POST-2015 WOMEN'S COALITION

A coalition of feminist, women's rights, women's development, grassroots and social justice organizations working to challenge and reframe the global development agenda.

An Advocacy Brief: Post 2015 Development Agenda

ASIA-PACIFIC REGIONAL BRIEF

Introduction

The sexual and reproductive health and rights (SRHR) agenda was affirmed in the Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994. The agenda included, promoting gender equality, empowerment of women, equal access to education for girls and the provision of universal access to family planning and sexual and reproductive health services and reproductive rights. Twenty years from the ICPD agenda, at the 13th session of the Open Working Group on the Sustainable Development Goals, ensuring universal access to sexual and reproductive health and reproductive rights was included as a sub-goal within Goal 5 on achieving gender equality and empowerment of all women and girls of the outcome document. Goal 3 of the document also includes ensuring universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030.

SRHR are intimately interlinked to other development agendas including the achievement of gender equality, human rights, elimination of poverty and inequality. Working on SRHR requires working at the intersections of several issues such as that of migration, health, climate change, population dynamics, conflicts and disasters, food and nutrition security, and access to resources. Challenges faced by women in realizing their SRHR should therefore be viewed in the context of these variables, so that appropriate and sustainable interventions can take place. Although the Millennium Development Goals (MDGs) highlight the importance of some of the SRHR agenda, they have also been criticized for the narrow interventions which often fail to consider the underlying social determinants and power dimensions of gender, poverty, inequality, inequity, ill-health and mortality. Twenty years since the ICPD agenda and the MDG framework, it is significant to assess progress towards SRHR in the Asia-Pacific region.

Context Analysis

Discussions on the progress of MDG goals needs to be located in the contexts and social environments of the diversity within the Asia-Pacific region (whether cultural, economic development, topographic, population size, political or social diversity), and inequities and inequalities. The Asia-Pacific region is also rife with multiple crises of energy, food and economy and complex issues of religious and political conservatism, erratic climate change issues, and migration, all of which have a bearing on women's SRHR. This is also a region where health systems of many countries are weak, which is aggravated by a host of factors including lack of political will and accountability by the state actors, low prioritisation to health, and national policies that push for reduced public expenditures and increased privatisation of health care, making publicly funded, comprehensive healthcare almost impossible in some countries.

These briefs are made possible through the generous support of Anonymous and the Ford Foundation.
The Center for Women's Global Leadership is the global coordinator of the Post 2015 Women's Coalition.
For more information, please contact info@post2015women.com.

Maternal Health, Mortality and Morbidity

Despite various attempts by local and international organizations to reduce the number of pregnancy and childbirth related deaths, Maternal Mortality continues to be one of the leading causes of death for many of the member countries in the Asia-Pacific region. In fact, most of these deaths are preventable and solutions for the complications that arise during pregnancy and childbirth are well-established.[1,2] In the last two decades, Southeast Asia has seen a healthy decline in the maternal mortality ratio.[3] However, as of 2010, the burden of maternal mortality is still high in this region. Every 2 out of 1,000 pregnant women are at risk for death due to prenatal and perinatal complications.[4] The risk of maternal mortality in the Western Pacific region, as defined by the WHO, is much less, averaging to about 50 deaths per 100,000 live births.[5] Although the main causes of maternal mortality include excessive haemorrhaging, hypertension, and abortion-related injuries[6], the underlying factors that predispose women to these circumstances should be viewed as causative agents to maternal mortality. These include inadequate access to health information and services, unaffordable medical costs, poor nutrition, and violence during pregnancy. Therefore, *ensuring provision of adequate and affordable access to the healthcare system*, especially to vulnerable populations, remains one of the main initiatives in the goal to reducing maternal morbidity and mortality. Maternal mortality rate is highly correlated with the *availability of and access to skilled attendants and antenatal care coverage*. Overall, as the percentage of births handled by skilled personnel increases, maternal mortality rate decreases. However, an increase in health labour force such as this requires sufficient funding to the health sector, which is not always possible in resource poor countries. *Antenatal care* typically includes medical care such as the treatment of pre-eclampsia, tetanus immunization, and nutritional support. In Southeast Asia, the average percentage of antenatal care, (which is defined as at least 4 visits), was 80% in 2009.[7] This figure is much higher in the Western Pacific region; approximately 92% of women aged 15–49 years with a live birth pregnancy during a specified period of time reported that they had at least four antenatal visits.[8] Afghanistan, Bangladesh, and Lao PDR however, have the lowest rates of antenatal coverage, ranging between 15% and 26%.[9] Antenatal care alone is not sufficient in preserving the health of mother and child; other services such as post-partum care and the provision of an emergency obstetrics system is also important in reducing the extent of maternal and neonatal mortality.

Access to Safe Abortion Services

One of the major factors contributing maternal mortality and morbidity is unsafe abortion. The incidence of unsafe abortion continues to be high in the Asia Pacific region. Safe abortion services are an essential component of maternal health services. Laws related to abortion are restrictive in several countries making access to safe abortion services for women and girls difficult. Only a few countries in the Asia Pacific region allow for abortion more liberally than others: China, Nepal, Vietnam, Cambodia and India.[10] When laws are restrictive, women often have to access services in unsafe settings as what happens in countries such as Lao PDR, the Philippines, Indonesia, Bangladesh and Pakistan.[11] Young women and adolescent girls often have to face additional challenges when accessing safe abortion due to age. It is necessary to have laws and policies which enable women to access safe abortion services, and to ensure that laws and policies are backed by provision of safe services.

These briefs are made possible through the generous support of Anonymous and the Ford Foundation.
The Center for Women's Global Leadership is the global coordinator of the Post 2015 Women's Coalition.
For more information, please contact info@post2015women.com.

Access to Contraception

Information on and access to safe and modern methods of contraception is also an important factor which helps women exercise control over their fertility, which in turn ensures women can delay child-bearing, space their children and prevent unwanted pregnancies and reduce maternal mortality. In the Asia-Pacific region, data on contraceptive prevalence is underestimated as in most countries only married women are surveyed. Lack of data on contraceptive use among young unmarried women is alarming, as this group, in particular, may face additional barriers in gaining access to information about contraception use and choice. Furthermore, a national study conducted in Pakistan in 2005 showed that the decision to use contraception was significantly associated with autonomy and education levels of women.[12]

Sexually Transmitted Infections, including HIV and AIDS

Apart from factors such as maternal mortality and morbidity and inadequate information and access to contraceptive services, there has also been an increase, both globally and in the Asia-Pacific region, of the incidence of sexually transmitted infections (STIs) including HIV. In Southeast Asia, the total number of new cases of STIs, encompassing the four main curable infections (chlamydia, gonorrhoea, trichomoniasis, and syphilis), was estimated to be 78.5 million.[13] In 2011, it was estimated that the Asia-Pacific region was home to almost 5 million people living with HIV.[14] Timely treatment and management is important in reducing the risk of HIV and AIDS. It is estimated that 2.4 million people living in Asia and the Pacific were in need of Anti-Retroviral Therapy (ARTs) in 2009; however, the mean coverage in the region is approximately 31%.[15] There are also gender disparities in access to treatment; in Mongolia and Sri Lanka, women are more likely to get treated equally as men, and the situation is reversed in countries such as Pakistan and Papua New Guinea.[16] Women make up 35% of the people living with HIV in Asia, and this figure has remained somewhat constant over the past decade.[17] Furthermore, it was estimated that the majority, over 90%, of women with HIV had contracted it from their husband or long-term partners.[18] The combination of lack of access to relevant information surrounding safe sex and protection against STIs, gender inequity, poverty, and rigid social norms surrounding sexual relationships prevent many of these women from getting the help they need to prevent or treat this infection acutely. It is important to have a paradigm shift from disease prevention to safe sex interventions to address STIs and HIV/AIDS in the region.

Young People and Comprehensive Sexuality Education

Globally, about 16 million girls aged 15-19 years give birth each year and these births happen predominantly in developing nations.[19] According to statistics, in developing nations (excluding China) 35% of young women aged 20-24 years marry below the age of 18 years and 12% below the age of 15; in South Asia, early marriage is predominant with almost half of all young women marrying below age 18 and almost one-fifth below age 15.[20] Additionally, 20% of young people aged 20-24 years in developing countries (excluding China) had begun child-bearing before they attained the age of 18.[21] While this data accounts for married young people alone, there would be many other undocumented cases of unmarried young people who may have begun child-bearing before the age of 18 as well. Early marriages often resulting in early child-bearing and unwanted and frequent pregnancies have a long-term and adverse impact on the health of women especially when they are young. Studies report inconsistent use of condoms or other contraceptives; only 15% of young men and women

reported the use of a condom in their last sexual encounter in South Asia.[22] Despite these statistics, knowledge of and accessibility to reproductive health services are limited especially for young people. In the Asia-Pacific region where sexuality is still taboo, patriarchal norms are still strong, and religious fundamentalisms are on the rise, comprehensive sexuality education which includes not only information on abstinence but also information on universal access to sexual and reproductive health and rights services including the right to access contraception is severely lacking.

Sexual Rights

Sexual rights include among other things, the right of all people to choose whether to be sexually active or not, right to choose one's partner(s), the right to adult consensual sexual relationships, and the right to decide whether and when to have children (or not). *Early and forced marriages* still remain the norm for many people in the Asia-Pacific region. Early marriages are detrimental to the rights of a child to bodily integrity and the right to decide if, when and who to marry. They hamper the healthy growth of children especially girls who are denied their right to education and the right to employment (should they desire to work) and often lead to early and unwanted pregnancies. Young women in early marriages have less access to reproductive health services as they will invariably be married to older partners, and have limited capacity to make healthy reproductive choices due to gender power imbalances. Interlinked with early and forced marriages; women and girls also have inadequate power to decide if, when and how many children they would like to have thus making them more vulnerable. In the Asia-Pacific region where a number of countries have inherited laws on sodomy from the colonial period, *the rights of people with diverse sexual orientation and gender identities* are often thwarted. With threats of criminalization from the state as well as unwarranted torture and assaults including sexual assaults by the police as well as members of the community, people with diverse sexual orientation and gender identities often lead lives full of fear and shame. People with diverse genders and sexualities are thus pushed underground and are unable to access SRHR health and other services thus making them more vulnerable to STIs including HIV. Sexual rights also include the rights to bodily integrity, and the right to be safe against sexual violence. Sexual violence may take different forms including sexual assaults and rape, sexual harassment and newer and emerging forms such as harassment over cyberspace. It is important therefore that efforts are made to have good laws and policies in place to mitigate and prevent sexual violence among women.

CASE STUDIES

Sexuality education in school, and access to contraception and maternal health services[23]

A young woman NGO worker from Mongolia related that when she got pregnant, it took her one week to get an appointment for antenatal care. Although she had knowledge about preventing pregnancies, she was scared to use condoms as people in her neighborhood and community had misconceptions about the risks of contraception. Because of this, she did not use condoms regularly.

On the day of the appointment at the antenatal care setting, some tests were administered early in the morning, and she had to stand in a long queue. The doctors also did not give her any information about those tests or about antenatal care. They said, 'If you need antenatal care, you should wait until your baby starts moving,' and 'Maybe you

will have a stroke or hemorrhage when you give birth, because your eyesight is bad.' They didn't tell her anything about what to do if she had a problem or needed information.

Although teenagers are supposed to learn about sex through the general education lessons which must include information about sexual rights and sexual education, she related that there was not enough time for the health lessons and the content was often not good. She mentioned that they were embarrassed during the classes on topics like condom wearing and girls' menstruation. She started to learn about sexual and reproductive rights only when she began working at a women's rights NGO from her 1st level of university.

Young people's lack of access to SRHR services in Lao PDR[24]

In a study conducted on 409 young people in the urban and rural areas of Luang Namtha province of Lao PDR which is a mountainous province and is home to a large number of ethnic minorities groups including the Khamu, Akha, Hmong, and Yao, it was found that Akha life was characterized by a ritual and ethical code which provides them with strict guidelines on how to live their lives, also known as the 'Akha way' which included not only their traditions, ceremonies and customary law, but also determines how they cultivate their fields, hunt animals, view and treat sickness, and the manner in which they both relate to one another and outsiders. The study revealed a moderate level of knowledge on reproductive health, a low level on STIs including HIV and AIDS and moderate to high knowledge on contraception among the participants. 57.7% of 409 female students reported ever having sexual intercourse. Of adolescent girls who had engaged in sexual intercourse during the last six months, 70% reported having a single sexual partner and 17.5% had two partners, the most partners a respondent had was 13. About 56.2% did not use condoms during the last six months prior to the interview and 46.3% did not use a condom during their most recent sexual encounter. They also practiced some sexual rites of passage such as – 'break through vagina' and 'welcome guest'. Thus, these behaviors made them more vulnerable to STIs including HIV. However, the study revealed the lack of access to SRH services and information.

Lack of access to quality maternal health services in Pakistan[25]

Feroza is 38 years of age. Educated till primary level, she was married 22 years ago at 16 years of age. She has three daughters and two sons. Her husband is a government employee and she herself is a former village councilor. She lives independently, separate from her in-laws. She said that they have no health facility in their village but a Lady Health Worker (LHW) visits the village and distributes contraceptive pills, tablets for strength and sometimes cold and fever medicine for children. She claimed that the injectable hormone is good and if they ask a doctor, they administer it. Feroza said that men voice strong opinions regarding family planning (FP). The opinion of in-laws on FP is not important because if the couple agrees, then no one interferes. However, if a woman has an operation (contraceptive surgery or tubal ligation), some people in the community may comment but now most women have started FP. The decision is mutual -- a woman is like a leaf in the wind, she cannot decide on her own. The Dai is available for RH but now the LHW also visits the village. However, the Government has provided no services. In case of any emergency, her husband takes her to the doctor in the nearby District Hospital using hired transport. She mentioned that the change in the last five years is that now men take their women for regular check-ups and follow the doctor's advice. Also, their town now has a lady doctor. She mentioned that although she had been taking the pill and using hormonal contraception, she conceived. However, because she is an independent woman, she talked to her husband and said she did not want this child as she felt unable to raise a small child. Her husband agreed and she went to a Lady Health Visitor (LHV) and had a dilation and curettage. It hurt a great deal but she had no choice. The LHV was untrained because after recovery she consulted a Lady Doctor who told her she had developed a wound in her uterus and that was why there was constant bleeding and fever. She treated her for three months and now she was better. Her family did not adversely react to her getting an abortion as it was a mutual decision of the couple. The couple is now careful in their use of FP so as to avoid going through another painful episode like that.

These briefs are made possible through the generous support of Anonymous and the Ford Foundation.
The Center for Women's Global Leadership is the global coordinator of the Post 2015 Women's Coalition.
For more information, please contact info@post2015women.com.

Key Policy Directions and Priority Actions

In view of the issues raised above, the following guidelines are recommended:

- Guarantee universal access to quality, comprehensive, integrated sexual and reproductive health services including contraception, maternal healthcare, safe abortion and STI and HIV prevention and treatment within primary health care.
- Review, amend, and implement policies that support sexual and reproductive rights, understanding that these rights underpin sexual and reproductive health outcomes. This includes, but is not limited to, policies involving the provision of contraception and abortion services, and the dispersion of adequate yet affordable health care services.
- Efforts should be strengthened to review, amend, and repeal discriminatory laws and policies pertaining to sexual and reproductive health and rights including laws related to sodomy. Policies against stigmatization and discrimination of those practicing their sexual and reproductive rights should be implemented. Laws and harmful practices that criminalize women for accessing sexual and reproductive health care (including abortion, emergency contraception, HIV) should be eliminated.
- Sufficient funding to the health sector should be provided, with the aim of ensuring universal access to comprehensive, affordable, quality, and gender-sensitive services, to enable the highest standard of sexual and reproductive health, and to bring health equity to vulnerable populations.
- Ensure that women, adolescents and girls receive comprehensive sexuality education and services that respects their human rights throughout their life cycle.
- Continued commitment and sustained investments in women's sexual and reproductive health and rights should be maintained by governments and donors, in order to achieve continual protection of these rights. Also, policies governing sustainability should be reviewed periodically to ensure that the needs of the people are being met adequately.

This regional brief was prepared by the Asian-Pacific Research & Resource Centre for Women (ARROW) for the Post 2015 Women's Coalition.

---

[1] World Health Organization. Maternal Mortality: Fact Sheet. Retrieved August 28, 2013 from the WHO Website: www.who.int/medicenter/factsheets/fs348/en/

[2] World Health Organization. (1986). Maternal Mortality: Helping Women Off the Road to Death. WHO Chronicle, 40 (5): 175-183. Retrieved August 28, 2013 from the WHO Website: http://apps.who.int/iris/bitstream/10665/46514/1/WHO_Chronicle_1986_40%285%29_175-183_eng.pdf

[3] World Health Organization. (2013). World Health Statistics 2013: Part III Global Health Indicators. Retrieved August 28, 2013 from the WHO Website: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2013_Part3.pdf

[4] World Health Organization. (2013). World Health Statistics 2013: Part III Global Health Indicators. Retrieved August 28, 2013 from the WHO Website: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2013_Part3.pdf

[5] World Health Organization. (2013). World Health Statistics 2013: Part III Global Health Indicators. Retrieved August 28, 2013 from the WHO Website: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2013_Part3.pdf

[6] World Health Organization. (2011). Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008, 6th ed. Retrieved August 28, 2013, from the WHO Website: http://www.apps.who.int/iris/bitstream/10665/44529/1/9789241501118_eng.pdf

[7] United Nations. (2011). Millennium Development Goals Indicators. Retrieved August 28, 2013 from the UN MDG Website: http://mdgs.un.org/unsd/mdg/data.aspx

[8] World Health Organization. (2009). MDG 5: Maternal Health: Women by WHO region. Retrieved August 28, 2013 from the WHO Website: http://apps.who.int/gho/data/view.main.1610?lang=en

[9] World Health Organization. (2013). World Health Statistics 2013: Part III Global Health Indicators. Retrieved August 28, 2013 from the WHO Website: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2013_Part3.pdf

[10] Thanenthiran, S., Racherla, S. J. M., & Jahanath, S. (2013). Reclaiming & Redefining Rights: ICPD+20: Status of Sexual and Reproductive Health and Rights in Asia Pacific. Kuala Lumpur, Malaysia, ARROW. http://www.arrow.org.my/publications/ICPD+20/ICPD+20_ARROW_AP.pdf

These briefs are made possible through the generous support of Anonymous and the Ford Foundation.
The Center for Women's Global Leadership is the global coordinator of the Post 2015 Women's Coalition.
For more information, please contact info@post2015women.com.

[11] Thanenthiran, S., Racherla, S. J. M., & Jahanath, S. (2013). Reclaiming & Redefining Rights: ICPD+20: Status of Sexual and Reproductive Health and Rights in Asia Pacific. Kuala Lumpur, Malaysia, ARROW. http://www.arrow.org.my/publications/ICPD+20/ICPD+20_ARROW_AP.pdf
[12] Saleem, S.; Bobak, M. (2005). Women's Autonomy, Education and Contraception Use in Pakistan: A National Study. Reproductive Health, 2. Retrieved August 28, 2013 from : http://www.reproductive-health-journal.com/content/2/1/8
[13] World Health Organization. (2008). Global Incidence and Prevalence of Selected Curable Sexually Transmitted Infections – 2008. Retrieved August 28, 2013 from the WHO Website: http://www.who.int/reproductivehealth/publications/rtis/stisestimates/en/index.html
[14] Kraus, S. (2012). Getting to Zero in Asia and the Pacific: Focus and Innovation. Retrieved August 28, 2013 from http://www.aidsdatahub.org/dmdocuments/Regl_Overview_RMM9_28Oct12.pdf
[15] UNAIDS (2011). HIV in Asia and the Pacific: Getting to Zero. Retrieved August 28, 2013 from the UNAIDS Website: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110826_APGettingToZero_en.pdf
[16] UNAIDS (2011). HIV in Asia and the Pacific: Getting to Zero. Retrieved August 28, 2013 from the UNAIDS Website: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110826_APGettingToZero_en.pdf
[17] UNAIDS (2011). HIV in Asia and the Pacific: Getting to Zero. Retrieved August 28, 2013 from the UNAIDS Website: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110826_APGettingToZero_en.pdf
[18] United Nations Population Fund (UNFPA) (2005). Cambodia at a Glance: Population, Gender and Reproductive Health. Cambodia: UNFPA.
[19] Khatiwada. N., Silwal, P. R., Bhadra, R., & Tamang, T. M. (2013). Sexual and Reproductive Health of Adolescents and Youth in Nepal: Trends and Determinants: Further analysis of the 2011 Nepal Demographic and Health Survey. Calverton, MD: Nepal Ministry of Health and Population, New ERA, and ICF International.
[20] Jejeebhoy, S. J., Zavier, A. J. F., & Santhya, K. G., (2013). Meeting the commitments of the ICPD Programme of Action to Young People. Reproductive Health Matters 21(41): 18-30.
[21] Jejeebhoy, S. J., Zavier, A. J. F., & Santhya, K. G., (2013). Meeting the commitments of the ICPD Programme of Action to Young People. Reproductive Health Matters 21(41): 18-30.
[22] Jejeebhoy, S. J., Zavier, A. J. F., & Santhya, K. G., (2013). Meeting the commitments of the ICPD Programme of Action to Young People. Reproductive Health Matters 21(41): 18-30.
[23] Unpublished case study
[24] Asian-Pacific Resource & Research Centre for Women (ARROW) (n.d.). Sex & Rights: The Status of Young People's Sexual and Reproductive Health and Rights in Southeast Asia. Kuala Lumpur, Malaysia: ARROW. http://arrow.org.my/download/PREVIEW_SRHR_Final.pdf
[25] Asian-Pacific Resource & Research Centre for Women (ARROW) (n.d.). Reclaiming & Redefining Rights: Thematic Studies Series 4: Maternal Mortality and Morbidity in Asia. Kuala Lumpur, Malaysia: ARROW. http://arrow.org.my/publications/ICPD+15Country&ThematicCaseStudies/MaternalMortality&MorbidityinAsia.pdf

These briefs are made possible through the generous support of Anonymous and the Ford Foundation.
The Center for Women's Global Leadership is the global coordinator of the Post 2015 Women's Coalition.
For more information, please contact info@post2015women.com.