General's database on violence against women.[172]

Table 33:
Anti-Trafficking Laws

Country	Anti-Trafficking
East Asia	
China	Amendments To Penal Code 1997 Regarding Trafficking
South Asia	
Afghanistan	---
Bangladesh	Suppression Of Violence Against Women And Children Act (2000)
Bhutan	Constitution 2008 (2008) Draft Legislation On Trafficking (2003 National Action Plan On Gender (2008-2013) Women And Child Protection Unit (2007)
Sri Lanka	Act No. 22 Amending The Penal Code In 1995 (1995)
Maldives	---
Nepal	Human Trafficking Control Act (2007)
Pakistan	Prevention And Control Of Human Trafficking Ordinance (2002)
India	Article 23 Of The Constitution Anti-Trafficking Law (1956)
South-East Asia	
Cambodia	Law On Suppression Of Human Trafficking And Sexual Exploitation (2008)
Myanmar	---
Lao Pdr	Law On The Development & Protection Of Women (2004)
Malaysia	Anti-Trafficking In Person Act (2007)
Philippines	Anti-Trafficking In Person Act (2003)
Indonesia	Law On Anti-Trafficking (2007)
Thailand	Prevention And Suppression Of Human Trafficking Act B.E. 2551 (2008)
Vietnam	Constitutional Provision, Penal Code (1992)
Pacific	
Fiji	---
Kiribati	---
Papua New Guinea	---
Samoa	---

Source: The UN Secretary-General's database on violence against women.[181]

This is almost always (thus far) perpetrated by jilted suitors and ex-partners. Anecdotal evidence suggests that such emerging forms of violence are increasing and there is currently very little retribution and no legal curbs for the perpetrators of these crimes. In these cases, very often, the media also passes judgement on accepTable and unaccepTable forms of sexuality – especially for young women – which is also problematic and worsens the situation for the victims. Countries such as Thailand,[179] the Philippines, Indonesia, China, Bangladesh, India and Pakistan have some form of laws on cyber crimes and electronic crimes; violence against women, however, has not been integrated into these laws as their current focus is fraud and terrorism.

It is also crucial to note that the data collected on violence against women are not disaggregated by women, men and transgender. In analysing violence as a manifestation of unequal power relations, we must recognise that women are not the only group that suffers from unequal power relations in any society. Violence does occur against lesbians, gays, bisexuals and transgendered (LGBT) people, but this is not documented statistically. LGBT may often stay silent about their sexual orientation for fear of discrimination and violence. LGBT may also face increased 'violence' and 'violations' from even conservative health providers and law enforcers.

An extreme case of this has been documented in the Philippines where a man had a canister stuffed up his rectum by a male sex worker. When he went to the hospital, his experience was recorded in the newspapers as a "rowdy surgery ... where the medical personnel joked about the misery of a patient while the procedure was filmed and later posted on the Internet."[120] These are the types of experiences which prevent sexual minorities from seeking treatment from service providers and which in many cases, constitute a form of violence.

Radhika Coomaraswamy from SRVAW, also supports such a perspective when she notes that "gender-based violence ... is particularly acute when combined with discrimination on the basis of sexual orientation or change of gender identity. Violence against sexual minorities is on the increase...."[121] Legal recourse and service provisions for cases of violence are all the more difficult for people of diverse sexual and gender identities in our region.[180]

v. Trafficking

Most countries monitored have some form of anti-trafficking laws in place as shown in Table 33. According to the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, trafficking is defined as:

a) "'Trafficking in persons' shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs;
b) The consent of a victim of trafficking in persons to the intended exploitation set forth in subparagraph of this article shall be irrelevant where any of the means set forth in subparagraph (a) have been used;
c) The recruitment, transportation, transfer, harbouring, or receipt of a child for the purpose of exploitation shall be considered 'trafficking in persons' even if this does not involve any of the means set forth in subparagraph (a) of this article;
d) 'Child' shall mean any person under 18 years of age."[182]

Bhutan, India and Nepal in South Asia; Cambodia, Indonesia, Malaysia, Nepal, the Philippines and Thailand in South-East Asia; and China in East Asia have crafted specific laws on trafficking. There are no legal provisions in place in the four countries in the Pacific.

While the laws in most countries seem to be in place, the implementation and enforcement of such laws is questionable. Despite the legislation in China, evidence shows that trafficking of girls and young women for sexual and labour exploitation occurs. Trafficking for marriage and sexual exploitation is expected to increase because there are many more males than females in many age groups (the sex ratio at birth is increasingly male).[183]

Afghanistan is a source, transit, and destination country for men, women, and children subjected to forced labour and sex trafficking. According to the Ministry of the Interior, trafficking within Afghanistan is more prevalent than transnational trafficking.[184] In India, evidence shows that trafficking of girls and young women for sexual exploitation and other abusive purposes is rampant. According to the 2006 Shadow Report, intra-country trafficking is very high, and it was also noted that 94% of trafficked women are from rural India and from the lower socio-economic levels.[185]

Pakistan is a source of transit and destination for victims of severe forms of trafficking. Women and girls are trafficked into Pakistan for commercial exploitation, bonded labour and domestic servitude. Pakistan is one of the major destinations for trafficked women and girls and also a transit point into the Middle East.[186] Trafficking and prostitution continue with the connivance of the police and this is evidenced during raids on brothels, where women and children are arrested but the pimps and male agents are spared.[187]

In South-East Asia, in Myanmar, the total number of trafficking cases in 2009 was 155. Of these, 85 cases involved forced marriage, 19 cases involved forced prostitution, 13 cases involved forced labour and 8 cases involved child trafficking.[188] Malaysia remains a destination, and to a lesser extent, a source and transit country for men, women, and children who are subjected to conditions of forced labour, and women and children subjected to sex trafficking. There remain many serious concerns regarding trafficking in Malaysia, including the detention of victims in government facilities.[189] The concerns remain despite the government's effort of having increased the number of convictions obtained under the Anti-Trafficking in Persons and Anti-Smuggling of Migrants Act during 2010, and continued efforts in public awareness on trafficking.

The Government of Papua New Guinea does not fully comply with the minimum standards for the elimination of trafficking and is not making significant efforts to do so. Despite the government's acknowledgement of trafficking as a problem in the country, the government did not investigate any suspected trafficking offenses, prosecute or convict any trafficking offenders under existing laws, address allegations of officials complicit in human trafficking crimes, or identify nor assist any trafficking victims during the year.[190] Young girls sold into marriage are often forced into domestic servitude for the husband's extended family. In more urban areas, some children from poorer families are prostituted by their parents or sold to brothels.[191] Migrant women and teenage girls from Malaysia, Thailand, China, and the Philippines are subjected to sex trafficking, whereas men from China are transported to the country for forced labour.[192]

vi. The status of sex work

Although sex work exists in every country, there can be great variations in the way governments deal with sex work. In general, there are four different approaches taken by policy-makers on sex work. Firstly, it is the abolition approach that considers prostitution as part of human trafficking or violence against women, in which prostitution must be eradicated, cracking down on all those involved in human trafficking/brothels while helping victims quit the flesh trade. Next, the criminalisation approach regards prostitution as a social but necessary evil and allows commercial sex under strict control with criminal punishment for sex workers in order to keep business discreet and to protect the clients. As for the decriminalisation approach, it allows sex workers to continue working independently and revokes all laws which criminalises or punishes sex workers. Finally, the legalisation approach, which considers sex work as a profession, registers sex workers as employees, regulates the business venue, and taxes it.[193]

Most approaches with regards to sex work in Asia-Pacific use a structural paradigm which regards sex work as a form of exploitation and sex workers as having no choice in their livelihoods (or their lives), and frame sex workers as victims.

Table 34:
Legality of adult sex work in Asia and the Pacific

Country	Sex work in Private	Soliciting	Brothel-keeping
East Asia			
China	Illegal	Illegal	Illegal
South Asia			
Afghanistan	Illegal	Illegal	Illegal
Bangladesh	Legal	Illegal	Illegal
Bhutan	Illegal	Illegal	Illegal
India	Legal	Illegal	Illegal
Maldives	Illegal	Illegal	Illegal
Nepal	Legal	Illegal	Not illegal
Pakistan	Illegal	Illegal	Illegal
Sri Lanka	Legal	Illegal	Illegal
South East Asia			
Myanmar	Illegal	Illegal	Illegal
Cambodia	Legal	Illegal	Illegal
Indonesia	Not illegal	Not illegal	Not illegal
Lao PDR	Illegal	Illegal	Illegal
Malaysia	Not Illegal	Illegal	Illegal
Philippines	Illegal	Illegal	Illegal
Thailand	Illegal	Illegal	Illegal
Vietnam	Illegal	Illegal	Illegal
Pacific			
Samoa	Legal	Illegal	Illegal
Fiji	Legal	Illegal	Illegal
Papua New Guinea	Illegal	Not Illegal	Illegal
Kiribati	Legal	Illegal	Illegal

Source: The Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nation Population Fund (UNFPA), & United Nations Development Programme (UNDP). (2012). *Sex Work and the Law in Asia and the Pacific.* Bangkok, Thailand: UNDP

Some approaches look at sex work from a 'free choice' paradigm. However, a more pragmatic approach would be to use the 'agency' paradigm which enables us to understand the structural constraints and respect the choices that women make.[194] Nevertheless, the agency paradigm of sex workers has not been mainstreamed in the thinking revolving around sex work in the region. This could be a useful approach especially to enhance HIV/AIDS interventions. However, there is still a long way to go before nations and societies can openly acknowledge the role of desire[195] and pleasure within social sciences, laws and public health, especially regarding sex work.

All 21 countries in the Asia and the Pacific region under review criminalise sex work or certain activities related to sex work as shown in Table 34.[196] Vietnam is a clear example of the abolitionist approach as it demonstrates all the specified criteria. On 12 December 1995, the Vietnamese government called for swift measures "to eliminate social evils" which were identified as prostitution, drug addiction and gambling. When this was implemented in subsequent years, prostitution received the greatest attention.[197] The Ordinance on Prevention and Suppression of Prostitution, No. 10/2003/PL-UBTVQH11, entered into force on 1 July 2003. This was the first ever specific document on the prevention and suppression of 'prostitution.' The Ordinance provides social and economic measures to prevent prostitution and punitive measures against customers, procurers and prostitution organisers. Prostitutes are considered as the victims who will be put into the state's programmes for treatment, rehabilitation and reintegration; and those who 'harbour prostitutes' can be prosecuted through Article 254 of the Penal Code.[198]

All forms of sex work including sex work in private, soliciting sex and brothel keeping are illegal in 10 out of the 21 countries: Afghanistan, Bhutan, Maldives, and Pakistan in South Asia; China in East Asia; Lao PDR, Myanmar, Philippines, Thailand, and Vietnam in South-East Asia.

In 7 out of the 21 countries, sex work in private is legal, whereas soliciting sex and brothel-keeping are illegal in the following countries: Bangladesh, India, Sri Lanka in South Asia; Cambodia in South-East Asia; and Samoa, Fiji, Kiribati in the Pacific. In Malaysia, sex work in private is not illegal.

In Indonesia, all three forms are not illegal. Soliciting sex is also not illegal Papua New Guinea, where as brothel -keeping is not illegal in Nepal, too.

Surprisingly, although both the Philippines and Thailand are known for their sex industry, both countries criminalise sex work. In the Philippines, sex work is governed by the Penal Code, which considers prostitution as a form of vagrancy, and the Anti-Trafficking in Persons Act of 2003. In Thailand, the Prostitution Prevention and Suppression Act (1996) covers soliciting in public, pimping, advertising, procuring sex workers and managing sex work business. In the Philippines and Thailand, while sex work is criminalised, the governments allow sex to be sold in certain premises and in particular premises, in particular areas. The law requires businesses such as entertainment venues, or massage parlours to be registered or licensed.[199]

Countries which have both a Penal Code and Sharia law may mete out punishments under both systems. In Afghanistan, sex workers can be charged with adultery under Article 427 of the Penal Code 1976, and punished with imprisonment up to 5-15 years. Courts also may impose punishments under Hanafi principles of Sharia law.[200] In Maldives, the Sharia Law criminalises all aspects of sex work with the Penal Code section 88 providing penalties for disobeying the Sharia Law.[201] In Pakistan, adultery is illegal and subject to punishment under 'Zina,' although there is no specific offence for sex work. [202] In Malaysia, state level Sharia law criminalises Muslim sex workers and their clients. The Penal Code in Malaysia provides offences for soliciting and keeping a brothel.[203] In Indonesia, there is no prohibition on sex work or brothels, some provinces or districts, however, have enacted local laws to regulate sex work, and some provinces and districts prohibit sex work or apply Sharia law.

Additionally, in reality it is reported that condoms are confiscated by police as evidence of sex work in China, Fiji, India, Indonesia, Malaysia, Myanmar, Nepal, Papua New Guinea, the Philippines, Sri Lanka and Viet Nam.

Some of these laws on sex work seem to be newer and are probably measures which have been brought about to curb trafficking as seen in Cambodia's constitution, which prohibits exploitation by prostitution, and the Law on the Suppression of Human Trafficking and Sexual Exploitation, 2008, which covers offences for soliciting and brothels.

Criminalisation of sex work or of some forms of sex work legitimises violence and discrimination. Incidents of sexual assaults by police and military personnel against sex workers has been reported in Bangladesh, Cambodia, China, Fiji, India, Kiribati, Myanmar, Nepal, Papua New Guinea and Sri Lanka.

4.6 SEXUAL RIGHTS AROUND IDENTITY: THE STATUS OF DIVERSE SEXUAL AND GENDER IDENTITIES AND RECOGNITION OF THEIR RIGHTS

Sexual orientation and gender identity are issues that are strongly contested in this region. At the same time, a vibrant sexuality movement calling for the recognition of sexual diversity and for non-discrimination against those who profess different sexual and gender identities has burgeoned in the region.

i. The status of laws related to same-sex sexual preferences, relations and marriage

For the purpose of analysis in this section, we will look at three aspects related to the issue of same-sex sexual orientation: same-sex preference, same-sex relationships and same-sex marriage, and of legislations in the countries under review within the Asia Pacific region.

In most of the countries in the region, the laws are silent on same-sex sexual preference, and hence, it is not criminalised. However, the institutionalisation of same-sex to recognise higher level of human rights of persons with same-sex sexual preferences, is of concern when problems surface.
Among the 21 countries monitored, same-sex sexual relations (both male to male and female to female) is illegal in Afghanistan, Bhutan, Myanmar, Malaysia, Maldives and Sri Lanka. Female to female relations are not illegal in Bangladesh, India, Pakistan, Kiribati, Papua New Guinea and Samoa. Same-sex sexual relations are not illegal in Cambodia, China, Fiji, most parts of Indonesia, Lao PDR, Nepal, Philippines, Thailand and Vietnam.[204]

In countries which have inherited the British system of law and within the penal code, there is a section which governs sex acts against the order of nature. This is a legacy from the 1800s, and criminalises ‘unnatural sex acts/against the order of nature’ which is a term that can loosely cover many sex acts including anal sex and even oral sex.

It is usually by this law that same-sex sexual relations are criminalised. These laws are uniform in almost all the ex-colonies of the British - Malaysia, India, Pakistan, Bangladesh, Bhutan and Sri Lanka. Similarly, in Afghanistan (South Asia), Myanmar (South-East Asia) and Samoa, Papua New Guinea and Kiribati (Pacific), the punishment for same-sex sexual relations is up to ten years of imprisonment.[205]

It is also interesting to note the antiquity of these laws, as they all refer to sodomy - within the framework of male desire, and within a framework in which women are still desired objects and not desiring subjects. Section 377 of the Pakistan Penal Code criminalises same-sex sexual relations, specifically, sodomy. Sodomy is punishable by imprisonment from 11 years to life. There is evidence that there are several convictions under this statute each year, although it is not possible to give precise statistics. The ambiguity in the designation ‘unnatural offences,’ as it is termed in the law, makes the challenge to change society’s perception of homosexuality even the more difficult.[206]

Bangladesh also retains the infamous British anti-sodomy law known as Section 377 which criminalises sexuality against the ‘order of nature.’ The punishments for crimes perpetrated under this section include fines and imprisonment of up to ten years.[207] Section 377 of the Indian Penal Code, enacted by the British in 1860, also criminalises what it calls, ‘sexual offences against the order of nature’ which include sodomy and other acts considered against the order of nature. Recent developments in India, however, are very promising. The High Court of Delhi has ruled in a landmark case of Naz Foundation (India) Trust v. Government of NCT Delhi and Others that the Section 377 of the Indian Penal Code is unconstitutional.

The judgment, handed down on July 2, 2009, overturned a 148-year old colonial law that criminalised same-sex sexual relations. The Court declared that this law no longer applies to consensual sexual acts of adults because it violates Articles 21 (protection of life and personal liberty), 14 (equality before law) and 15 (prohibition of discrimination) of the Indian Constitution.[208] The case is currently being pursued in the Supreme Court.

In Malaysia, Section 377 of the Penal Code identifies different sub-sections pertaining to: carnal intercourse against the order of nature; punishment for committing carnal intercourse against the order of nature; committing carnal intercourse against the order of nature without consent; and outrages on decency. Interestingly enough, this law was used to topple and end the career of an ambitious politician – Anwar Ibrahim, who at that time occupied the office of the Deputy Prime Minister. In addition, “several states in Malaysia have instated Islamic Sharia laws, applying to male and female Muslims, criminalising homosexual and lesbian acts with up to three years imprisonment and whipping. The Sharia Penal law in the Malaysian state of Sharia prescribes penalties for sodomy *(Liwat)* and lesbian relations *(Musahaqat)* with fines of RM5,000.00, three years imprisonment and 6 lashes of the whip. All these penalties can be combined.”[209] These Islamic Sharia laws are similar to those in other Muslim countries such as Nigeria and Iran.

In Indonesia, same-sex sexual relations are not prohibited according to the national Penal Code. The only provision to deal with such relations is Article 292 which prohibits sexual acts between persons of the same sex, if committed with a person under the legal age. However, in 2002, the national parliament gave the Aceh province the right to adopt Islamic Sharia laws. These laws only apply to Muslims. This trend has also been followed in the city of Palembang in South Sumatra which has introduced jail time and hefty fines for same-sex sexual relations.[210]

In Myanmar, same-sex sexual relations is criminalised and the punishment is less than ten years in prison. In the other countries of the Mekong valley, however, the status of same-sex sexual relations has not been criminalised to the extent that it has been in the ex-colonies of Britain. The laws are largely silent on these aspects and hence, they can be construed as legal.
There is no law against same-sex sexual preference or same-sex sexual relations in Vietnam. However, the government recently passed a law which criminalises same-sex marriage in Vietnam. In Lao PDR and Cambodia, there exists no law which prohibits same-sex sexual preferences or relations. However, in Cambodia,

former King Sihanouk has called for the legalisation of gay marriage, although no policy has been issued.[211]

In the Philippines, the "criminal law is silent on the subject of same-sex relationships; there is little or no persecution under other statutes."[212] The most progressive country in the region is Nepal. In 2008, the Supreme Court of Nepal recognised lesbians, gays, bisexuals, transgenders, and inter-sexed (LGBTIs) persons as natural persons. The Court issued directive orders to the government of Nepal to ensure rights to sexual orientation and gender identities, and to introduce laws providing equal rights and amend all the discriminatory laws against people of diverse sexual orientation and gender identities. The Supreme Court also ordered the government to formulate an act on same-sex marriage.[213]
ICPD brought with it a life-cycle approach to women and their reproductive health and reproductive rights. There is also a life-cycle of sexuality and that individual human beings may experience different sexual identities in the same life-time. Hence, governments should move towards recognising and protecting the human rights of all people including those of diverse sexual orientation and gender identities.

ii. The status of transgenderism

It is important to separate the issues that affect LGB and the issues that affect transgenders. Transgenderism is an over-arching term for people whose anatomies and/or appearances do not conform to the hetero-normative framework. Transsexuals, cross-dressers, inter-sex people, queers, drags, androgynies and others fall under the category of transgenders. Transgenderism is an issue of gender identity. There can be issues of sexual orientation as well.

Transgender people comprise of some of the most marginalised and most vulnerable groups within societies in the Asia-Pacific region and the issues that affect them can be vastly different from other sexual identity groups. Literature and information is scarce in the region on the study of transgenderism, especially on Female to Male transgendered people. There has been some research and interest in Male to Female transgendered people. For this reason, the evidence for this indicator mainly focuses on the experiences of Male to Female transgendered people.
This review focuses mainly on attitudes and perceptions on transgenderism inherent in the region. There is a paucity of laws and policies in the region which protect and promote the rights of transgender people as citizens with rights, and their access to services, although they may find social acceptance within the communities they live in.

Within the 21 countries in Asia-Pacific, there is a range of attitudes and perceptions about transgenders and how they are treated within countries. In some societies, they are more easily accepted than in others. This is especially true in the Mekong societies of Thailand, Lao PDR and Cambodia, where transgendered people are referred to as *'kathoey'*, which literally means the third gender.

For the purposes of this report, we will be using the terms 'third gender' to mean 'another' gender, especially to challenge the gender binary. It is not meant to describe a hierarchy of genders. In Lao PDR, a research team found a high level of acceptance in Lao families and the community at large, but there was conflicting information. "*Kathoey* are present in all kinds of female activities. They are seen in all walks of life in Lao but *Kathoey* are more present in the private sector of the economy and only marginally among professional and governmental officers. But their visibility on the prostitution scenes does not mean they are locked into this kind of occupation but use it as an addition to a more legal income."[214]

In Cambodia, anecdotal evidence suggests that although the legal situation of transgenders is unclear, many transgendered people are high-profile actresses and actors, who have been supported by the Ministry of Culture.

Thailand is one of the most progressive countries with regards to the third gender and which often easily enables sex reassignment surgery. Traditionally, Thailand has had a history of recognising three genders right up till the mid-twentieth century.[215] In general, there is agreement that there are factors which contribute substantially to the Thai attitude: "While the ethical principles of Buddhism, along with a generally non-interventionist state, are important factors in the international perception of Thailand as a 'tolerant,' and even accommodating place for sex/gender diversity, the most recent research suggests that attitudes toward transgendered persons are far from homogenous, even, or especially, within their families,[216] and more so for the public - Thai and non-Thai - at large."[217]

Recent developments in Thailand also mark progress. In 2004, the Chiang Mai Technology School allocated a separate restroom for *kathoeys,* with an intertwined male and female symbol on the door. The 15 *kathoey* students are required to wear male clothing at school but are allowed to sport feminine hairdos. The restroom features four stalls, but no urinals.[218] *Kathoeys* are hoping for a new third sex to be added to passports and other official documents, and in 2007, legislative efforts have begun to allow *kathoeys* to change their legal sex if they have undergone genital reassignment surgery; this latter restriction was controversially discussed in the community.[219] In Vietnam, however, a mingling of Confucian, Buddhist, Christian and Communist moralities has more often than not tried to suppress gender identity issues. Literature is scarce on the subject.[220]

In the Philippines, transgendered people are usually referred to as *'bakla.'* The Philippines does not offer any legal recognition to same-sex marriage, civil unions, or domestic partnership benefits, although there is an increasingly heavy debate about them. In 1998, Senators "Marcelo B. Fernan and Miriam Defensor

Santiago submitted a series of four bills that barred recognition of marriage involving transgendered individuals, contracted in the Philippines or abroad, and barred recognition of marriages or domestic partnerships between two people of the same biological sex contracted in countries that legally recognise such relationships." As of 2006, three anti-same-sex marriage bills have been introduced and are pending before the Senate and Congress.[221]

In Malaysia, transgendered people are referred to as *'mak nyah.'* Cross dressing is illegal and in 1998, 45 transgendered people were arrested in the Kedah state while taking part in a beauty pageant. Most were charged with wearing female clothes and impersonating women, charges that could include up to 6 months incarceration.[222]

Malaysia has a majority Muslim population and there is a *fatwa* (religious edict) against sex reassignment surgery. This is largely governed by Islamic tenets that there are four perceived gender identities: male, female, *khunsa* (hermaphrodite) and *mukhannis* (cross-gender identity)/*mukhannas* (cross-gender behaviour only). While a *khunsa* can take action in relation to his condition (through sex reassignment surgery), the *mukhannis* or *mukhannas* is forbidden to do so.[223]

This is largely because the *khunsa* are perceived as products of 'nature' while the *mukhannis* and the *mukhannas* are products of 'choice.'

The *'mak nyahs'* often face much harassment from the police. If the *'mak nyahs'*, caught by the police, are Muslims, they can be sent to the Sharia department to be charged at the Sharia Court for offences against the Islamic law. The penalty incurred could be a fine of between RM800 to RM3,000 (i.e. US$200-$750) or imprisonment, or both. The Islamic religious authority, like the police, can also carry out raids among the Muslim community to identify wrong doings against the Islamic law Section 21 Minor Offences Act 1955.

In South Asia, too, there are differing attitudes towards transgendered people. In India, the third gender called the *'hijra',* are regarded as neither man nor woman. The *'hijra'* community plays important roles within cultural practices such as collecting payment for performances at weddings, births of children, and funerals; collecting alms from shopkeepers; collecting money from the general populace; working as entertainers and sex-workers. Some progress can be seen in Tamilnadu where the state government has offered to reimburse money for sex reassignment surgery for the *'aravanis.'* [224]

In Pakistan, there is also a large community of *hijras.* They tend to be largely poor and are subject to much discrimination and exploitation, especially sexual exploitation. They may also engage in sex work. On the other hand, many people believe that they have special spiritual powers and go to them when they want a particular wish fulfilled, such as wanting a child. In Pakistan, the *hijra* community has now become very scattered, making it much more difficult to reach them for services.

In Nepal, the third gender is also called *'methis.'* Nepal seems to be the most progressive country in the region, having decriminalised laws which control sexuality and having recognised sexual minorities as citizens with equal rights regardless of sexual orientation and gender identity. Transgendered people are now able, through a Supreme Court ruling to amend the Constitution, to obtain citizenship with the identity of the third gender. A government committee has also been set up to review the marriage system to amend it accordingly with this new ruling.

In countries such as Afghanistan, Malaysia and Samoa, laws criminalise the way transgender people look by outlawing cross-dressing as imitation or impersonation of the other sex, seen as un-Islamic or as indecent behaviour.

The legal environments in the region marginalise transgender people, with insufficient legal provisions in place against discrimination and abuse. Instead, the legal frameworks themselves discriminate against transgender people by criminalising transgender people's sexual or gendered behaviours, subjecting them to gender-inappropriate detention or incarceration practices, and by withholding either practical or legal recognition of self-affirmed gender.[225]

In a report by the United Nations Development Programme (UNDP), it was noted that an attempt was recently made to categorise Asia-Pacific legal environments and law enforcement practices on a five-point scale running from highly prohibitive environments to those (at the other extreme) offering protection with recognition (in regard to sexual and gender minorities). None of the 21 countries monitored fell into the category 'protection with recognition measures.' In fact, 'highly prohibitive' countries included 9 out of the 21 countries monitored: Afghanistan, Bangladesh, Myanmar, Kiribati, Malaysia, Maldives, Pakistan, Papua New Guinea and Samoa. [226]

It is apparent that nowhere is the struggle between the private and the public so apparent as it is in the case of diverse sexual and gender identities. There are some interesting examples that have emerged which demonstrate that the region is beginning to open up to these issues. However, it must be noted that in some countries conservative and religious forces are extremely strong in holding the fort against the tide.

Nevertheless, it is also important to note that people with diverse sexual and gender identities have often been able to negotiate a space within families and societies through identities such as son/daughter; father/mother which are equally important (if not more important) within the Asian context rather than just a sexual/gender identity.[227] This contrasts with the Western emphasis

on sexual orientation and gender identity being "the public expression of one's true self'" and of the "individual experience of sex/gender dysphoria."[228]

The issue of transgenderism is an important aspect within the ICPD PoA, which talks of provision of services to and the rights of 'women.' Is gender identity and the rights that come along with gender identity only ascribed to biological sex or should it be ascribed to those who profess the identity of 'woman'? Does this mean especially including some of the most marginalised and vulnerable amongst 'women'?

SUMMARY

The challenge for sexual health and sexual rights in the region is positioned within non-reproductive functions and expressions of sexuality.

There is a whole spectrum of sexual rights. All countries in the region recognise and accept the sexual rights of minors through the enactment of a legal age of marriage. Enforcement of the legal age of marriage is problematic in only a few countries. All countries recognise the rights of women to freely choose their partners and enter into consensual marriages. In some countries in South Asia, traditional practices may interfere with this choice and the exercise of choice. All countries also recognise the rights of women and girls to bodily integrity and to live free from sexual violence: rape and sexual harassment. Marital rape is still a problematic concept in the region, though it is gaining acceptance. All countries recognise the need to address trafficking of women and girls.

However, when it comes to issues of unmarried adolescents sex work, same-sex sexual relations and marriage, and transgenderism, these issues are not recognised as important enough to merit law and policy making to ensure that the SRHR of these groups are protected and promoted. Although, it needs to be noted that recent developments in Nepal and India bode well for broadening and expanding the understanding and acceptance of sexual rights in the region.

CONCLUSIONS

From the review of sexual health and sexual rights indicators across 21 countries in the region, the following conclusions are made:

1. Sexual health is still being framed in limited paradigms across the region

HIV/AIDS continues to set the defining framework for both STIs intervention and HIV/AIDS intervention although the population vulnerable to STIs is larger and more diverse. This means that groups who may be needing screening and treatment interventions are not receiving them.

The impact of STIs on the sexual and reproductive lives of people is not being given the rightful recognition it deserves. This is reflected by the limited data on STIs in the region. The epidemic pattern of HIV in the region is largely concentrated among higher risk groups such as men who have sex with men, sex workers and injecTable drug users, and interventions are framed within a 'disease prevention' paradigm which create access to services based on the concept of targeting risky behaviours instead of recognising the rights of these groups to access services without stigma and discrimination. There is a still a long way to go to having issues of sexual health and rights being framed in the paradigm of pleasure, autonomy and self-determination in all 21 countries.

2. Political will of governments is crucial in recognising the sexual health and sexual rights of citizens

Political will of governments is a key factor for the achievement of sexual health and sexual rights outcomes. Governments in the region have shown commitment by passing laws, policies and programmes to address stigma and discrimination, improved coverage of access to voluntary counselling and testing as well as anti-retroviral therapy. This has been done with sheer political will of the countries. At the same time, lack of political will of the state has resulted in poor implementation of laws, policies and programmes pertaining to sexual health and rights.

When governments commit to enacting legislation on the legal age of marriage and sexual violence, as in many countries, it is done. When governments pass legislation to recognise same-sex sexual relations and transgenderism as in Nepal, it is done. Once the political will to pursue the issue has been established, governments create policies and programmes and deploy budgets and trained personnel and provide facilities and access.

3. Sexual rights are not as contentious as perceived

Many aspects of sexual rights have been accepted and legislated by the governments in the 21 countries. Most countries recognise women's right to bodily integrity and freedom

from sexual violence and have legislated accordingly. All countries recognise the rights of choosing partners, entering into consensual marriages and consensual sexual relations although cultural practices may hinder this in some countries. Politically, governments are comforTable only in recognising the reproductive functions of sexuality and the sexual rights that go hand-in-hand with these. The non-reproductive functions are considered secondary and have not been attributed as much commitment and importance. It is necessary to delve into the bases of political power and political motivations to understand this better. However, there is still hope to shift this paradigm as shown in Nepal. In order to promote equality and prevent discrimination it is essential to move member states to gradually accept and adopt the principles of sexual rights.

ENDNOTES

1 As said in Paragraph 7.34: "Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the physical integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour." This is reiterated under the section's objectives in Paragraph 7.36: "permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals."
Paragraph 7.35 also recognises that: "In a number of countries, harmful practices meant to control women's sexuality have led to great suffering." Paragraph 7.38 encourages governments to "base national policies on a better understanding of the need for responsible human sexuality and the realities of current sexual behaviour."

2 Paragraph 4.1 states that: "The power relations that impede women's attainment of healthy and fulfilling lives operate at many levels of society, from the most personal to the highly public.... In addition, improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction."

3 Paragraph 4.4 (c) under Actions proposes: "Eliminating all practices that discriminate against women; assisting women to establish and realise their rights, including those that relate to reproductive and sexual health."

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chapter 5

recommendations

5. RECOMMENDATIONS

The recommendations focus on the areas that need urgent improvement in order to meet the ICPD PoA targets and objectives in the Asia-Pacific region. These recommendations include: universal access to quality, affordable and gender-sensitive services in order to achieve the full realisation of sexual and reproductive health and rights; policy changes that take into account the commitments made to the ICPD PoA and the MDGs in terms of realising sexual and reproductive health and rights of women, young people and adolescents; sexual and reproductive health and rights of all are fully realised and exercised, especially those of young people and adolescents, those with diverse sexual orientation and gender orientation and marginalised groups; governments and donors ensure that women's sexual and reproductive health and rights are prioritised and invested in.

This chapter puts forward recommendations of the writers as well as takes recommendations from various ARROW processes in the lead up to ICPD +20 since 2009. These recommendations draw strongly from the ARROW ICPD+15 monitoring and research publication and additional updated recommendations are drawn from ARROW partners, and allies participation in various ARROW processes, regional meeting and the Kuala Lumpur Call to Action in the lead up to ICPD+20. The recommendations are focused on the four major areas where urgent improvement is necessary in order to press forward to fulfil the commitments to the ICPD PoA: policy change with respect to reproductive rights and sexual rights; universal access to optimal sexual and reproductive health; continued, committed and sustained governmental and donor investment in women's sexual and reproductive health; and the concretisation of sexual and reproductive health and rights for adolescents and other marginalised groups.

5.1 POLICY CHANGE UNDERPINNED BY COMMITMENT TO THE ICPD POA, WITH RESPECT TO REPRODUCTIVE RIGHTS AND SEXUAL RIGHTS

The political will of governments is essential to improving the status of women's sexual and reproductive health and rights. In all areas where progress has been noted, government policies and implementation were critical for success. Now, 19 years after Cairo and Beijing, it is imperative that governments become more cognisant of their women citizens and their needs and aspirations. Women are disproportionately affected by sexual and reproductive health issues, and improving sexual and reproductive health outcomes should be viewed as critical to government efforts to improve women's status and eliminate gender inequality.

Recommendations include:

1. Population policies continue to be driven by demographic norms rather than by meeting women's needs. Policies pertaining to women's sexual and reproductive health need to be underpinned by the PoA and the underlying concepts of reproductive rights and sexual rights. Policies on sexual and reproductive health and rights need to be mainstreamed into already existing national machineries, national policies and national plans in a cohesive manner.
2. Policies that determine sexual and reproductive health and reproductive rights should be aligned to provide access to a range of contraceptive methods, abortion services, pregnancy related mortality and morbidity interventions, STIs and HIV and AIDS, reproductive cancers, and male responsibility in sexual and reproductive health. Policies should also enunciate measures against stigma and discrimination.
3. Policies should be implemented and backed by functional health systems, adequate budgets, trained human resources and updated training and curriculum for health professionals. Policies that determine SRHR must recognise the need for inter-sectoral coordination and cooperation. Existing policies which are progressive must be publicised, especially to service providers and to women, and must be translated into programme and project implementation.
4. Policies and policy review should be informed by robust data, should measure new indicators of reproductive rights, should include groups (beyond the traditional married women aged 15-49 years) such as unmarried single women, and include input from qualitative research in order to ensure that these policies are continually relevant to the people. Intersectional analysis would enable governments to understand differences in policy implementation for different marginalised groups.
5. Policies and policy reviews that determine SRHR need to be created and implemented in secular spaces, free from the influence of fundamentalisms and other doctrines that restrict human rights.
6. Policy review efforts should be integrated into CEDAW, ICESR and HRC reporting mechanisms in order to put pressure on governments to meet international commitments. After 20 years of the Cairo PoA, it is essential to create a monitoring mechanism to ensure government commitment to the ICPD. ICPD national action plans have not materialised in any concrete manner in most countries.
7. Policy review efforts should integrate the good practices of neighbouring countries as performance benchmarks and engage in knowledge-sharing and learning between countries.
8. At the same time, efforts should be made to review, amend and repeal discriminatory laws and policies pertaining to sexual and reproductive health and rights. These include amending laws that deny access to SRHR information and

services such as those that require parental and husband's consent to initiate certain medical procedures for women, conscientious objection, laws that criminalise abortion, HIV transmission, sex work, and persons of diverse sexual orientation and gender identities.[1]

9. Laws also need to be instituted to address human rights violations, including gender based violence, early and forced marriages, early childbirth, homophobia and transphobia and discrimination against people living with disability have to be drafted and implemented.[2]

In these last 19 years, the new cadre of policy-makers is unfamiliar with the ICPD PoA and the commitments that their governments have made. There is a dire need to reintroduce the PoA into the mindsets and agendas of the policy-makers.

5.2 ENSURE UNIVERSAL ACCESS TO COMPREHENSIVE, AFFORDABLE, QUALITY, GENDER-SENSITIVE SERVICES TO ENABLE THE REALISATION OF THE HIGHEST STANDARD OF SEXUAL AND REPRODUCTIVE HEALTH

Lack of access to SRH services and information contributes to high levels of morbidity and mortality for largely prevenTable SRH problems, particularly in developing countries. In 2010, a significant 29% of the 287,000 maternal deaths occurred in South Asia. These women have died due to prevenTable causes of maternal deaths including lack of access to life-saving emergency obstetric services. In 2011, nearly 5 million people are living with HIV in the region and there is a need to reach out to these groups with universal access to ART. In addition, lack of information and education on HIV/AIDS and condoms, as well as insufficient provision of condoms have contributed to the spread of STIs, including HIV. Restricted access to abortion services, contraceptives, and information on sexuality and reproductive health has led to unwanted pregnancies, botched abortions, women's impaired health and well-being, and women's deaths. Policy formulation must be backed up by service provision ensuring universal access to sexual and reproductive health. Additionally the region is unprepared to meet the challenge of burden of disease caused by reproductive cancers. Access to assisted reproductive technologies to reduce the burden of infertility continues to be largely inaccessible. Social protection for sexual and reproductive health services is largely ignored.

Recommendations include:

1. Make comprehensive SRH services available, affordable, and accepTable at all levels starting from the primary health care level. Health systems should be geared to provide universal access to a continuum of quality care and comprehensive SRH services, supplies and information, through all levels of health care and public provisioning. The primary health care level is the one which is most accessible to most of the population and hence, the essential sexual and reproductive health services should be made available at this level.
2. There needs to be renewed commitment to making available the full range of contraceptive methods (including emergency protection and condom promotion as a dual protection method); the full range of abortion services and post-abortion care; the full range of services that prevent maternal deaths especially emergency obstetric care services and adequately equipped facilities; and the full range of services to identify and to treat victim-survivors of violence including counselling. Counselling services, especially to ensure informed choice, should also be provided. Contraceptives, antiretroviral drugs, antibiotics, and other supplies ought to be adequately stocked in health facilities or other centres where younger and older women and men are able to gain access to them. Information and education campaigns are important but behavioural change communication strategies have been shown to alter health-seeking behaviour significantly in many cases.
3. There needs to be renewed commitment to staffing health facilities with skilled and trained human resources and to increasing the proportion of gynaecologists and anaesthetists. In the recent years, task shifting has been experimented and its potential has to be unleashed to make services available universally. Countries are experiencing serious scarcities of almost all health workers due to economic and fiscal difficulties as well as out-migration of health workers, especially nurses and medical doctors, from developing to developed countries. There is a need to:
   a. Assess the types of health workers most required, based on a careful analysis of: the country's burden of disease rather than an idealised notion of care that is desired; the sustainable size of the health workforce; the balance between different types of workers and the sustainable size of the country's health facility network itself; and the role of private providers in the country's health system including the interactions and cooperative partnerships that could be established between public and private providers.
   b. Strengthen the information base for human resource planning, deployment, and management, with specific attention to health workers in sexual and reproductive health. Health ministries need up-to-date information to be able to monitor the staffing situation and to use this in their policy and administrative deliberations and dialogue with donors. of care that is desired; the sustainable size of the health workforce; the balance between different types of workers and the sustainable size of the country's health facility network itself; and the role of private providers in the country's health system including the interactions and cooperative partnerships that could be established between public and private providers.
   c. Mobilise the collection of information on current number and deployment of staff, intakes and outputs of pre-service training programmes, departures from

civil service, particularly in SRH, as all of these can highlight and quantify human resource problems of which central health and finance ministries are often unaware. These include, among others, staff shortages, distribution, loss rates, and inadequate training.

d. Reduce the rigid barriers to professional practice to enable health workers to take on additional functions, increase and improve service delivery, and reduce costs. Evidence from Mozambique and Afghanistan shows that training, monitoring, and supervising technical assistants and nurses in carrying out caesarean sections and some types of anaesthetic procedures have yielded positive results, i.e., lower sepsis rates, improved quality of care, and women's and newborns' lives being saved.

4. There is a dire need to integrate services, especially RH and HIV services which have generally been funded separately and operated vertically, meaning that clients see a different provider for each health service Integration is a feasible means to achieve multiple key goals: prevent new HIV infections among women and girls; reduce HIV transmission from mother to child; prevent more AIDS orphans; and support HIV-positive women's reproductive rights and fertility choices.
5. From the perspective of ethics and programme operations, women and girls who access HIV testing, counselling, and treatment through HIV/AIDS programmes have a compelling need for RH and FP services, especially relating to their fertility choices, just as much as women and girls accessing RH and FP services have a critical need for HIV information and services. In this aspect we need to:
   a. Develop more effective strategies to help HIV positive women prevent unwanted pregnancies and access contraception: this underscores the need for comprehensive SRH services where providers do not judge their clients and for the provision of safe spaces for young, HIV-positive women to access services. Responses to address negative, judgmental attitudes of service providers toward HIV-positive women, especially those wanting children, are needed.
   b. Strengthen the ability of local government units and NGOs to reach adolescent girls, including married adolescents, with RH and HIV information and services: adolescent girls have poor access to confidential and affordable reproductive health and HIV services, making it difficult for them to protect themselves from HIV and unwanted pregnancy. This is an area that demands greater innovation and attention, both through facility-based approaches and other activities to reach young people.
   c. Develop programmes that integrate RH/FP programmes in HIV/AIDS prevention strategies. This is critical: programmes that help prevent women from acquiring HIV but programmes to help women prevent pregnancy are not sufficient. Women need to use dual protection -- contraception and condoms – to prevent unwanted pregnancy and HIV.
6. Service providers should incorporate gender sensitive approaches and be receptive to differences in sexual orientation and gender identities. Service providers should also mitigate misconceptions on all aspects of sexual and reproductive health. Service provision should also include accountability mechanisms and redressal mechanisms for patients and clients.
7. Registration systems for births, deaths and marriages must be instituted within health systems and the relevant government departments. This is vital for tracking and recording maternal deaths and the causes of maternal deaths as well as preventing early, unintended pregnancies and the resulting mortalities and morbidities.

5.3 ENSURE CONTINUED, COMMITTED AND SUSTAINED INVESTMENTS IN WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS BY GOVERNMENTS AND DONORS

Even as many countries in the region are coming under the bracket of middle-income countries and thereby no longer a priority for aid, drastic inequality and inequities remain. Despite the great need and demand in the region, in 2010 alone, the gap was US$6.73 billion.[3]

Recommendations include:

1. Advocate for political support and encourage donors and governments to meet the agreed funding requirements to ensure universal access to sexual and reproductive health services by 2015 and beyond:
   a. At the global level: by ensuring sexual and reproductive health and rights remains a priority intervention in the post -2015 development agenda; by influencing the allocation of ODA to sexual and reproductive health and rights (SRHR) through partnerships forged with global inter-government agencies and international NGOs;
   b. At the regional level: by impressing the central role of SRHR in the achievement of the ICPD and, by extension, the MDGs upon regional institutions such as Asian Development Bank, Association of South East Asian Nations (ASEAN), South Asian Association for Regional Cooperation (SAARC) and UN agencies such as Economic and Social Commission for Asia and the Pacific (ESCAP), regional offices of other UN agencies such as UNDP and UNAIDS;
   c. At the national level: by prioritising SRHR in the respective national development plans, and legislative initiatives and by ensuring that SRHR is supported by funds stipulated in the national budget; as well as by incorporating SRH service components, especially important country specific SRH issues, into the

Essential Service Packages (ESP) determined by these plans.

d. At the sub-national or local level: by prioritising SRHR in local or provincial investment health plans at the local level, i.e., local government units, and by ensuring that funds are invested in interventions and activities that support and sustain efforts to achieve the ICPD PoA.

2. Advocate that governments, who are now required to report the national health accounts (NHA), to track the expenditure on SRH. Currently, the NHA, in the 21 countries, does not capture funds used specifically for services to prevent maternal mortality and SRH nor does it show whether funds are being spent on the right interventions and in the right proportion.
   There is a compelling need to create Sexual and Reproductive Health Sub accounts. This is a crucial tool for setting priorities, allocating budgets, and advocacy as well as for increasing transparency and drawing accountability from governments tasked with providing RH services.
3. Strengthen the capacity of partners and their constituencies to engage effectively in policy making and political decision-making processes, i.e., to appreciate the context and understand the processes of policy making such as setting priorities and drafting policies; to participate in developing and monitoring PRSPs, and engaging in health sector wide approaches; to strategically apply political and technical tools, e.g., national health accounts and sub-accounts on RH to influence priorities and budgetary allocations; to forge alliances and coalitions; and to demonstrate results.
4. Donors should fulfil their commitments to the vision set out by the PoA, by funding all components of SRHR and health system strengthening from primary health care levels. Review vertical funding mechanisms for components of SRH services, and put them under the same umbrella. Shifting the agenda from ICPD to MDGs, has resulted in the loss of the rights-based approach so crucial to the full realisation of sexual and reproductive health. With the shift in agenda, the push from donors to governments to adopt women's rights, reproductive rights and sexual rights, is waning in strength.

5.4 ENSURE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF ALL ARE FULLY REALISED AND EXERCISED, ESPECIALLY THOSE OF YOUNG PEOPLE AND ADOLESCENTS, THOSE WITH DIVERSE SEXUAL ORIENTATION AND GENDER ORIENTATION AND MARGINALISED GROUPS

It needs to be remembered that although sexual and reproductive health and rights issues are about gender inequity, it is also an issue of socio-economic inequity. Women, young people and adolescents, people of diverse sexual orientation and gender identities constantly face barriers in the realisation of their sexual and reproductive health and rights. These include women from the rural areas, who are from the lower wealth quintile, who are less educated, who are from indigenous or tribal communities or from different ethnic minorities. All these individuals have one thing in common: they have greater difficulties in accessing SRH services and information, thus, stunting their realisation of their sexual health and rights.

1. Provide Comprehensive Sexuality Education (CSE) to adolescents and young people, focusing not only on reproduction and biology, but include the rights aspect as well. CSE needs to be provided at different levels of education. Educators need to be given the training needed on sex and sexuality education, in order to accurately educate adolescents and young people with regards to sex and sexuality. The training needs to not just focus on the biology of reproduction and transmission of sexually transmitted diseases, but also include the different aspects of sexual rights - dimensions, communication and negotiation.
2. Create adolescent-friendly policies and services, as this is the group that faces the greatest barriers in accessing information, education and services for sexual and reproductive health. Eliminate barriers of consent and discrimination which prevent adolescents, especially unmarried adolescents, from accessing all sexual and reproductive health services including contraception, abortion and post-abortion care and counselling.
3. Create comprehensive programmes, policies and plans to address marginalised groups. Ethnic minorities, tribal groups, the poor, elderly, disabled, migrants, and those living in mountainous areas and coastal areas will require more than one intervention to improve their sexual and reproductive health and rights. Understand the barriers that impede their access, and work deliberately and systematically to remove these barriers. Ensure national resources are also allocated to these marginalised groups. Understand the sexual and reproductive health needs of these groups in a non-judgemental manner; and create service provision if previously non-existent.
4. Create policies which will include sex-workers and people with diverse sexual orientation and gender identities within service provision and which will ensure they are entitled to equal, fair, non-discriminatory sexual and reproductive health services, care and treatment. Create and enact legislation which will enable these groups to also realise their sexual and reproductive rights to the fullest.
5. Implement policies and programmes with an understanding of the different aspects of vulnerability: exposure to risks and danger as well as lack of the capacity to cope with the negative consequences of risks and threats of these marginalised groups. In situations of emergencies and disasters, fully understand the increased risk for marginalised groups in these situations and incorporate SRH into the formulation and implementation of disaster-preparedness, response and recovery plans.[4]

ENDNOTES

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