

Action for Sexual and Reproductive Health and Rights: Strategies for the Asia-Pacific beyond ICPD and the MDGs

Thematic Papers - Beyond ICPD and the MDGs:

NGOs Strategizing for Sexual and Reproductive Health and Rights in Asia-Pacific Thematic Papers Presented at the Regional Meeting 2-4 May 2012; Kuala Lumpur, Malaysia

Opportunities for NGOs at National, Regional, and International Levels in the Asia-Pacific Region in the Lead-up to 2014: NGO-UNFPA Dialogue for Strategic Engagement, 4 May 2012; Kuala Lumpur, Malaysia



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*NGOs Strategizing for Sexual and Reproductive Health and Rights in Asia-Pacific
Thematic Papers Presented at the Regional Meeting*

Thematic papers presented at
Beyond ICPD and the MDGs: NGOs Strategizing for Sexual and Reproductive Health
and Rights in Asia-Pacific Region and Opportunities for NGOs at National, Regional,
and International Levels in the Asia-Pacific Region in the Lead-up to 2014:
NGOUNFPA Dialogue for Strategic Engagement

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Glossary

ACHIEVE	Action for Health Initiatives, Inc. Philippines	INR	Indian Rupees
AFC	ARROWs For Change	IOM	International Organization for Migration
AIDS	Acquired Immunodeficiency Syndrome	JAG	Joint Action Group for Gender Equality
ARRM	Autonomous Region of Muslim Mindanao	JUNIMA	Joint UN Initiatives on Mobility and HIV/AIDS in South East Asia
ARROW	Asian-Pacific Resource & Research Centre for Women	LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer
ARSH	Adolescent Reproductive and Sexual Health	MDG	Millennium Development Goal
ART	Antiretroviral Therapy	MMR	Maternal Mortality Ratio
CC	Climate Change	NAPAS	National Adaptation Plans of Action
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women	NCMS	New Co-operative Medical Scheme
CJ	Climate Justice	NCW	National Commission on Women
CSO	Civil Society Organisations	OECD	Organization for Economic Co-operation and Development
DHS	Demographic and Health Surveys	OOP	Out-of-pocket
FGD	Focus Group Discussion	PCVA	Participatory Capacity and Vulnerability Analysis
FGM	Female Genital Mutilation	PMTCT	Preventing Mother-to-child Transmission
FSL	Fair Share Level	PoA	Programme of Action
GBV	Gender Based Violence	PPP	Purchasing Power Parity
GDP	Gross Domestic Product	RH	Reproductive Health
GHGE	Green House Gas Emissions	RTI	Reproductive Tract Infection
GHI	Global Health Initiatives	SAARC	South Asian Association for Regional Cooperation
HEF	Health Equity Fund	SCOA	Syari'ah Criminal Offences Act
HIV	Human Immunodeficiency Virus		
ICPD	International Conference on Population and Development		

Glossary

SDG	Sustainable Development Goal	UNDP	United Nations Development Programme
SDIP	Safe Delivery Incentive Programme	UNFCCC	United Nations Framework Convention on Climate Change
SRH	Sexual and Reproductive Health	WHA	World Health Assembly
SRHR	Sexual and Reproductive Health and Rights	WHO	World Health Organization
STD	Sexually Transmitted Diseases	WHO	World Health Organization
STI	Sexually Transmitted Infections		
UHC	Universal Health Coverage		
UN	United Nations		
UNAIDS	Joint United Nations Programme on HIV/ AIDS		

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Foreword



ARROW and her partners completed, in 2009, a 12-country report on the status of women's sexual and reproductive health and rights (SRHR) in Asia. Key findings of this seminal report, "Reclaiming and Redefining Rights" were:

- Not a single country had achieved all the targets of the International Conference on Population and Development (ICPD). For example, unmet need for contraception and unwanted fertility was still a major issue for less-educated, low-income women resident in remote or hard-to reach areas.
- Informed contraceptive choice was practised nowhere by service providers.
- Male responsibility for contraception remained as rhetoric.
- Eighty percent skilled attendance at birth had not been achieved in 7 of 12 countries and access to emergency obstetric care was far from accessible to women in many countries.
- Access to safe abortion was restricted by law and unsafe abortion continued to be an important cause of maternal death.
- Access to safe abortion is not only determined by legislation, but also that progressive policies need to be backed by service provision and quality of care.
- Reproductive cancers are yet to be addressed in a comprehensive and cohesive manner within the health systems in the region.
- In all the countries reviewed, women who are poor, less educated, and living in remote and/or rural areas face greater difficulties in accessing sexual and reproductive health services

and realizing the autonomy of their bodies. Tribal women, women from ethnic minorities, women from lower castes, and younger women are also marginalised.

These SRHR issues occur in a region where women are lagging behind in terms of decision-making and political power; and female economic activity declined since 1990 in Bangladesh, China, Cambodia, India, Thailand, and Vietnam despite overall national economic growth. The evidence demonstrated what we have already heard from our partners working on the ground that, after all these years, governments' uptake of the ICPD agenda has been inconsistent.

The driving frameworks which would help our partners and our constituencies 'repoliticise' the SRHR agenda in Asia in the lead-up to 2015 are lacking. In 2011, in preparation for the regional meeting – 'Beyond ICPD and the MDGs: NGOs strategizing for SRHR in Asia-Pacific' - we embarked on a survey, which was initiated during the 6th Asia-Pacific Conference on Reproductive and Sexual Health and Rights in Yogyakarta, Indonesia to again ask NGOs in our region what the key issues of the region are, and from that, derive the thematic issues that were presented at the meeting and in this publication.

Five of those thematic issues are presented in this publication. These include the thematic issues of universal access to sexual and reproductive health; poverty; migration, climate change and religious extremisms and the impact of these issues on SRHR in the Asia-Pacific.

These papers look in-depth at how issues of poverty, migration, religious extremisms and climate change compromise the potential of attaining the highest standard of sexual and reproductive health. Using evidence and research the writers look at interactions between sexual and reproductive health and rights and that of poverty, migration and climate change and point out to the synergistic nature of SRHR with these larger, macro socio-economic and structural factors.

The integration of human rights, gender and equality concepts into the public health agenda is essential to create enabling environments for all including women and young girls in the society. The papers call for addressing the inequitable distribution of power, money, and resources that underlie health inequities.

The papers call for enabling policies, and its implementation through programmes and strategies at the national, regional and international level. Collaborations are required between countries, between regions, between movements to enable the optimal realisation of SRHR for all.

The paper on universal access examines the current scenario in terms of universal access to sexual and reproductive health services, and identifies major barriers to universal access for women in the reproductive age group in 21 Asia-Pacific countries.

It calls for addressing the fragmentation of ICPD's comprehensive sexual and reproductive health agenda, and at the same time notes that it is not only

important to revive the ICPD agenda, but to expand it to include the needs of population groups who have remained invisible within this agenda: e.g. people of diverse sexualities, persons with disabilities, older persons.

Overall the papers present some strategic way forwards and action agenda for the region that need to be strongly considered by all who work in the field of SRHR.

The primary reason of looking at SRHR through various linkages such as poverty, food security, migration, climate change, and universal access was to help craft SRHR, not as the small side-issue as it is often dismissed, but as that key development agenda that we know it to be. The overall values which guided the development of these thematic papers which led the discussions at the 'Beyond ICPD and the MDGs: NGOs strategizing for SRHR in Asia-Pacific' were feminist and women-centred; rights based; southern-centred; and focused on equality, equity, and social justice.

These papers and the regional meeting also enabled the SRHR community to place their agenda within a broader development framework. ARROW is committed to take forward the outcomes from this meeting to position the SRHR agenda in more concrete ways within national, regional, and global contexts.

We are living in a pivotal moment in time. There is a window of opportunity for us as NGOs working in SRHR in the next three years. The first is the ICPD review process, which is happening at the global,

regional, and national levels. One part of it, the "Operational Review" presents the opportunity to use a technical positioning of critical, and much contested issues such as access to safe abortion services, young people's access to comprehensive sexuality education, and sexual rights in a framework of technical UN document which cannot be ravaged by negotiation. The other opportunity is the proposed "World Conference on Women", which provides the impetus for women's equality and equity. These thematic papers presented at this meeting are one of ARROW's offerings to the movement to help position SRHR issues as strongly as possible.

Sivananthi Thanenthiran
Executive Director
Asian-Pacific Resource & Research Centre
for Women
(ARROW)

The 'Beyond ICPD and the MDGs: NGOs strategizing for SRHR in Asia-Pacific' was an incredible meeting, which brought together 127 participants from 30 countries in the Asia and Pacific regions, resulted in three key outcomes. First is a regional call to action on the critical issues that need to be fed into international review processes and considered by UN agencies, international donors, and the development industry.

The second is the formulation of a regional plan of action to operationalise our calls to governments, and regional and international bodies. The third is the formation of a group, to continue to mobilise in the region, and to work towards pushing forward on the women's SRHR agenda in the region.



Thematic paper 1:
**Universal Access To Sexual
And Reproductive Health In
The Asia-Pacific Region:**
How Far Are We From The Goal Post?

by TK Sundari Ravindran

1. Introduction

Background

In 1994, at the International Conference on Population and Development (ICPD) in Cairo, 179 countries pledged themselves to achieving the goal of universal access to reproductive health services, and it is stated as follows in the ICPD Programme of Action (PoA):

All countries should strive to make accessible, through the Primary Health Care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. (ICPD PoA paragraph 7.6)¹

Formidable barriers have been encountered in moving forward towards this goal, ranging from lack of political will to outright opposition, and inadequate commitment of financial resources. For example, only 46% of the ICPD financial goal of \$5.7 billion in international assistance by the year 2000 was met and this declined in subsequent years.² The omission of sexual and reproductive health in the Millennium Development Goals (MDGs) in 2000 was another major setback contributing to the neglect of sexual and reproductive health services.

The first five years into the new millennium saw a situation of having to run to stay in place. It took five years of intensive advocacy efforts to reinstate the ICPD goal of universal access to reproductive health. In 2006, the UN General Assembly adopted a new MDG target for universal access to reproductive health by 2015 (MDG 5b), as part of the MDG goal 5 of improved maternal health.

Gender power inequalities, which are a disadvantage to women in the Asia-Pacific Region, represents another major barrier to the achievement of universal access to reproductive health. Principle 4 of the ICPD Programme of Action identified gender equity and equality, the elimination of all forms of violence against women, and women's ability to control their fertility as the cornerstones of population and development related programmes. In the Asia-Pacific, while there has been progress in some areas in achieving gender equality, especially in relation to laws and policies, considerable challenges remain. These include women's predominance in insecure and underpaid employment; low level of representation in the political arena and in decision-making position; participation, the lack of social protection to older women; and violence against women.³

This paper aims to examine the progress towards universal access to reproductive health services in the Asia-Pacific Region, identify major barriers to universal access in the Region, and propose some ways of addressing these barriers. It is not meant to be a comprehensive review of evidence, and is more of an exercise in exploring the ways to move towards universal access in sexual and reproductive health.

The paper is structured as follows. Following this background, the introductory section outlines the concepts and definitions of universal access and of sexual and reproductive health services as used in this paper. Section two examines the progress towards universal access to

reproductive health services in the Region using data for selected indicators and countries. Sections three and four discuss the major barriers to achieving universal access. Section five provides a summary and outlines an advocacy agenda.

Concepts And Definitions

Universal Access And Universal Coverage

Universal Access

Despite its wide acceptance as an objective of health systems, the term *universal access* lacks a clear definition. A commonly used definition of universal access in relation to reproductive health is that information and services are "available, accessible and acceptable" to meet the different needs of all individuals.⁴

The limitation of this definition is the tautological inclusion of the word "access" in the definition of access, which renders it logically untenable. In its broadest sense, universal access implies the ability of those who need health care to obtain it.⁵ It has also been defined as "the absence of geographic, financial, organizational, socio-cultural and gender-based barriers to care"⁶

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

Access is thus a multi-dimensional concept. Each of these dimensions may be measured separately. In common practices, the 'use' of health services is measured to indicate 'access'. When this is the case, caution is needed in interpretation, in terms of examining whether supply or demand or both sets of factors are responsible for the level of observed utilisation.

Universal Coverage

Universal Coverage is another term often encountered in discussions on universal access. The concept of universal coverage, however, is more limited than universal access. It means that "financing and organisational arrangements are sufficient to cover the entire population, removing ability to pay as a barrier to accessing health services and protecting people from financial risks".⁷ In other words, universal coverage implies attempts to remove financial barriers to access through suitable health financing mechanisms adopted by the health system.

Universal coverage is a necessary but not sufficient condition for universal access. Despite universal coverage, universal access may not be achieved because of other 'supply-side' barriers such as availability of service delivery points and of specific services; and also because of 'demand-side' barriers including cultural factors, perceived quality and efficacy of services, and gender power relations which deter health-care seeking.

This paper is based on the premise that universal access to reproductive health can be realised as a part of universal

access to health care, overall. When the health system is not geared to provide universal access to essential preventive, promotive, curative and rehabilitative health care, it can hardly be competent to do so for one aspect of health alone.

This assumption is borne out by evidence from the assessment of the impact on health systems of Global Health Initiatives⁸ which are internationally funded single-issue-focused vertical health interventions. This evidence points out that while focused vertical interventions do bring about improvements in coverage and access for a specific health service, these gains are often made at the cost of corroding the already weak health systems in many low-income countries.

In an assessment conducted in 2009, World Health Organization (WHO) examined the implications for country health systems of four major GHIs, in which between them account for two-thirds of the global assistance for HIV/AIDS.⁹ The assessment lists a number of positive outcomes at the country level. In terms of service delivery, there has been an increase in access and utilisation of health services for 'targeted' health concerns; health equity effects have been noted because targeted services are free at the point of delivery; and the improvement in quality of treatment and services have been brought about by the promotion of standardised guidelines.

GHIs have also contributed to a phenomenal increase in the financial resources for the targeted services and contributed to improving the knowledge and skills of the health workforce.¹⁰

The negative implications, which make up an equally long list, appear to outweigh these positive contributions in terms of their effects on health systems of countries. GHIs have moved the clock back to vertical interventions, which pay scant attention to social determinants of health or seek to redress inequities in health.

New sources of inequity have emerged because access to and utilisation of targeted health services have developed far more rapidly than services not targeted by GHIs. For example, while access to HIV services increased from 5% to 31% over 4 years (2003-2007), the proportion of births attended by skilled birth attendants showed a very small increase – from 61% to 65% in the 16 years between 1990 and 2006.¹¹

Further, disease-specific funding, in many instances, is not aligned with national health priorities. The influx of money for such interventions into the national health system often distorts health service delivery away from other, equally if not more important, health concerns.¹² In addition, the health workforce has had to shoulder a vastly increased burden as a result of the rapid scale-up of disease-specific efforts, often at the cost of attention to other important health services. The presence of highly-paid positions in non-state sector projects funded by GHIs has contributed to an already high-level of attrition of the health workforce through international migration.¹³

For all these reasons, we believe that quick-fix vertical programmes to promote

universal access to SRH services are not the way forward, and that the solution lies in strengthening health systems and promoting universal access to health care overall.

Universal Access To Reproductive Health Or Sexual And Reproductive Health, Or Sexual And Reproductive Health Services?

The ICPD Programme of Action as well as MDG 5b state universal access to 'reproductive health' as the desired goal. However, this paper explores access to 'sexual and reproductive health'. The following definition of 'universal access to sexual and reproductive health' has been suggested by a WHO Consultation:

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

- *Decide freely how many and when to have children and to delay and prevent pregnancy*
- *Conceive, deliver safely, and raise healthy children and manage problems of infertility*
- *Prevent, treat and manage major reproductive tract infections and sexually transmitted infections including HIV/AIDS, and other reproductive tract morbidities such as cancer; and*
- *Enjoy a healthy, safe and satisfying sexual relationship which contributes*

*to the enhancement of life and personal relations.*¹⁴

How does one measure access to reproductive health? The list of indicators used for tracking MDG 5 and 5b includes only two health impact indicators (adolescent birth rates and maternal mortality ratio), while the remaining are indicators of health care (proportion of births attended by skilled birth attendants, contraceptive prevalence rate, antenatal coverage [at least one visit; four visits]). In other words, access to reproductive health services is used as a proxy for access to reproductive health. This is common practice because of the limited availability of health outcome information, Information about the level of satisfaction with existing services, and data on the impact of current arrangements on the quality of life and wellbeing of the populations they are designed to serve, are rarely collected, if at all.

In this paper, the access to sexual and reproductive health services using mostly health service-use or 'coverage' indicators is examined. Women are the main focus due to the non-availability of similar data for men or for sexual minorities. Even within this, only a small number of reproductive and sexual health needs of women have been examined. Many important issues such as reproductive cancers, reproductive health concerns of the disabled, and reproductive health concerns during humanitarian crises have not been included, due to limited data availability, and time and resource constraints. Standard internationally comparable data sets have been used.

The absence of data on several vital areas of sexual and reproductive health - including data disaggregated by age, sex and socio-economic position - is a commentary on the distance needed in achieving universal access to sexual and reproductive health.

2. Access To Reproductive And Sexual Health In The Asia-Pacific

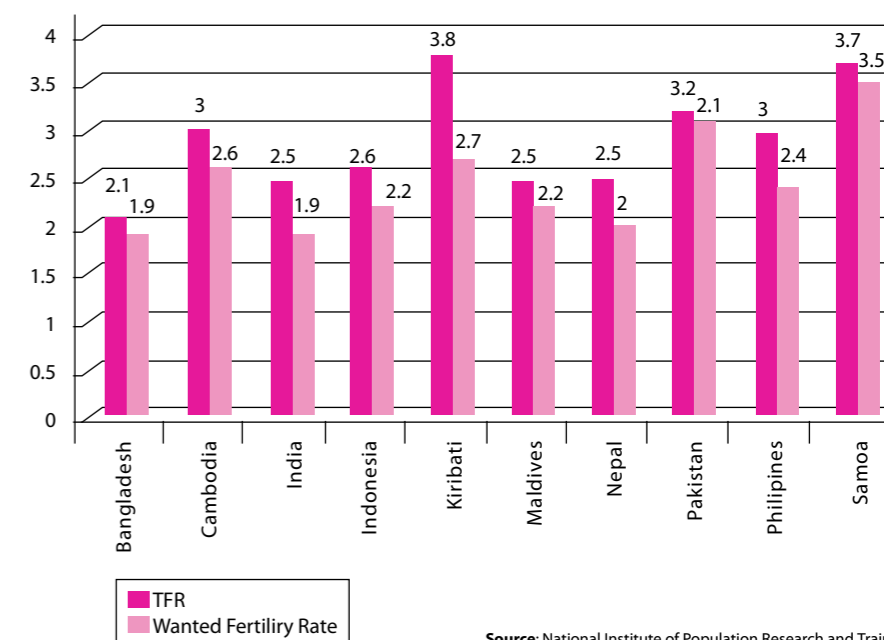
Data on access to the following five aspects of SRH are examined in this section: fertility and contraception, maternal health, abortion, and HIV as well as adolescent sexual and reproductive health. Data for 21 countries included in a regional review, currently being carried out by the Asian-Pacific Resource & Research Centre for Women (ARROW), have been examined. Internationally comparable data sets such as Demographic and Health Surveys (DHS), Millennium Development Goal (MDG) databases, UNAIDS sources, and the World Health Statistics Annual have been used.

2.1 Access To Fertility Control And Unmet Need For Contraception

Control over fertility, and access to means of fertility control are a few of the basic reproductive health needs with consequences for reproductive well-being. Data on total and wanted fertility rates available from 10 of the 21 countries,

considered in this paper, indicate that this basic need is not being met (Figure 1). In every 1 of the 10 countries, women's total fertility rate was higher than wanted fertility rate, with substantial differences between the two rates in India, Kiribati and Nepal.¹⁵

Figure 1: Total and wanted fertility rates in selected countries, Asia-Pacific, various years



Source: National Institute of Population Research and Training (NIPORT), Mitra and Associates, & Macro International (2009); National Institute of Statistics, Ministry of Planning, Directorate General for Health, Ministry of Health, MEASURE DHS, & ICF Macro (2011); International Institute for Population Sciences (IIPS), & Macro International Inc (2007); Statistics Indonesia, National Family Planning Coordinating Board, Ministry of Health, & Macro International (2008); Secretariat of the Pacific Community (2010); Ministry of Health and Family and Macro International (2010); Population Division, Ministry of Health and Population, NEW ERA, & Macro International (2007); National Institute of Population Studies & Macro International (2008); National Statistics Office (NSO) & ICF Macro (2009); Ministry of Health, Bureau of statistics, & ICF Macro (2010)¹⁶

In 12 of 18 countries for which comparable data are available, less than 50% of women in the reproductive age group used a modern method of contraception, between half and two-thirds of the women used a modern method in three countries, and more than two-thirds of women in the reproductive age group used modern methods of contraception in only two countries. At least one-fifth of the women in reproductive ages had an unmet need for contraception in 8 of 13 countries with data on this indicator, and only four countries had less than 10% of women aged 15-49 years with an unmet need for contraception (Table 1).¹⁷

Table 1: Contraceptive prevalence rates and unmet need for contraception

Country	% using any method	% using any modern method	% with unmet need for for contraception	Year
Afghanistan	18.6	15.5	n.a	2006
Bangladesh	55.8	47.5	16.8	2007
Bhutan	65.6	65.4	n.a	2000
Burma	41	38.4	19.1	2007
Cambodia	50.5	34.9	25.1	2005
China	84.6	84.0	2.3	2006
India	54.0	47.1	12.8	2005/06
Indonesia	60.3	56.7	9.1	2007
Kiribati	22.3	18.0	n.a	2000
Lao PDR	38.4	35.0	27.0	2000
Maldives	34.7	27.0	28.1*	2009
Nepal	49.7	43.2	24.6	2006
Pakistan	29.6	21.7	24.9	2007/08
Philippines	50.7	33.6	22.3	2008
PNG	35.7	-	n.a	2006
Samoa	28.7	26.7	45.6	2009
Sri Lanka	68.0	52.8	7.3	2006/07
Thailand	81.1	79.8	3.1	2006
Vietnam	78.5	56.7	4.8	2007

2.2 Access To Maternal Health Services

Three indicators have been considered under access to maternal health services: maternal mortality ratios, proportion of women who had skilled birth attendance at delivery, and proportion of pregnant women who had at least one antenatal care visit. Data is from the MDG database and findings show that utilisation of maternal health services is far from universal.

Of 20 countries with recent (2008) estimates of maternal mortality ratio (MMR), only 7, or just about a third have

met the ICPD target of achieving an MMR of less than 60/100,000 in intermediate mortality countries and of 75/100,000 in countries with the highest levels of mortality. Coverage by skilled birth attendance is 80% and above in only 8 of 21 countries. Less than a quarter of the women have skilled birth attendance at delivery in four countries; about half or less have used skilled birth attendance in another four countries (Table 2).¹⁸

When compared to skilled birth attendance, coverage by antenatal care fares better. Ten countries have more than 90% of women with at least one antenatal visit. It would be more important to have data on four antenatal visits because a pregnant woman needs 3-4 antenatal visits in which the appropriate check-ups and procedures are carried out (Table 2). The MDG database does not have these data. One also needs to probe the poor correlation between maternal mortality ratios and proportion of women with at least one antenatal visit.

Source: United Nations Populations Division. (2011). *World Contraceptive Use survey 2011*. New York: Department of Economic and Social Affairs; Ministry of Health (Maldives), & ICF Macro. (2010). *Maldives Demographic and Health Survey 2009*. Calverton, USA: ICF Macro.

Table 2: Maternal mortality ratios and utilisation of maternal health care

Country	Maternal mortality Ratio (per 100,000 live births) 2008	Whether ICPD target for 2015 met ^a	% of deliveries attended by skilled birth attendants	Whether ICPD/ICPD+5 Target for 2005 met ^b	% covered by at least 1 antenatal visit
Afghanistan	460	No	24.0 (2008)	No	36.0 (2008)
Bangladesh	240	No	24.4 (2009)	No	51.2 (2007)
Bhutan	180	No	71.4 (2007)	No	88.0 (2007)
Burma	200	No	63.9 (2007)	No	79.8 (2007)
Cambodia	250	No	43.8 (2005)	No	69.3 (2005)
China	37	Yes	99.1 (2008)	Yes	91.0 (2008)
Fiji	26	Yes	99.0 (2008)	Yes	100.0 (2008)
India	200	No	52.7 (2008)	No	75.2 (2008)
Indonesia	2200	No	74.9 (2008)	No	93.3 (2007)
Kiribati	n.a.	--	65.0 (2008)	No	100.0 (2008)
Lao PDR	470	No	20.3 (2006)	No	35.1 (2006)
Malaysia	29	Yes	98.6 (2007)	Yes	78.8 (2005)
Maldives	60	Yes	94.8 (2009)	Yes	99.1 (2009)
Nepal	170	No	18.7 (2006)	No	43.7 (2006)
Pakistan	260	No	38.8 (2007)	No	60.9 (2007)
Philippines	99	No	62.2 (2008)	No	91.1 (2008)
PNG	230	No	53.0 (2006)	No	78.8 (2006)
Samoa	n.a	No	80.8 (2009)	Yes	93.0 (2009)
Sri Lanka	35	Yes	98.6 (2007)	Yes	99.4 (2007)
Thailand	48	Yes	99.4 (2009)	Yes	99.1 (2009)
Vietnam	59	Yes	87.7 (2006)	Yes	90.8 (2006)

^a: 60 per 100,000 live births for countries with intermediate levels of mortality and 75 for countries with the highest levels of mortality ^b: By 2005, 80% of deliveries to be attended by skilled birth attendance

Source: Column 2: World Health Organization. (2012). *World trends in maternal mortality: 1990 to 2010* WHO, UNICEF, UNFPA and The World Bank estimates. Geneva: WHO;¹⁹

Columns 4 and 6: United Nations Statistics Division. (n.d.). Millennium Development Goal Indicators. Retrieved 5 April 2012 from <http://mdgs.un.org/unsd/mdg/Data.aspx>;²⁰ Columns 3 and 5: computed

2.3 Access To Safe Abortion Services

There is no comparable data across countries that would help understand women's access to safe abortion services even within the framework of restricted abortion legislations in different countries. The regional estimates of WHO are available on the incidence of unsafe abortions and extent of mortality from

unsafe abortions for 2003.²¹ Despite being somewhat dated, these provide some insights into access to safe abortion services in the Region and the fatal health consequences of not having such access. Unsafe abortion rates are considered to be negligible in East Asia because of the wide availability of safe abortion services. South-Central Asia (or South Asia) with a very large overall population size is estimated to have 6.3 million unsafe

abortions a year, followed by South-East Asia with 3.1 million. Both the incidence rates and ratios are high. Unsafe abortions are a heavy toll on women's lives, contributing between 10% and 16% of maternal deaths in the Region.²²

Table 3: Estimates of annual incidence of unsafe abortion and associated mortality in 2003. Rates and ratios calculated for all countries and, in parenthesis, only for countries with evidence of unsafe abortion

	Unsafe abortion			Mortality due to unsafe abortion		
	Number (rounded)	Incidence rate (per 1000 women aged 15-44 years)	Incidence ratio (per 100 live births)	Number of deaths (rounded)	% of all maternal deaths	Mortality ratio (per 100,000 live births)#
East Asia	negligible	negligible	negligible	negligible	negligible	negligible
South-central Asia	6,300,000	18	16	24,300	13	60
South-eastern Asia	3,100,000	23(27)	27(31)	3,200	14 (16)	30
Oceania*	20,000	11	8	<100	10	20

*Does not include Australia and New Zealand

#Figures may not add up to total because of rounding

Source: World Health Organization. (2007). *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003*. Geneva: WHO²³

2.4 Access To Services For Sexually Transmitted Infections And Hiv

There is limited comparable information on access to education on sexuality and services for the prevention and treatment of sexually transmitted infection. In Table 4, the following data available are examined: coverage by antiretroviral treatment of persons living with HIV; coverage of pregnant women with HIV testing; and coverage with antiretroviral treatment to prevent mother-to-child transmission of HIV. All figures are estimates with a wide range, and these figures are at best indicative.

Of 19 countries (out of 21) with data, Cambodia stands out as the only country with more than 90% coverage with ART of people living with HIV. Five other countries have achieved coverage of more

than 50%. The remaining 13 countries cover less than 50%, with two countries covering less than 5%.²⁴

Coverage rates for HIV testing of pregnant women vary widely, from < 1% in Bangladesh to >95% in Maldives. Coverage is less than 25% in seven countries, of which it is less than 5% in five. In terms of PMTCT coverage, only Burma, Fiji and Thailand seem to have achieved reasonable coverage of roughly 50% or above.²⁵

Table 4: Antiretroviral treatment and testing and treatment for prevention of Mother-to-Child Transmission

Country	Estimated ART coverage based on 2010 WHO guidelines, 2010 [range]	Pregnant Women Tested for HIV (estimated coverage %)	Estimated % of pregnant women living with HIV who received ARV recommended by WHO to prevent mother-to-child transmission
Afghanistan	3% [1-6%]	n.a	..[0%]
Bangladesh	33% [26-46%]	<1%	..[8-20%]
Bhutan	27% [20-45%]	40%	..[17-42%]
Burma	24% [21-27%]	35%	..[49-95%]
Cambodia	92% [68-95%]	74%	..[17-40%]
China	32% [26-37%]	64%	..[21-48%]
Fiji	33% [24-43%]	83%	..[78-95%]
India	...[30-38%]	23%	...
Indonesia	24%[17-35%]	<1%	..[5-15%]
Kiribati	n.a	84%	..
Lao PDR	51%[33-73%]	2%	..[7-15%]
Malaysia	36%[27-44%]	77%	..[29-53%]
Maldives	14%[11-17%]	>95%	..[0%]
Nepal	18% [11-26%]	13%	..[4-14%]
Pakistan	9% [4-13%]	<1%	..[1-2%]
Philippines	51%[38-83%][3-8%]
PNG	54%[43-65%]	24%	16%[13-22%]
Samoa	n.a	n.a.	n.a
Sri Lanka	25%[19-34%]	4%	..[3-6%]
Thailand	67%[55-85%]	94%	..[59-95%]
Vietnam	52%[43-61%]	52%	..[26-46%]

Source: Joint United Nations Programme on HIV/AIDS (UNAIDS). (2011). *Global HIV/AIDS Response. Epidemic update and health sector progress towards universal access. Progress report 2011*. Geneva: UNAIDS

2.5 Adolescent Reproductive And Sexual Health

Four indicators of adolescent sexual and reproductive health have been analysed, namely access to sexuality education, adolescent birth rate, contraceptive knowledge and use rates among adolescents, and knowledge related to HIV/AIDS and its transmission.

Evidence demonstrates that well-planned and executed sexuality education

programmes implemented in schools and communities result in increased knowledge of human sexuality. They can help delay the onset of sexual activity among adolescents and young people, reduce the frequency of unprotected sex and the number of sexual partners, and increase condom use and contraceptive use.²⁶

Status of sexuality education curricula in the countries examined is taken as a proxy for access to sexuality education.

According to a 2012 review of sexuality education policies in the Asia-Pacific Region, in 19 of 20 countries considered in this report, with the exception of Pakistan, sexuality education is part of the national secondary school curriculum. No information was available on Kiribati. There was limited information on the coverage of sexuality education for out-of-school populations. However, both coverage and content varied widely across countries, and across levels of education. In some instances, selected

areas of knowledge were covered through extra-curricular or non-compulsory subjects, and overall, the emphasis was on knowledge and less on imparting life skills.²⁷

Adolescent birth rates range from very high to high (above 100) in four countries: Afghanistan, Bangladesh, Lao PDR and Nepal, while it is very low (10 or less) in two countries: China and Maldives. In other words, there are some countries in the Region where adolescent birth rates are ten times higher than other countries of the Region. In addition to the health risks that adolescent births represent, they are also indicators of the lack of access to information and methods of fertility control.²⁸

Table 5: Adolescent birth rates

Name of the country	Adolescent birth rates (per 1000 girls aged 15-19 years)
Afghanistan	151
Bangladesh	133
Bhutan	46
Burma	-n.a
Cambodia	52
China	5
Fiji	30
India	45
Indonesia	52
Kiribati	39
Lao PDR	110
Malaysia	12
Maldives	14
Nepal	106
Pakistan	20
Papua New Guinea	70
Philippines	53
Samoa	29
Sri Lanka	28
Thailand	43
Vietnam	35

Source: World Health Organization. (2012). *World Health Statistics Annual 2011*. Geneva: WHO

Time trend data show that between 1990 and 2008 adolescent birth rates have decreased in the Region, with South Asia (89 to 54 per 1000) and the Pacific (83 to 62 per 1000) experiencing the highest decreases.²⁹

Many adolescent pregnancies may happen without intention, whether within marriage (as in many South Asian countries) or outside marriage. This is suggested by information available on contraceptive prevalence rates in selected countries.

Table 6: Current use of contraception among adolescent girls (15-19 years), selected Asia-Pacific countries, various years

Country	Percentage of all women aged 15-19 who use a modern method of contraception	Percentage of currently married women aged 15-19 who use a modern method of contraception	Year
Cambodia	1.4	13.7	2005
Philippines	1.6	14.3	2008
Samoa	0.8	8.1	2009
Vietnam	n.a.	19.2	2002

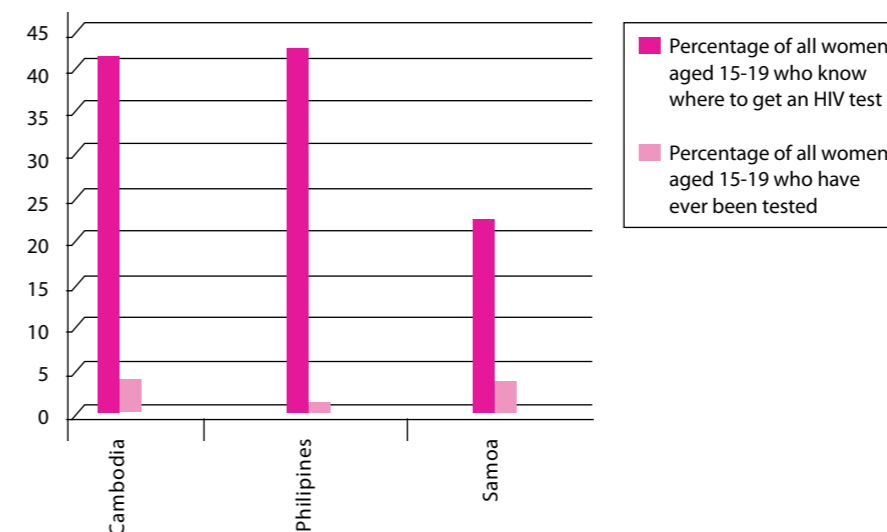
Source: National Institute of Statistics, Ministry of Planning, Directorate General for Health, Ministry of Health, MEASURE DHS, & ICF Macro (2011); National Statistics Office (NSO) & ICF Macro (2009); Ministry of Health, Bureau of

In terms of knowledge about where to get HIV testing, DHS data for Cambodia, the Philippines and Samoa show that while between 25-40% knew where they could obtain the tests, less than 5% had ever been tested (Figure 2).

The next two sections examine some of the major barriers to universal access to sexual and reproductive health services. Three main categories of barriers have been considered:

- Financial barriers, discussed in section three;
- Supply-side barriers influencing availability of services;
- Demand-side barriers, both of which are discussed in section four.

Figure 2: Knowledge of HIV/AIDS testing and coverage by testing services among adolescent girls (15-19 years)



Source: National Institute of Statistics, Ministry of Planning, Directorate General for Health, Ministry of Health, MEASURE DHS, & ICF Macro (2011); National Statistics Office (NSO) & ICF Macro (2009); Ministry of Health, Bureau of statistics, & ICF Macro (2010)³¹

3. Removing Financial Barriers To Universal Access

3.1 Share And Magnitude Of Out-Of-Pocket Expenditure

In many countries of Asia-Pacific, a combined variety of financing mechanisms are funding health care services. In all countries, there are both public and private health service provisions.

The government provides a basic package of services financed usually by tax revenue through its own service delivery points. For services and supplies that are not part of this package (e.g. diagnostic tests, supplies and drugs not available through the system), people seeking health care in these facilities have to pay 'out-of-pocket'. The smaller and more basic package, the higher one has to pay 'out-of-pocket'.

'Out-of-pocket' health expenditure may also be incurred when a person seeks services from the private health sector because there is no government service delivery point in the vicinity – as is usually the case in rural and remote areas; or when the perceived quality of services in government facilities are not satisfactory. When 'out-of-pocket' expenditure is the main source of paying for health care, ability to pay becomes the major determinant of whether or not a person is able to access health care when s/he needs it most.

One of the first steps towards achieving universal access is to remove financial

barriers to access. In practical terms, this means moving gradually away from 'out-of-pocket' (OOP) expenditure towards a greater share of government expenditure on health through tax revenue and through social insurance paid for jointly by users, employers and/or government reduce, for example.

In nine of the 21 countries examined, the share of out-of-pocket expenditure on health is high (51-65%) or very high (66% and above): Afghanistan, Bangladesh, Burma, Cambodia, India, Lao PDR, Pakistan and Vietnam, with Burma registering the highest share of OOP.

Seven countries are largely financed by the government and have very low (< 10%) to low (11-25%) share of 'out-of-pocket' expenditure: Kiribati, Papua New Guinea, Samoa, Fiji, Thailand and Bhutan, with Kiribati having almost no 'out-of-pocket' expenditure (Table 7). Five countries may be classified as having 'medium' OOP share (26-50%): China, Indonesia, Malaysia, Nepal, Sri Lanka and the Maldives.³²

On comparing countries' share of OOP with their achievements in access to sexual and reproductive health (health care), it is observed that while a low OOP does not guarantee better access to services, a high OOP is definitely a deterrent.

Few countries with high or very high OOP have low unmet need and high contraceptive prevalence rate or have achieved the ICPD targets for maternal mortality ratio and skilled birth attendance.

Small-scale studies from the Region indicate that high levels of 'out-of-pocket' expenditure are an important deterrent to access to reproductive health care. In Cambodia, "getting money needed for treatment" was mentioned by 75% of the women of childbearing age as the most important reason why women were unable to access pregnancy and delivery care services. The poorest women were most affected: 86% of women from the lowest wealth quintile stated this as the main reason, as compared to 54% in the highest wealth quintile.³³

In urban Nepal, a 2006 study reported the cost of delivery care in public sector facilities to be between Nepali Rupees 2826 and 3018, or US\$39-42 (according to the exchange rates in 2006). The cost of receiving an abortion was around US\$34.4, and the cost of treating an episode of reproductive tract infection could be as high as US\$52.

The average per capita monthly expenditure of households surveyed was US\$40. In other words, paying for delivery care or abortion was equivalent to or a little more than the average per capita monthly expenditure for this population while RTIs cost much more. For the nearly 25% of Nepal's population, in 2008, who lived below the poverty line of US\$12 around the time of this study, paying for reproductive health care would be unthinkable.³⁴ The low level of utilisation of maternal health care in Nepal (Table 2) is not surprising.

The existence of financial barriers to health care is also indicated by the presence of inequalities in access to care

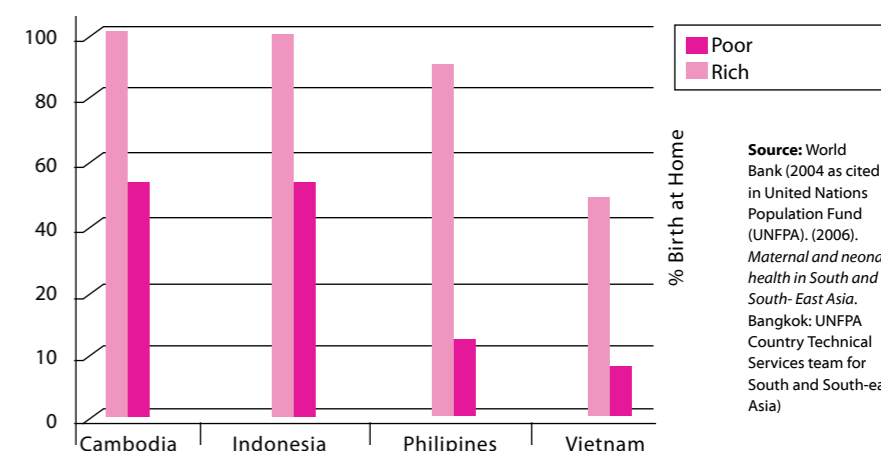
Table 7: Pattern of health financing in selected countries of Asia-Pacific, 2008 estimates

Country	Total expenditure On health as % of GDP	General govt. expenditure on Health as % as % of Total Health expenditure	Out-of-pocket (OOP) expenditure On health as % of Total Health expenditure
Afghanistan	7.4	21.5	77.6
Bangladesh	3.3	31.4	65.7
Bhutan	5.5	82.5	17.5
Burma	2.3	7.5	88.6
Cambodia	5.7	23.8	64.5
China	4.3	47.3	43.5
Fiji	3.5	75.3	15.5
India	4.2	32.4	61.4
Indonesia	2.3	54.4	32.0
Kiribati	12.5	84.3	0.1
Lao PDR	4.0	17.6	62.5
Malaysia	4.3	44.1	40.9
Maldives	13.7	61.2	27.9
Nepal	6.0	37.7	45.2
Pakistan	2.6	32.3	53.7
Philippines	3.7	34.7	53.8
PNG	3.2	80.1	8.1
Samoa	5.9	84.7	9.6
Sri Lanka	4.1	43.7	48.8
Thailand	4.1	74.3	17.6
Vietnam	7.2	38.5	55.5

Source: World Health Organization. (2012). *World Health Statistics Annual 2011*. Geneva: WHO.

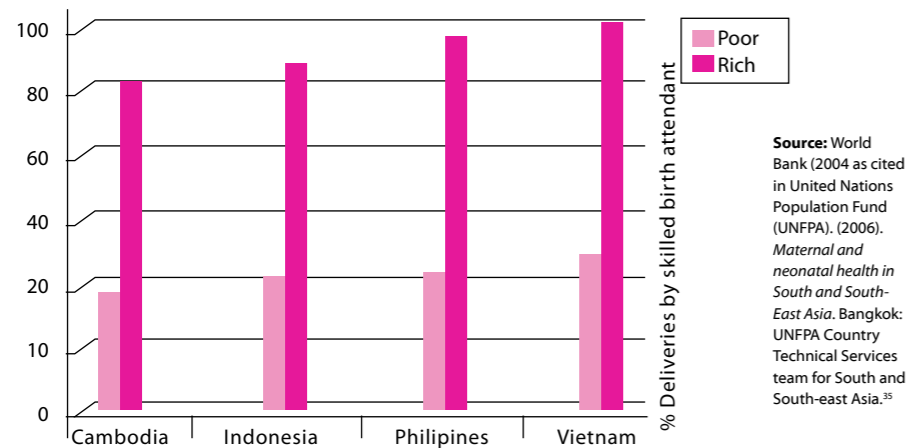
based on income group. A much higher proportion of women from the lowest income quintile households have home deliveries compared to women from the highest wealth quintiles in Cambodia, Indonesia, Philippines and Vietnam. The proportion of women receiving skilled birth attendance in delivery also varies, substantially, between women from the lowest and highest income quintiles in these same countries (Figures 3&4).

Figure 3: Percentage of deliveries at home for poorest and richest quintiles



Source: World Bank (2004 as cited in United Nations Population Fund (UNFPA). (2006). *Maternal and neonatal health in South and South-East Asia*. Bangkok: UNFPA Country Technical Services team for South and South-east Asia)

Figure 4: Percentage of births with skilled attendance for poorest and richest quintiles



Moving towards universal coverage means reducing the 'out-of-pocket' expenditure through pre-payment schemes, such as social health insurance that is compulsory, financed by a combination of payroll deductions, employer contributions, and government contribution and 'covers', or insurance that provides financial protection to the entire population. In such social insurance schemes, the government pays for or subsidises vulnerable and low-income groups.

It is not only the proportion of the population covered that matters for reduction of 'out-of-pocket' expenditure, but also the range of health services included in the 'benefits' package (often also called Essential Services Package) and the financial ceiling of coverage. For services that are not part of the benefits package or which exceed the financial ceiling, people still have to pay 'out-of-pocket'. It is, therefore, important to ensure that a reasonably wide range of sexual and reproductive health services

are included in the Essential Services Package.

Commonly used indicators to signify progress towards financial protection are reduction in inequalities in utilisation of health care services across income quintiles; reduction in the proportion of population that is 'impoverished' (moves from above poverty line to below poverty line) as a consequence of spending on health; and reduction in the proportion of households who experience 'catastrophic' health expenditure. Catastrophic health expenditure is usually defined as annual expenditure on health care in excess of 10% of average annual household expenditure, although this threshold is sometimes increased to 25% -40%.

Targeted Interventions To Protect Low-Income Groups

In a number of countries in the Asia-Pacific Region, governments have resorted to schemes to protect the poor and vulnerable groups from catastrophic

health expenditure as an interim measure in the pursuit of universal coverage. Some examples of such schemes are the New Co-operative Medical Scheme (NCMS) in China and the Health Equity Fund in Cambodia. Conditional Cash Transfer schemes for maternal health in India and Nepal are also targeted interventions albeit with conditions. As shown below, these have remained partial solutions, which bring some relief but may not be sufficient to remove financial barriers, or reach out to the most vulnerable groups.

The NCMS in China was an attempt to protect the population from catastrophic health expenditure. The Scheme, which began in 2003, has voluntary membership and is financed by funding from the Central and local governments, and individual contributions. In 2008, 92% of the rural population were enrolled in this scheme. The scheme is administered by the country government which can decide the content, coverage and reimbursement model. The benefit package includes maternal health care. The package reimburses a fixed proportion of cost of delivery or a fixed flat rate.³⁶

A study on utilisation of maternal health care before and after the introduction of NCMS (2002 and 2007) in western rural China found that facility-based deliveries increased dramatically from 45% to 80%, and the differences across income groups narrowed. The 'out-of-pocket' expenditure for delivery as a proportion of mean annual household income decreased for all income groups, but the lowest income group still bore a substantial financial burden.³⁷ Another study examining national data for the same research

period, confirmed these findings. 'Out-of-pocket' expenditure on facility-based deliveries as a proportion of the mean annual household income for low-income groups reduced from 18% in 2002 to 13% in 2007, which was above the threshold of 10% of mean household income for catastrophic health expenditure.³⁸

The Health Equity Fund (HEF) in Cambodia reimburses health facilities the fees they forego by not charging the poor. The poor get free services and the health facilities do not lose any revenue. Health staff gets a share of total user fees earned – those from paying patients and from the HEF – as supplemental salary. Several studies on how HEP functions have established that almost all who have received HEF support are poor, who have been able to access inpatient services that were unaffordable in the past.

While there were no leakages, one study found that more than half (51.6%) of the poorest 40%, according to the asset index, were not supported by HEF. Reasons included lack of awareness about the Scheme and of eligibility criteria.³⁹

In another study, HEF support covered only 40% and 56% of the total average that the poor and poorest groups are spending, respectively.⁴⁰ A WHO study in 2009 found that up to 36% of HEF patients from rural areas still borrowed money for the current episode of care, in addition to older debt.

In the urban area, borrowing for the current episode was much less among HEF patients (4%) against those who were not supported by HEF (17%).⁴¹

Conditional Cash-Transfers typically consist of making cash payment to households or individuals from groups identified as under-served and it is conditional based on the desirable health behaviours that they have adopted, such as attendance for preventive health services by children and pregnant women. Conditional Cash-Transfers are a category apart from other measures to improve access and offer financial protection for the poor. The imposition of conditionality for receiving services represents a violation of women's right to health care.

Ideological reservations apart, what is the track record of Conditional Cash-Transfers in improving access to reproductive health care? In the *Muthulakshmi Reddy Maternity Benefit Scheme* in Tamil Nadu, India, a substantial cash incentive is provided to low-income women, conditional on institutional delivery, in which it is only applicable for the first two deliveries. The Scheme has contributed to increased rates of institutional delivery especially among the poorest women.⁴²

At the same time, women from the poorest and most socially marginalised households were disproportionately represented among those excluded from the Scheme. Reasons included -pregnancy of higher than second order – thus not fulfilling the eligibility criterion, but more importantly, of not being able to produce documentary proof of poverty status and residence due to the lack of information, time and resources.⁴³

The *Safe Delivery Incentive Programme (SDIP)* in Nepal doubled the rate of institutional deliveries and substantially

increased the use of skilled birth attendants. However, those who were better-off benefitted more than the poor. Because there was no set target, the wealthiest 20% of the women received 60% of the conditional cash-transfer. Also, the SDIP offered little protection against catastrophic payments because the cash incentive amount of Nepal Rupees 1000 given covered no more than 25% of the cost of a normal delivery and 5% of the cost of a caesarean section.⁴⁴

Universal Health Care Coverage in Thailand

Thailand adopted the Universal Health Care Coverage in 2001 to expand coverage to those who were not covered by existing social insurance schemes. Financing is provided from tax revenue. Entire households are covered. The Benefits package is comprehensive and includes preventive, promotive, curative, and rehabilitative services with a small number of exceptions. In 2006, ARV for HIV was included in the Benefits package and in 2008, renal replacement therapy was added on.⁴⁵ Moreover, a wide range of sexual and reproductive health services is covered. The safe abortion service, however, is covered only for rape victims and for those whose health is at risk. Essential obstetric care is covered only for the first two deliveries.

Universal coverage successfully reduced the incidence of catastrophic health expenditure from 5.4% in 2000 to 2% in 2006. Not a single household had experienced impoverishment due to health expenditure in 21 of 76 provinces in 2008.⁴⁶ A study covering 40,000 women

in 2005-06 found that there were almost no rich-poor gaps in access to maternal health care and contraceptive services.⁴⁷ Thailand has made major strides towards removing financial barriers to accessing sexual and reproductive health care. However, universal access is still some way off. This is not only because of restrictions on some essential reproductive health services such as safe abortion care and essential obstetric care for women of parity three or higher. Other supply-side limitations such as unequal distribution of service delivery points across different regions and rural-urban locations, availability of drugs and equipment, and gender and other social barriers limiting demand to care needed to be overcome as well.

4. Supply And Demand Side Barriers

4.1 Availability Of Personnel, Facilities And Supplies

Table 8 provides information on the availability of professional care providers and hospital beds in the 21 countries considered. According to the World Health Report 2006, to achieve skilled birth attendance coverage of 80%, it would require the availability of at least 23 professional care providers per 10,000 people.⁴⁸ Seven of 21 countries met this requirement: China, Fiji, Indonesia, Kiribati, Malaysia, Maldives, Philippines and Sri Lanka, with Vietnam close to this number. It is interesting to observe that

there is a significant overlap between these countries and countries with a high public expenditure on health. Fourteen countries did not meet this requirement, and some countries had less than half the number of professional care providers required even to reach this single target of skilled birth attendance.⁴⁹ The magnitude of the human resources gap would be much larger when other reproductive and sexual health needs are included.

WHO mentioned a benchmark for availability of maternity beds which is 10 beds per 1000 pregnant women.⁵⁰ Since data on this indicator could not be located, the availability of hospital beds per 100,000 population was used as a proxy. Only 5 of 19 countries with data for this indicator met the WHO benchmark of 25 beds per 10,000.⁵¹

Not only are far fewer personnel and facilities available than required in most of the countries examined, their distribution is skewed heavily towards urban areas. There are also wide within-country disparities in distribution of facilities and personnel.⁵²

Another supply-side bottleneck is the availability of reproductive health commodities. Reproductive health commodities include a wide range of contraceptives to suit the specific needs of different individuals, other essential drugs, equipments, reagents and supplies. The bare minimum list of essential life-saving drugs whose availability is vital includes oxytocin/ergometrine/misoprostol to prevent and manage postpartum haemorrhage; magnesium sulphate for the management of pre-

eclampsia and eclampsia; and antibiotics for the management of infections. In many countries, these are not always available when needed. While absolute short supply may be one reason, lapses in procurement and supply-chain management, poor storage of drugs leading to or damage or loss of efficacy are also common reasons.⁵³

Many low-income countries are dependent on donors for supplies of contraceptives, and interruptions in donor funding is another important contributor to lack of supplies.

4.2 Social Franchises As A Means Of Increasing Availability Of Reproductive Health Services

One approach to tackling the 'availability' bottleneck in access to sexual and reproductive health services has been the setting up of social franchises in health. A social franchise in health is a network of for-profit private health practitioners linked through contracts to provide a specific package of health services, usually contraceptive and a few other reproductive/sexual health services.

There has been considerable donor enthusiasm over the past decade in investing in social franchises because they are deemed to "offer the possibility of sustainable provision of priority reproductive health services"; and as an effective model of harnessing resources from the private sector towards achieving universal access to reproductive health services by 2015.⁵⁴

Table 8: Health personnel population ratio, selected Asia-Pacific countries 2000-2010

Country	Physicians/ 10,000 Population	Nursing & midwifery Personnel / 10,000 population	Total	Whether Meets the Requirement for achieving 80% skilled birth attendance	Hospital beds/ 10,000 Population	Whether meets The benchmark Of 25/100,000
Afghanistan	2.1	5.0	7.1	No	4	No
Bangladesh	3.0	2.7	5.7	No	4	No
Bhutan	0.2	3.2	3.4	No	17	No
Burma	4.6	8.0	12.6	No	6	No
Cambodia	2.3	7.9	10.2	No	n.a	--
China	14.2	13.8	28.0	Yes	41	Yes
Fiji	4.5	19.8	24.3	Yes	21	No
India	6.0	13.0	19.0	No	9	No
Indonesia	2.9	20.4	23.3	Yes	6	No
Kiribati	3.0	30.2	33.2	Yes	15	No
Lao PDR	2.7	9.7	12.4	No	12	No
Malaysia	9.4	27.3	36.7	Yes	18	No
Maldives	16.0	44.5	60.5	Yes	26	Yes
Nepal	2.1	4.6	6.7	No	50	Yes
Pakistan	8.1	5.6	13.7	No	6	No
PNG	0.5	5.1	5.6	No	n.a	--
Philippines	11.5	60.0	71.5	Yes	5	No
Samoa	2.7	9.4	12.1	No	10	No
Sri Lanka	4.9	19.3	24.2	Yes	31	Yes
Thailand	3.0	15.2	18.2	No	22	No
Vietnam	12.2	10.1	22.3	Borderline	29	Yes

Source: World Health Statistics Annual. (2012). *World Health Statistics Annual 2011*. Geneva: WHO.

Evidence to date does not bear out the high hopes pinned on social franchises as a potentially major contributor to universal access. An assessment based on descriptive data of 45 social franchises from 27 countries of Asia, Africa and Latin America offering contraceptive and other reproductive health services, was recently carried out.⁵⁵

This assessment found that social franchises in general have not added much to the range of reproductive health services offered; rather, they have focused

on making existing services – mainly contraceptive services – more widely available. Social franchises were found to address non-availability of services in rural and remote areas. Because social franchises are entered into with already existing clinics, no additional service delivery points have been added in places where none exists.⁵⁶

Social franchises do not remove financial barriers to access. Out-of-pocket payment is the dominant mode of payment in most of the franchises and although waivers

for low-income groups are mentioned, the proportion receiving waivers and subsidies was insignificant.⁵⁷

Based on what we know thus far, it does not seem like social franchises would help to remove the significant supply barrier to accessing sexual and reproductive health services.

4.3 Legal And Other Restrictions

Resource constraints are not the only factor limiting availability of sexual and reproductive health services. Ideological and religious opposition to safe abortion services and the resulting legislations restricting access to safe abortion services are other barriers to access. Table 9 provides information on the legal status of abortion in the 21 countries examined. In 6 of 21 countries, abortion services may only be provided to save the life of

a woman; in five others, these services can also be provided to preserve the physical and mental health of the women. Abortion on request is available only in four countries: Cambodia, China, Nepal and Vietnam.⁵⁸

Denial of sexual and reproductive health services happens with or without legal sanction on the case of adolescents and young people. Of the 21 countries, in four countries - Vietnam, Cambodia, China and Lao PDR – adolescent sexual and reproductive health services have been

recognised in policy. These may, however, not be available in practice with providers acting as gatekeepers to determine who may or may not receive a specific service.⁵⁹ In India, the Adolescent Reproductive and Sexual Health (ARSH) Programme is supposed to operate through the regular government health facilities. While both married and unmarried adolescents are mentioned in the target group, counselling and information/education seem to be targeted at unmarried adolescents. Almost all services are oriented towards maternal health care

Table 9: Legal status of abortion in selected Asia-Pacific countries, 2011

Country	Abortion services are available to						
	Save a woman's life	Preserve a woman's physical health	Preserve a woman's mental health	Rape/incest	Because of Foetal impairment	For Economic Or social reasons	On request
Afghanistan	x						
Bangladesh	x						
Bhutan	x		X	x			
Burma	x						
Cambodia	x	x	X	x	x	x	x
China	x	x	X	x	x	x	x
Fiji	x	x	X	x	x		
India	x	x	X	x	x	x	
Indonesia	x						
Kiribati	x						
Lao PDR	x	x					
Malaysia	x	x	X				
Maldives	x	x					
Nepal	x	x	X	x	x	x	x
Pakistan	x	x	X				
PNG	x	x	X				
Philippines	x						
Samoa	x	x	X				
Sri Lanka	x						
Thailand	x	x	x	x	x		
Vietnam	x	x	x	x	x	x	x

Source: United Nations Population Division (2011). *World abortion policies 2011*. New York: United Nations. Retrieved 2 April 2012 from www.un.org/esa/population/publications/2011abortion/2011wallchart.pdf

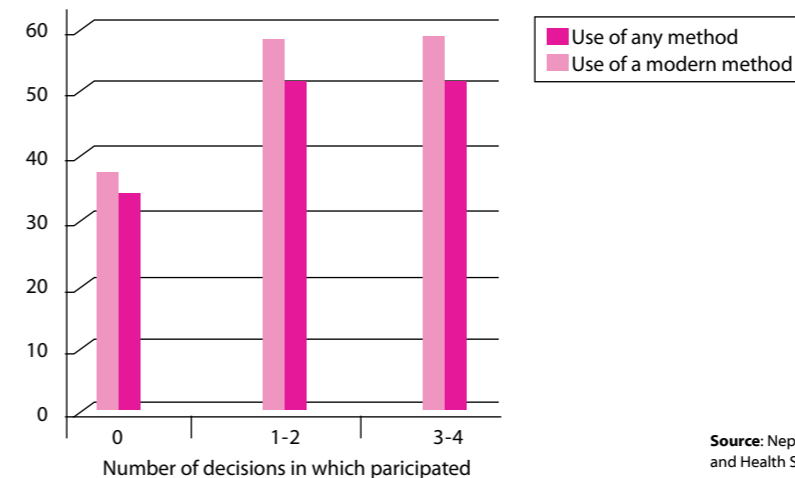
and family planning, which are, in practice, offered only to married women.⁶⁰

4.4 Gender-Power Inequalities Limiting Ability To Seek Care

Gender power inequalities within the household have also been found to limit women's ability to make decisions related to their own health care, and represent a demand-side barrier. For example, decisions of women's health care were made without their participation in the majority of Nepal households (72.7%), and approximately half of Bangladesh (54.3%) and Indian (48.5%) households. In Sri Lanka, decision making for contraceptive use was a collective responsibility in the majority (79.7%) of cases.⁶¹

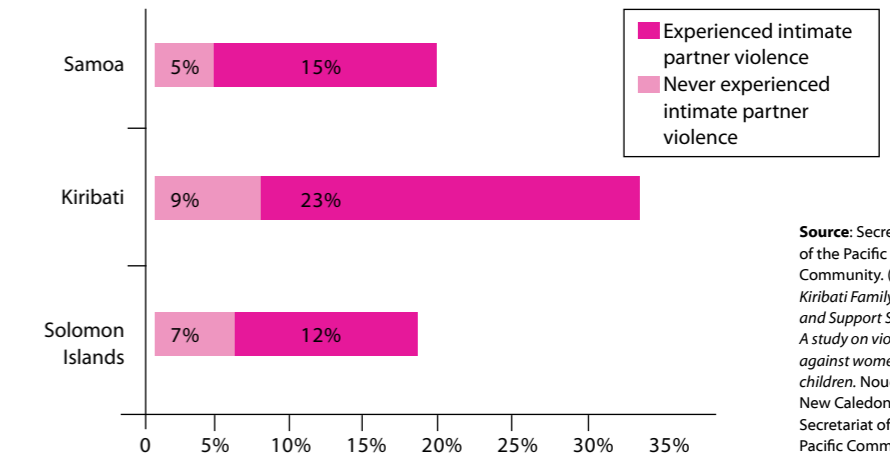
One of the many reasons that women give for non-use of contraception in Demographic and Health Surveys is the opposition from husband or other members of their households. The

Figure 5: Women's participation in household decisions and contraceptive use, Nepal 2006



Source: Nepal Demographic and Health Survey 2006.⁶⁴

Figure 6: Partner ever tried to stop family planning (ever-partnered women aged 15-49 years)



Source: Secretariat of the Pacific Community. (2010). *Kiribati Family Health and Support Study: A study on violence against women and children*. Noumea, New Caledonia: Secretariat of the Pacific Community.

proportion of women thus reporting ranged from 1%-10% in the 12 countries (of 21) for which DHS data was available.⁶² According to the Nepal Demographic and Health survey (2006), women who are more involved in household decision-making are more likely to use a modern method of contraception (Figure 5).⁶³

Women, who experience intimate partner violence and whose autonomy is therefore likely to be severely limited, have also been reported to be less able to terminate an unwanted pregnancy, adopt a method of contraception or practice safe sex. Data for some Pacific countries illustrates this relationship (Figures 6 & 7).⁶⁵ However, caution needs to be exercised in assuming any direct cause and effect between women's decision-making power and use of services⁶⁶ since actual service-use is mediated by a host of health systems factors including affordability and availability. Also, the extent to which women's 'autonomy' within the household would limit access to reproductive health services may vary across caste/race/ethnic groups and by economic class.

Besides the ability to make decisions, gender norms about appropriate behaviour for women also create barriers. For a significant proportion of women from Cambodia, Nauru, Samoa, Solomon

Islands and Tuvalu, where Demographic and Health Surveys have been carried out, having to take transportation, not wanting to go alone, getting money needed for treatment, and concern that there would be no female provider were all important barriers to accessing health care services in general.⁶⁷ Another barrier cited was perceived poor quality of care: women were concerned that there may

be no provider or drugs in the health facility to serve them and this dissuaded them from seeking care (Table 10).

To some extent the reasons cited above (other than needing permission) are also supply-side or health system-related. A functioning health system (which has availability of drugs and providers) that is responsive to gender-based

disadvantages experienced by women would design programmes to reach women closer to their homes at affordable prices and ensure availability of female providers. This in turn requires political commitment and determination, and strong policy and legislative backing for gender-equitable responses to health challenges.

Organising services at times and locations that are convenient to women; ensuring visual and auditory privacy and confidentiality; integrating services – for example, maternal health and family planning with HIV/AIDS; and according greater autonomy to women seeking health care – these are health system factors that have been identified as important for increasing women's access to health care overall, and are true also for sexual and reproductive health services.⁶⁸

5. Summary And An Agenda For Action

5.1 Summary

This paper set out to examine the current scenario in terms of universal access to sexual and reproductive health services, and identify major barriers to universal access for women in the reproductive age group. A set of 21 countries from the Asia-Pacific Region was considered. There is a dearth of information on comprehensive sexual and reproductive health services. Internationally comparable data are available for a limited range of indicators being globally tracked either for MDGs or for achieving universal access to antiretroviral treatment for HIV/AIDS. This limits the ability to assess how far countries have progressed in achieving universal access.

Although cursory and based on limited data, the exercise leaves no doubts as to the gap between the present situation and universal access to sexual and reproductive health. Some of the main findings are that

- Access to contraceptives is far from universal and a substantial proportion of women (a fifth of all women in reproductive age group) have unmet need for contraception in the vast majority of countries examined.
- Only 8 of 16 countries examined have 80% or more deliveries with skilled birth attendance and in 8 countries, more than 50% of women deliver with no skilled help. Coverage by antenatal care is much better (90% or more in 10 countries), but this is for

a single antenatal visit and not four visits which are advised by WHO as necessary to provide care that limits the risks to the health of mother or baby.

- There is poor access to safe abortion services. Unsafe abortions account for 10-16% of all maternal deaths.
- Barring a few exceptions, coverage by ARV is below 50% of all people living with HIV/AIDS. In about a third of the countries (8), less than 25% pregnant women receive an HIV test in most countries, with some countries testing less than 5% of pregnant women. Coverage by ARV of pregnant women living with HIV is lower than 25% in all but four countries.
- While all countries report including sexuality education in secondary school curricula, the emphasis was more on knowledge and less on life skills. Adolescent girls in the Region experience high fertility in some of the countries. Contraceptive prevalence rates are low, which suggests that sexually active adolescents may not have the means to control their fertility. While knowledge on HIV testing appears to be reasonable among adolescent girls, less than 5% of adolescent girls actually get tested.

Any attempt to make progress towards universal access to sexual and reproductive health in the Asia-Pacific Region will have to take cognisance of the social determinants of health: poverty and social and economic inequalities, hunger and malnutrition, unemployment, poor living and working conditions of the people, and the disadvantages that women experience as a result of gender-

power inequalities. Economies in crises do not lend themselves to improving people's wellbeing.

Another overarching issue that needs to be tackled is the fragmentation of ICPD's comprehensive sexual and reproductive health agenda into narrow silos of 'maternal health', 'HIV/AIDS' and 'other sexual and reproductive health' needs which receive more lip service and less investment or political commitment.

As long as this fragmentation continues, there can be little hope of achieving universal access to SRH services. There is need, not only to revive the ICPD agenda, but to expand it to include the needs of population groups who have remained invisible within this agenda: e.g. people of diverse sexualities, persons with disabilities, older persons.

Turning now to changes required within the health sector to enable universal access to sexual and reproductive health services, financial barriers would be one of the first obstacles that need to be tackled. Out-of-pocket health expenditure is substantial and acts as a deterrent to seeking sexual and reproductive health care in many countries.

Using delivery and abortion services, and services for reproductive tract infections can cost close to a household's average monthly income and could be several times more than the monthly household income of households living below the poverty line. One approach to addressing financial barriers has been through targeted interventions, some of which impose conditionality for financial

Figure 7: Respondents having not used condoms during last sex because their partners did not want to

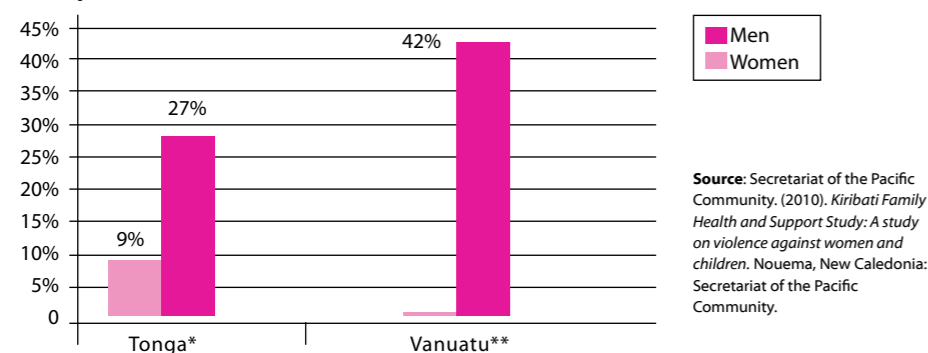


Table 10: Problems in accessing health care when they were sick among women aged 15-49 years, Selected Asia-Pacific countries, various years

Country	Percentage of women aged 15-49 years who had one or more of the following problem in accessing health care when they were sick								Year
	Getting permission to go for treatment	Getting money needed for treatment	Having to take transportation	Not wanting to go alone	Concern no female provider available	Concern No Provider available	Concern No Drug available	At least one problem in accessing health care	
Cambodia	14.3	74.1	38.7	45.0	36.9	50.5	51.4	88.5	2005
Nauru	10.3	25.7	49.4	34.3	42.5	69.8	82.1	91.9	2007
Samoa	29.4	55.2	51.8	38.5	61.3	74.5	80.0	92.4	2009
Solomon Islands	27.5	62.3	54.5	43.5	58.6	85.3	89.2	95.8	2009
Tuvalu	11.2	19.9	24.9	24.7	71.7	92.8	96.3	98.3	2007

Source: WHO Western Pacific Region (WPRO). (2011). *Women and health in the Western Pacific Region. Remaining challenges and new opportunities*. Manila: WHO WPRO.

assistance. While these have succeeded in increasing overall utilisation, they have been unable to achieve full coverage of the poorest groups and unable to fulfil their objective of mitigating catastrophic health expenditure. Needless to say, even those covered would only get access to care if services were actually available. Thailand's tax-revenue funded Universal Health Coverage Scheme is a better option to pursue if financial protection is the goal.

This is not only because of the wide coverage of the population but also because of the comprehensive range of sexual and reproductive health services included in the essential services package. It is often argued that low-income countries are not in a position to venture into such UHC schemes and that targeted interventions are a good stop-gap measure.

However, given the many limitations of targeted interventions as compared to the cost, and the fact that they would fail unless service availability was increased and better distributed, it would seem wiser not to invest on these but to channel more resources into strengthening the health system. This would at least help countries take a few steps forward towards the goal of universal access.

There are also huge gaps in availability of services. The health professional/population ratio and the bed/population ratio fall considerably short of requirement in the majority of countries examined. These grossly inadequate services are in many instances distributed

unequally across different regions of the country and across rural and urban locations, making access much more difficult for women living in rural, less economically developed and remote areas. The availability of reproductive health commodities are also a concern for many countries, especially for those dependent on donor funding and imported supplies.

Social franchising mechanisms for provision of sexual and reproductive health services can play an important role in expanding health coverage as well as population coverage in specific circumstances such as when contraceptive or abortion services are not provided by the publicly funded services. Their scope for contributing to universal coverage seems limited given evidence to date.

Legislative restrictions on safe abortion services and policies that restrict the access of adolescents and young people to several sexual and reproductive health services are another major supply-side barrier. Even where policies are in favour of safe abortion services, and services for adolescent sexual and reproductive health, social norms prevent many women and girls from using these and health providers may themselves act as gatekeepers to prevent access to services. Any discussion on access to sexual and reproductive health would be incomplete without acknowledging the significant barriers posed by gender-power inequalities in society.

Women's limited decision-making power, which includes matters relating to their

own health, is an important determinant of contraceptive use and practice of safe sex. Restrictions on women's mobility, hesitation and lack of experience in travelling unescorted, and social norms against being examined by male providers are all factors discouraging use of sexual and reproductive health services in the limited number of instances where they are available and affordable.

The blindness of health systems towards gender-related barriers exacerbates these difficulties.

What would be the way forward in addressing these barriers? How do we get from here to universal access?

5.2 An Agenda For Action

- Universal access to sexual and reproductive health needs to be seen within the context and the larger goal of universal access to health care overall. 'Silo[ed]' approaches that narrowly focus on one specific area such as reproductive health or HIV/AIDS could result in inefficient investment of resources in weak health systems (which may even result in their further weakening) and unachieved desired goals.
- Reducing the proportion of health expenditure from out-of-pocket payment and increasing the proportion of government spending should be one of the first action points in any intervention towards universal access.
- Tax-revenue based funding aimed at universal rather than targeted coverage, and including a reasonably

wide range of sexual and reproductive health services to offer adequate financial protection would be the path to pursue. For countries with a narrow tax base, a beginning could be made with a narrower essential services package with a commitment to progressively widening the package.

- Substantial investment in increasing the availability of services overall and prioritising closing the gap in distribution of services across rural/urban locations and geographic regions of the country are important areas for immediate action.
- There is insufficient evidence on the ability of social franchises in reproductive health to justify the considerable donor investments on such schemes. These resources may be better invested in strengthening the availability and better distribution of health care services, increasing the availability of human resources, and achieving reproductive commodity security.
- Consultation with communities about appropriate and acceptable health care and services is essential to greater usage. In many instances, negotiation and cooperation between state health care providers and community-based organizations can resolve the cultural and social barriers to access. For example, negotiation about acceptable birthing position and process can increase the levels of trained attendance assisting births.
- Last but not least, investment and action are needed in increasing health system responsiveness to gender-based inequalities deterring access to much needed services.

Some examples are: making services available at suitable locations and timings, integrating different sexual and reproductive health and other needed services, and facilitating women's informed participation in their own health care.

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Thematic paper 2:
**Poverty And Its Impact On
Sexual And Reproductive
Health And Rights Of
Women And Young People
In The Asia-Pacific Region**

by TK Sundari Ravindran and Manju R Nair

1. Introduction

"The biggest enemy of health in the developing world is poverty."

Kofi Annan

The linkages between poverty and ill-health have been recognized for more than two centuries. In his work on the conditions of the English Working Class in the mid nineteenth century, Fredrick Engels wrote about the poverty and squalor in which the workers lived and how this directly caused their ill-health.

Others have pointed out that illness further impoverishes the poor and the near-poor, trapping them in a vicious cycle of poverty and ill-health.¹ More recently, the World Health Organization (WHO) Commission on Social Determinants of Health highlighted the gross inequities in health between and within countries because people who grew up and live in poverty were deprived of the most essential resources necessary to become and remain healthy.

The poor were not only more likely to fall ill, but less able to find prompt and appropriate medical help, care and support to deal with their ill-health because of *"the systems put in place to deal with illness"*.

Poor women suffer a double jeopardy; their poverty compounding inequalities related to gender in educational attainment, occupational status and access to cash income, and lack of decision-making power.

Chapter three of the ICPD Programme

of Action (1994) recognizes widespread poverty as a major challenge to sustainable development and a barrier to improved sexual and reproductive health. It also identifies the elimination of gender-based discrimination as the lynch-pin that would contribute to both, poverty eradication and improved sexual and reproductive health.³

Building on the work of Kygombe (2003), Hulme and Lawson (2006) identified six pathways linking poverty to poor health.⁴ Using a slight adaptation⁵ and applying a gender perspective, the following are some major pathways linking poverty to sexual and reproductive health and rights.

Under-Nutrition And Anaemia

Intra-household discrimination in food allocation to women and girls may predispose more girls and women than boys and men to undernutrition and anaemia even when there is no scarcity of food at the household level. Poverty accentuates this disadvantage.

For example, in India and Bangladesh, 40-50% of the poorest women aged 15-49 are underweight while the proportion is about one fifth in Cambodia and Nepal.⁶ Anaemia affects 64.3% of the poorest women in India, 52.9% in Bangladesh, and 34.5% in Nepal. The comparable figures for women from the richest quintile were 34.4%, 46.1%, and 31.2%, respectively.⁷

Undernutrition affects health in many fundamental ways. An undernourished person suffers from compromised natural immunity and is highly susceptible to infections. In turn, infections worsen

nutritional status because of lack of appetite, malabsorption or loss of nutrients. Undernourished women are at greater risk of infections in pregnancy and childbirth, and of STIs and RTIs. Undernourished girls grow up into stunted women and are more likely to give birth to low birth weight babies. Anaemia (haemoglobin < 11g/dL) also increases susceptibility to infections, and besides, is an important direct as well as contributory cause of maternal mortality in Asia. An estimated 25,560 maternal deaths associated with anaemia – 50% of all global maternal deaths due to anaemia – take place in Asia.⁸

Low Educational Attainment

Girls and women living in poverty are much less likely to have had any schooling as compared to those who are better-off. For example, in Pakistan (2006-07), 95% of women from the poorest wealth quintile had no schooling as compared to 23.5% of women from the wealthiest quintile,⁹ while in the Philippines, which has a near-universal literacy, 6% of the poorest women had no schooling as compared to universal schooling among better-off women.¹⁰ Low educational attainment has an impact on sexual and reproductive health.

Gender norms in most Asian societies require girls and women to be "innocent" on matters related to their bodies, and to sexuality and reproduction, and there are few avenues for them to access appropriate information on these matters. For those with schooling and higher education, there may be opportunities to gain such knowledge through books

and other means. For girls and women with low educational attainment, such opportunities would be rare. In Lao PDR, 60% of youth age 15-24 years with some schooling had knowledge of contraceptive methods as compared to only 21% among those with no schooling.¹¹ In the Philippines, in-school youth were much more knowledgeable about reproductive health than out-of-school youth.¹²

Besides this direct connection to knowledge and awareness on sexual and reproductive health, there also appear to be many intangible benefits of schooling contributing to better health. For example, in Mongolia, girls who had completed grade 10 had a much lower pregnancy rate than those who had completed only primary schooling.¹³

Risk of maternal deaths also appears to be lowered for women with some education, according to the World Bank, which estimates that for every 1000 women, an extra year of schooling could prevent two maternal deaths.¹⁴ Women with schooling may also be more willing to learn new information and try new behaviour because schooling socialises them to do so. This would influence their ability and willingness to make sexual and reproductive health-related behavioural changes.

Poor quality of shelter

Good physical and mental health depends on living in homes and neighbourhoods where a child feels safe and secure, and enjoys some control over his/her surroundings. Bad housing is linked,

for example, to debilitating childhood illnesses such as meningitis, tuberculosis and asthma, and childhood accidents. Overcrowded houses with limited privacy could affect children's ability to learn at school and study at home. Persistent and frequent health problems and low educational attainment in childhood are associated with unemployment and employment in poorly paid jobs for young people.¹⁵ In some countries and especially in urban settings, high-poverty neighbourhoods are associated with negative peer influences, greater availability of illegal drugs and more street violence.¹⁶

Households with a low level of assets often live in poor quality shelters without access to basic amenities such as toilets and drinking water. For women and girls, poor toilet facilities make management of menstruation difficult and contribute to the risk of reproductive tract infections. Urinary tract infections may also be more common among women without access to toilets within or close to their homes.

Non-availability of toilets and limited availability of water would also make it difficult for women to use barrier methods of contraception such as diaphragms and female condoms. Poor access to drinking water may restrict water intake, contributing to urinary tract infections, while limited access to water for washing could affect general and genital hygiene.

Low quality water also causes numerous other water-borne diseases, some of which can affect pregnancy outcomes. Women living in urban slums face additional problems related to physical

security and risk of violence, including sexual violence.

Unsafe And Unhealthy Work Environment

Women are disadvantaged in the labour market (see next section), and for those who are poor, there may be few options of working in a safe environment. Physical and biological agents in the workplace and a variety of work situations and conditions can have negative reproductive health effects. For example, stress, rotating shifts, and exposure to some organic solvents can cause menstrual problems which in turn affect ovulation. Exposure to radiation and some chemicals can damage eggs and sperms causing miscarriages, stillbirths and birth defects, while mutagenic substances in the work environment may cause reproductive and other cancers. Long hours of standing and heavy lifting during late pregnancy increase the risk of pre-term delivery and low birth weight babies.¹⁷

Many young people from poor households find themselves working in low-paid jobs for long hours in sweat-shops or in agriculture, engaged in hazardous and arduous jobs. This is because of limited economic opportunities available for those with limited education, and also because of the increasing opportunities available in export-promotion zones.¹⁸

Substance Use

In the Asia-Pacific Region, one of the most common substances used by women is

smokeless tobacco. The use of smokeless tobacco is much more common among poorer women than women from better-off groups.

For example, according to the latest Demographic and Health Surveys (DHS) data, the use of smokeless tobacco among women of the lowest wealth quintile was 11.2% and 14.4% in Cambodia and Nepal respectively, while for the highest wealth quintiles the use of smokeless tobacco was far lower, at 0.6% and 1.4% respectively.¹⁹

A study from India shows that pregnant women, who used smokeless tobacco, had a three-fold increased risk of stillbirth and a 2-3 fold increased risk of having a low birth weight baby.²⁰ It also predisposes women to preeclampsia, which if not treated could develop into eclampsia which is among the three top causes of maternal mortality.²¹

No data is available on substance use among low-income young people in the Asia-Pacific region. However, growing up in poverty may mean receiving relatively less parental supervision and also being more exposed to substance use among adults. This may increase the probability of substance use among young people from low-income households, especially if they start working and earning at a young age in order to supplement their family incomes.

Sexual Abuse And Intimate Partner Violence

Sexual abuse and intimate partner violence against women is another

pathway through which gender and poverty, in tandem, affect women's sexual and reproductive health and rights negatively. In Asia, the greater Mekong sub-region is a major transit point for trafficking of human beings. While adolescent girls are especially at risk of sexual exploitation, adolescent boys are also found to be vulnerable.²²

The rapid movement of some countries from centrally planned to open-market economies, has increased the number of households living on the margins of society with few or no economic assets except their bodies.

All countries of the Region have reported the existence of intimate partner violence among women, with some of the highest prevalence rates for life time intimate partner violence (above 50%) reported from the Pacific countries.²³

DHS data for Asia-Pacific countries show that the poorer the women, the higher the prevalence of life-time intimate partner physical and/or violence (see section 3).

The adverse sexual and reproductive health consequences of intimate partner violence have been well documented by the WHO Multi-Country Study on women's health and domestic violence. Abused women face a higher risk of unwanted pregnancy, poor pregnancy outcomes including miscarriages, stillbirths and pre-term deliveries, reproductive tract infections, and sexually transmitted infections, including HIV.²⁴

Intimate partner violence has also been found to contribute to maternal mortality

and morbidity in India and Bangladesh.²⁵

Poor Access To Health Care Services

In addition to low level of knowledge and awareness about sexual and reproductive health, lack of decision-making power, restrictions on mobility and cultural norms requiring women to be seen only by women health providers pose major barriers to women's access to health care services. Women across all economic strata may experience one or more of these barriers. For example, between 55% and 87.5% of women from the wealthiest sections of society in seven Asia-Pacific countries covered by the DHS had one or more of the above problems in accessing health care.²⁶

Cost of health care services is also a barrier for all women who do not have access to cash income even if they belong to wealthy households. However, a greater proportion of women from poorer sections of the population are likely to face the cost barrier. For example, 17% and 38% of the richest women in Nepal and the Philippines, respectively, mentioned not having money as a problem in accessing health care services. In the same countries, 72% and 74%, respectively, of the poorest women were not able to use health services because they did not have the money.²⁷

One of the major barriers to progress in the Asia-Pacific Region in realizing the sexual and reproductive health goals by ICPD has been the large population living in poverty. Also, even when numbers are not very large, many of the poor

may experience multiple disadvantages besides a low income, which increase their vulnerability to illness and results in poor sexual and reproductive health status. This paper aims to consolidate current evidence on the impact of poverty on sexual and reproductive health and rights of women and young people in the Asia-Pacific Region, and to explore the gendered pathways through which the impact operates. The first section of this paper will, following this introduction, define concepts and present the methodology adopted for the analysis presented in this paper.

Section two will provide an overview of the current scenario of poverty in the Asia-Pacific Region. The third section will present available country-level data and information from studies on the impact of poverty on SRHR in the Asia-Pacific Region. The fourth and concluding section will highlight the main findings and discuss the implications for advocacy and action beyond ICPD+20.

Concepts And Methods

The links between poverty and health are often compared at the level of countries and regions, based on the income levels or Gross Domestic Products of countries. This paper considers poverty at the household and individual level, and examines its impact on sexual and reproductive health and rights of women and young people.

Poverty was defined by the World Summit on Social Development in Copenhagen in 1995 as a multidimensional phenomenon. Manifestations of poverty include

*"a lack of income and productive resources to ensure sustainable livelihoods; hunger and malnutrition; ill health; limited or lack of access to education and other basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments and social discrimination and exclusion. It is also characterized by lack of participation in decision making and in civil, social and cultural life."*²⁸

Thus, a lack of adequate income is only one dimension of poverty, labelled as *"income poverty"*. It has become common for countries to establish an income-based or consumption-based poverty line. For purposes of global comparison, the World Bank calculated the international poverty lines as a consumption of less than 1.25 PPP (Purchasing Power Parity) dollars per day. Those who consume below this level are classified to be 'living below the poverty line'.

A report on the world's most deprived (2007) found it useful to further sub-divide those living in income poverty into three categories: the subadjacent poor, the medial poor, and the ultra-poor. The ultra-poor were those who earned below 50% of the international poverty line income, the medial poor those who earned between 51% and 75% of the poverty line income and the subadjacent poor, those who earned between 76% and 100% of the poverty line income. This allowed for assessing which group of poor people were being reached by poverty alleviation programs.²⁹

Absolute poverty refers to some absolute standard of minimum requirement – for example, below the income poverty

line. In contrast, relative poverty refers to falling behind most others in the community: for example, belonging to the poorest quintile or decile of the population. Both absolute and relative poverty are usually in relation to income poverty.

Multidimensional poverty index captures dimensions of poverty beyond income. It identifies multiple deprivations at the individual level in education, health, and standard of living, measured through 10 component indicators. It gives a measure not only of the proportion of people suffering deprivations in health, education, and living conditions, but also of the intensity of poverty in terms of number of areas in which an individual is deprived.³⁰

In this paper, we have used the 'wealth index' and the distribution of population into wealth quintiles related to this index, a measure of relative poverty, as the indicator of poverty and economic inequalities. This is based on pragmatic considerations. Demographic and Health Surveys, which are the major source of data on sexual and reproductive health data globally and in this paper, use this wealth index.

The wealth index is constructed from data on household assets, characteristics of the dwelling and availability of basic amenities such as drinking water, toilets and electricity, and captures dimensions of poverty beyond income. Individuals are ranked on the basis of the wealth index score of the household in which they reside, and the entire sample is then divided into five quintiles, the first quintile

having the lowest wealth and five, the highest.

The poorest quintile in the different countries may have different average income levels and differing proportions of people living in absolute poverty. Comparison of sexual and reproductive health indicators across these wealth quintiles essentially captures differentials and inequalities across wealth status rather than the effect of absolute poverty. Indicators of reproductive and sexual health are likewise chosen from those for which multi-country comparable data are readily available from the DHS.

These include total and wanted fertility rates, contraceptive prevalence rates and unmet need for contraception; maternal mortality ratio, attendance by a skilled birth attendant for child delivery, and utilization of antenatal care; comprehensive knowledge of AIDS and coverage by HIV testing services; median age at marriage, proportion of young women who have begun childbearing; proportion of young people with comprehensive knowledge of AIDS and knowledge of a source for obtaining condoms; and proportion engaging in high risk sexual activity.

Data from the most recent DHS for 11 countries of the Asia-Pacific region have been used: Afghanistan, Bangladesh, Cambodia, India, Indonesia, Kiribati, Maldives, Nepal, Pakistan, the Philippines, and Samoa.

A straight-forward presentation of relevant data and discussion of its implications has been complemented by

information from studies from the region examining the association of poverty, and sexual and reproductive health. Limitations of time and resources did not permit statistical analysis based on the original DHS data sets, which would have given more definitive results. For the purpose of identifying studies on the topic, a systematic search was carried out in Google and in Pub Med.

We used both broad search terms such as "sexual health" + "poverty/inequality" and "reproductive health+poverty/inequality" as well as specific dimensions such as "contraceptive prevalence rate" + "poverty/inequality" and so on corresponding to each of the SRHR indicators used in the data compilation process. Very few studies were found for countries in the Region, which have systematically examined the actual associations and linkages between household and individual poverty, and different dimensions of SRHR, and these were used.

2. Poverty In The Asia-Pacific

2.1 Dimensions Of Poverty

For the discussion on poverty in the Region, we have included a set of 21 countries which are being monitored by ARROW for performance against ICPD goals. Nine of the 21 countries considered may be classified as poor, with a per capita gross domestic product of less than 3000 PPP\$ (2005 constant prices) per annum.

Table 11. Income, poverty and inequality in selected countries of the Asia-Pacific Region

Country	GDP per Capita in PPP dollars (constant 2005) 2010	% population living in poverty (PPP\$1.25 per day) 2000-2009	Quintile income ratio* 2000-2011	% population living in multidimensional poverty 2010
Afghanistan	1083	n.a	n.a	n.a
Bangladesh	1488	49.6	4.3	57.8
Bhutan	4780	26.2	n.a	27.2
Burma**	n.a	n.a.	n.a	31.8
Cambodia	1968	28.3	7.8	52.0
China	6819	15.9	8.4	12.5
Fiji	4154	n.a.	n.a	n.a
India	3039	41.6	5.6	53.7
Indonesia	3885	18.7	5.9	20.8
Kiribati	2214	n.a	n.a	n.a
Lao PDR	2313	33.9	5.9	47.2
Malaysia	13214	0.0	11.4	n.a
Maldives	7387	1.5	6.8	5.2
Nepal	1079	55.1	8.9	64.7
Pakistan	2411	22.6	4.7	49.4
Philippines	3560	22.6	9.0	13.4
PNG	2217	n.a	12.5	n.a
Samoa	3943	n.a	n.a	n.a
Sri Lanka	4601	7.0	6.9	5.3
Thailand	7673	10.8	15.0	1.6
Vietnam	2875	13.1	6.2	17.7

*Quintile income ratio is the ratio of the average income/ consumption of the top 20% of the population to the average income/ consumption of the bottom 20%. It is a measure of income inequality

Source: Column 1: The World Bank (WB). (n.d.). Data: GDP per capita, PPP (current international \$). Retrieved 25 July, 2012 from <http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD>; Columns 2-4: United Nations Development Programme (UNDP). (2011). *Human Development Report 2011*. New York: UNDP.

Seven others do only slightly better, with a per capita GDP of between 3000 and 6000 PPP\$ and only 4 countries – Malaysia, Thailand, China and Maldives have a relatively higher income, with Thailand lagging behind Malaysia as a distant second (Table 11).

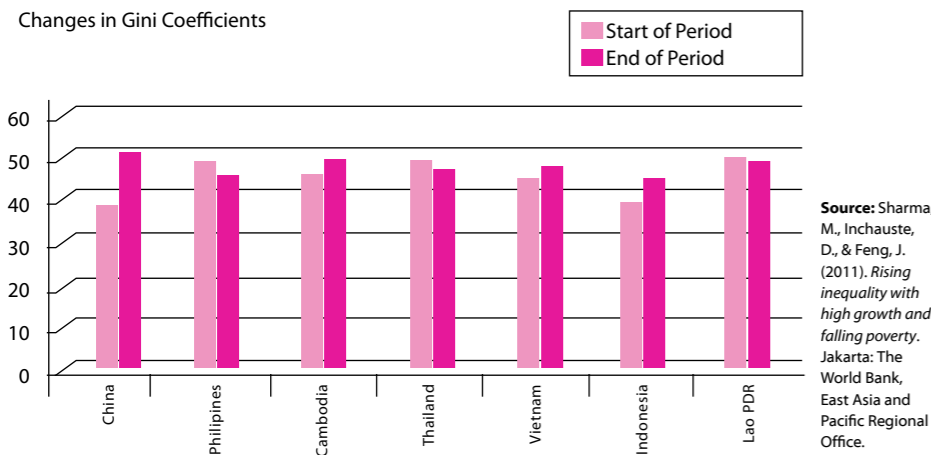
In 2008, about 22% of the population of the Asia-Pacific Region was estimated to be living below an income of PPP\$1.25 per day, with considerable intra-regional differences. Incidence of poverty (2008) is highest in South Asia, with three countries, including India with a billion

plus population having more than 40% of the population living in income poverty, and every second person poor in Bangladesh and Nepal. In South-East Asia, there is greater diversity, and the proportion of income poor ranges from 0% in Malaysia to 33% in Lao PDR. China has about 15% of its population living in income poverty.

Some of the highest income gap between the poorest and the richest 20% are recorded by countries with the lowest levels of poverty. For example, in Thailand,

the richest earn 15 times as much as the poorest, and the comparable figure for Malaysia and China are 11.6 and 8.4, respectively. At the same time, there are also countries with high levels of poverty as well as relatively high income inequality: In Nepal, where 55% of the population live in income poverty, the richest quintile has an average income that is almost 9 times that of the poorest. Data on multidimensional poverty provides further insights. In South Asia, all countries except Sri Lanka have a greater proportion of people living in multi-

Figure 8. Changes in Gini co-efficient of income distribution during the past three decades, selected SE Asian countries



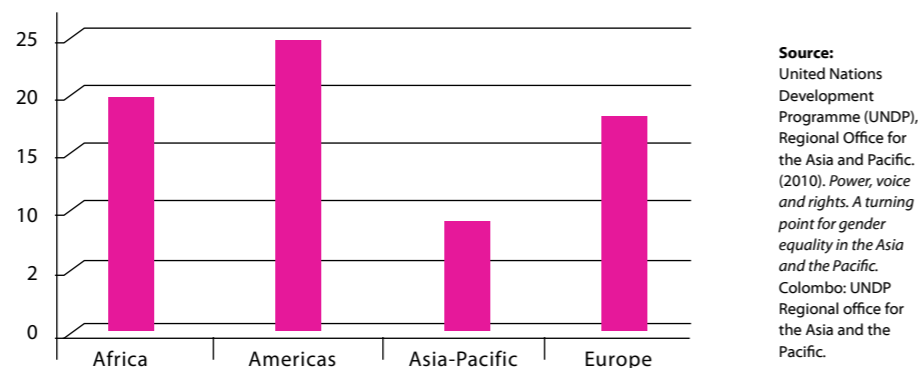
dimensional poverty as compared to income poverty.

This indicates the multiple disadvantages that the poor suffer – they not only earn and consume very little, but are deprived of health and educational resources, and live in squalor without basic facilities. It also indicates that many of the non-poor, according to income criterion, also live a life deprived of access to basic needs and resources. In contrast, in all but a few countries of Southeast and East Asia, at least some proportion of the income poor do not live in multidimensional poverty, most probably as a result of public investments in providing basic facilities universally. In Thailand, for example, although about 10% of the population is income poor, less than 2% live in multidimensional poverty.

Between 1990 and 2008, the proportion of people living below PPP\$1.25 per day in the Asia-Pacific Region nearly halved, from more than 50% to about 22%. The

absolute number of people living in poverty also came down from 1.6 billion to about 0.9 billion during the same period.³¹ Decline in poverty was, however, accompanied by an increase in within-country inequalities, which was especially marked in South-east Asian countries and in China. The Gini-coefficient of inequalities income distribution, already high in several countries in the Region,

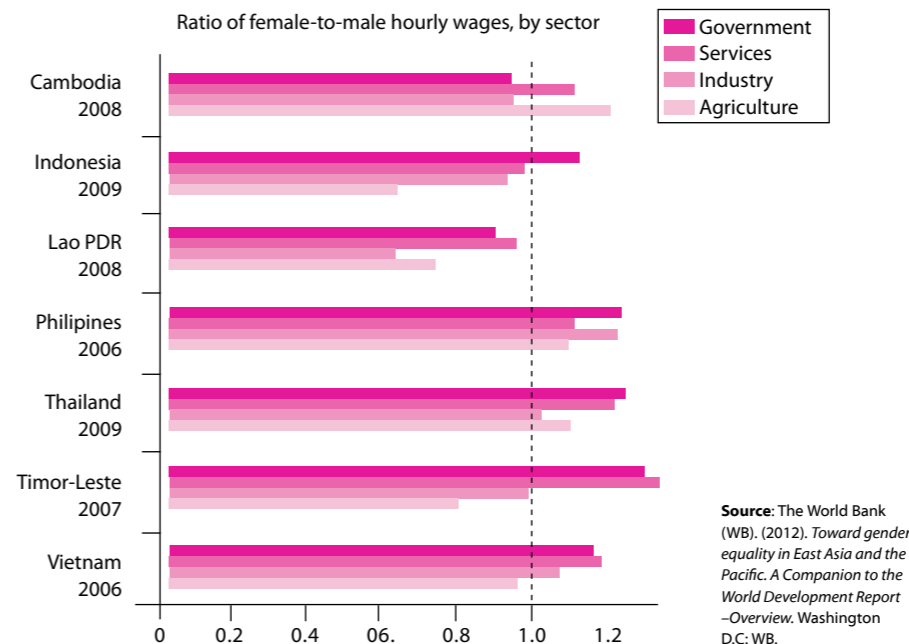
Figure 9. Fewer women own farmland in Asia-pacific than elsewhere in the world



further increased during 1990-2010 (Figure 8).³² Rural urban inequalities widened in countries such as China and India mainly because of a much faster rate of decline in urban as compared to rural poverty.³³ In Cambodia, Lao PDR, Thailand and Vietnam, intra-rural inequalities are much higher than rural-urban divide, while in the Philippines and Indonesia, intra-urban inequalities contributed most to inequalities overall.³⁴

Internationally comparable data on income and multidimensional poverty is not available for the Pacific countries considered in this report. However, information is available on the poverty as measured by a National Basic Needs Poverty Line, which is a measure of the minimum income needed to buy sufficient food and meet basic requirements such as housing, clothing, transport, school fees etc. About 38% of the population in Papua New Guinea, 25% in Fiji, and 20% in Samoa are reported to be living under the National Basic Needs Poverty Line.³⁵

Figure 10. Women's wages are lower than that of men's across sectors



The global financial crisis of 2008 resulted in a decline in the rate of growth of GDP in the Asia-Pacific region from 3.1% in 2008 to 0.5% in 2009. Sub-regions that depend largely on exports and from remittances from abroad were more seriously affected. Fall in exports meant loss of jobs in the export-manufacturing sector, while lower external revenues had negative implications for government budgets. According to estimates in 2009, Between 65 million and 85 million more people will remain in poverty due to the crisis.³⁶

2.2 Women And Poverty

Women constitute about two-thirds of the poor in Asia. Discrimination in education and employment resulting in economic insecurity and lack of cash income are major contributors to poverty among women. A smaller proportion of women

in the Asia-Pacific Region own farm land as compared to elsewhere in the world (Figure 9); and yet, they do most of the agricultural work in the Region.³⁷

Women's participation in the labour force falls short of male participation rates throughout the Region. In 2007, 70% of the women from East Asia, 58.9% of women from SE Asia and the Pacific, and only 37.4% of women from South Asia participated in the labour force. The comparable figures for men were 83.1%, 87.8%, and 86.4%, respectively. Women in the Region are also much more likely to be unemployed: in 2007, the difference between male and female unemployment rates in the Region was twice the global average.³⁸

Women's wages are lower than male wages across all sectors in many countries

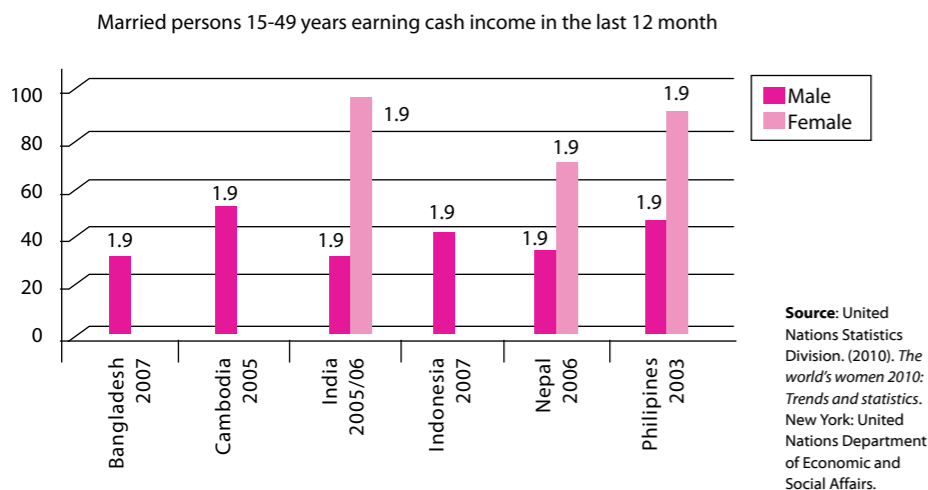
of the Region (Figure 10). Women earn only 54%-90% of what men earn. This happens not only because women are concentrated in lower-paid occupations, but also because they are paid less for similar or comparable jobs. Much of the work that women do may be unpaid, including work carried out in family farms and enterprises. The proportion of women aged 15-49 years who had a cash income during the past year ranged from 27% in Bangladesh to 47% in Cambodia (Figure 11). The vast majority of women are thus without access to cash, and they are dependent on their family members when they have to access any paid services, including health care. This is true irrespective of the poverty status of the household, and is worth bearing in mind.³⁹

2.3 Poverty Among The Young

Adolescents and young people constitute a little over one-fourth (25.8%) of the total population in the Region.⁴⁰ The proportion of young people in the population is higher than ever before because of the fertility transition happening in many countries of the Region. The pattern of economic growth with increasing inequalities has failed to create enough jobs to absorb the emerging labour force. Young people constitute about 50% of all unemployed persons in the Region and are six times more likely to be unemployed as compared to their older counterparts.

Literacy levels for the Region as a whole are 62% for young women and 77% for young men.⁴¹ Migration of young people

Figure 11. Women's access the cash income in selected countries of Asia-Pacific



from rural to urban areas and across countries in search of employment is becoming more common than ever before. For example, a migration survey in Lao PDR found that more than 20% of all rural to urban migrants were under 18 years old and that 67% of them were girls.⁴² Although no data is available specifically on poverty among young people, the Region has the highest number of young people living in poverty, a hundred million of them in India (67.7 million) and China (33.3 million) alone, and 20 million living in Bangladesh, Pakistan, Indonesia and Vietnam.⁴³ Poverty, low

educational status, unemployment and migrant status interact to make young people in the Region especially vulnerable to sexual and reproductive health risks, as we shall see in later sections.

3. Association Of Wealth Status With SRHR In The Asia-Pacific Region

Gwatkin et al (2007) have demonstrated the association of wealth status with sexual and reproductive health in an extensive analysis of data from Demographic and Health Surveys for more than 50 countries across the globe.⁴⁴

Examining indicators of fertility, mortality, and their determinants, he found that the health of those belonging to the lowest wealth quintile was notably poorer, and

they also used health services less, when compared to those belonging to higher wealth quintiles, with each subsequent economic group doing progressively better in most instances in terms of health status and access to health services. This section examines the most recent Demographic and Health Survey data for selected countries of the Asia-Pacific Region to identify the patterns of health inequalities related to health status and utilization of health care services.

3.1 Fertility And Contraceptive Use

In most countries of the world where fertility transition is underway, it has been observed that the total fertility rate for the poorer sections of the population is much higher than for the better-off sections.

The same is seen for countries in the Asia-Pacific region. In each of the 11 countries for which DHS data are available, the poorest women had one to three or more additional children in their life times. The divergence between the lowest and highest wealth quintiles in fertility is widest in the Philippines (3.2), followed by Pakistan (2.8) and Nepal (2.6), Cambodia (2.4), Kiribati and India (2.1) (Table2).

If such differentials were noted in mortality rates, we may immediately conclude this to be health inequity. In the case of fertility, however, differentials may be the consequence of a higher desired family size among poorer women. We, therefore, examined the absolute difference between total fertility rates and 'wanted fertility rates' across wealth quintiles.

Table 12. Total fertility rates across wealth quintiles, selected countries of the Asia-Pacific

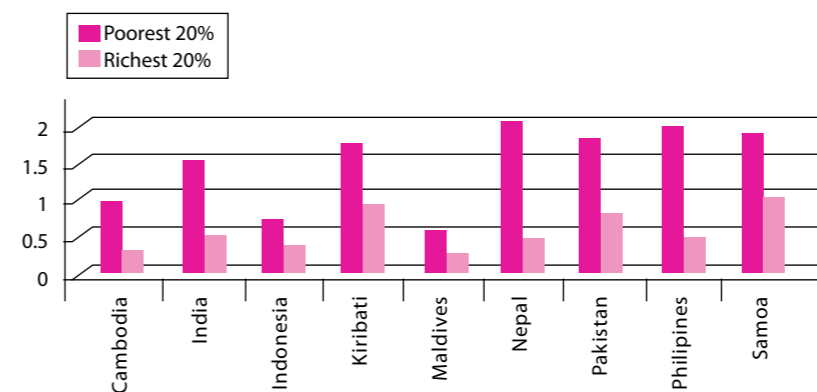
Country	Year	Total Fertility rate					
		For the three years preceding the survey; women age 15-49					
		Low	2nd	3rd	4th	High	Pop. Average
Afghanistan	2010	5.3	5.0	5.4	5.2	4.8	5.1
Bangladesh	2007	3.2	3.1	2.7	2.5	2.2	2.7
Cambodia	2010	4.5	3.3	3.0	2.7	2.1	3.0
India	2005/06	3.89	3.17	2.58	2.24	1.78	2.68
Indonesia	2007	3.0	2.5	2.8	2.5	2.7	2.6
Kiribati	2009	5.0	3.9	4.0	3.5	2.9	3.8
Maldives	2009	2.8	2.9	2.7	2.4	2.1	2.5
Nepal	2011	4.1	3.1	2.7	2.1	1.5	2.6
Pakistan	2006/07	5.8	4.5	4.1	3.4	3.0	4.1
Philippines	2009	5.2	4.2	3.3	2.7	1.9	3.3
Samoa	2009	5.9	4.3	4.7	4.4	4.0	4.6

Source: Latest DHS data for the countries⁴⁵

As Figure 12 clearly indicates, while women in the poorest groups have up to 2 more children than they actually desire, women in the richest groups generally tend to come closer to fulfilling their fertility preferences. In other words, higher fertility rates among poorer women is not, in general, because they desire to have more children as compared to the

rich, but because for some reason, they are unable to find the means to control their fertility. In order to understand this further, it is necessary to look into contraceptive prevalence rates across wealth quintiles (Table 13). Table 13 reveals inequities across wealth quintiles in terms of access to contraception. Overall, contraceptive prevalence is lowest in the lowest wealth quintile and highest

Figure 12. Difference between wanted and total fertility rate across wealth quintiles



in the highest wealth quintile, but there is no general pattern of step-wise increase in contraceptive prevalence with increase in health. In Cambodia, while the use of any method increases from the poor to the rich, use of modern methods actually declines with increasing wealth.⁴⁷

Table 14 shows that there is substantial unmet need for contraception across all wealth groups in a number of countries, but is highest among the poorest. Unmet need for contraception is defined as the proportion of currently married women who do not want any more children but are not using any form of contraception (*unmet need for limiting*); plus the proportion of currently married women who want to postpone their next birth for two years but are not using any method of contraception (*unmet need for spacing*).

High unmet need among the poorer groups could be due to the following reasons: a) poor women do not have geographical access to services; b) they are unable to afford the cost of services even when there is geographic access (services are not free or subsidized); and c) they have other problems related to using contraceptives. There may often be more than one reason.

For example, in South Asia, from the number of women who were not currently using contraception but did not intend to use contraception in the future either, 54% stated 'opposition to use' as the reason, followed by 37% who had concerns related to health and side-effects. Only 4% gave cost as the barrier and 0.4% found the service to be inaccessible or too far. In South Asia,

Table 13. Contraceptive prevalence rates by wealth quintiles, selected countries of the Asia-Pacific

Country	Year		Contraceptive prevalence rate (% of currently married women age 15-49)					Pop. average
			Low	2 nd	3 rd	4 th	High	
Afghanistan	2010	Any	17.1	19.8	17.8	20.7	34.0	21.8
		Modern	16.2	18.7	16.6	18.9	29.2	19.9
Bangladesh	2007	Any	54.8	54.7	54.1	55.2	59.9	55.8
		Modern	46.9	47.2	46.1	47.6	49.4	47.5
Cambodia	2010	Any	45.2	47.5	51.3	52.6	56.0	50.5
		Modern	35.2	37.0	37.0	33.9	31.4	34.9
India	2005/06	Any	42.2	51.1	56.8	62.5	67.5	56.3
		Modern	34.6	43.5	49.8	55.2	58.0	48.5
Indonesia@	2007	Any	53.0	63.3	62.4	63.8	63.5	61.4
		Modern	49.9	60.3	59.0	59.1	57.9	57.4
Kiribati	2009	Any	32.4	22.5	18.9	16.2	21.0	22.3
		Modern	26.4	17.8	14.2	14.5	16.9	18.0
Maldives	2009	Any	36.9	35.4	34.3	33.4	33.9	34.7
		Modern	29.1	27.0	27.4	25.6	26.0	27.0
Nepal	2011	Any	40.4	46.3	48.2	52.0	59.6	49.7
		Modern	35.6	41.1	43.3	45.3	48.9	43.2
Pakistan	2006/07	Any	15.6	20.8	30.1	36.8	43.4	29.6
		Modern	12.4	15.5	21.9	26.3	31.6	21.7
Philippines	2009	Any	40.8	52.7	54.0	55.8	50.0	50.7
		Modern	26.0	35.7	36.6	38.5	33.1	34.0
Samoa	2009	Any	28.2	26.9	29.1	24.3	35.4	28.7
		Modern	27.9	25.9	26.7	21.6	32.0	26.7

@ Data pertain to all women
Source: Latest DHS data for the countries⁴⁸

contraceptive services are provided free of cost in the public sector.⁵⁰

'Opposition to use' indicates women's inability to make their own decisions in relation to contraception, while health related concerns suggest that low-income women, whose health status may be poor to begin with, may fear compromising it further through contraceptive use, especially if quality of

contraceptive services is low. Attitudinal factors and spousal communication may also influence differentials across wealth quintiles in contraceptive use. A study analyzing 2002-03 DHS data from Indonesia found that poor women were less likely to approve family planning (87-91% vs. 93%) when compared to better-off women, and they were less likely to discussed this topic with their husbands (42-46% vs. 52%).⁵¹

Kiribati is an outlier where unmet need actually increases with increasing economic status. This pattern is also seen in countries such as Bolivia, Ghana, Togo, and Zimbabwe. One explanation is that this is a pattern seen in countries in the earlier stages of declining family size. Desired family size declines first and faster among the wealthier groups and they have a higher unmet need because family planning programmes are also in

Table 14. Unmet need for family planning by wealth quintiles, selected countries of the Asia-Pacific

Country	Year	Unmet need for family planning (% currently married women age 15-49)					
		Low	2 nd	3 rd	4 th	High	Pop. Average
Bangladesh	2007	17.4	18.6	17.1	17.0	15.6	17.1
Cambodia	2010	20.5	19.3	16.3	14.9	11.8	16.6
India	2005/06	18.2	14.8	12.8	10.6	8.1	12.8
Indonesia	2007	12.7	8.5	8.9	7.3	8.2	9.1
Kiribati	2009	24.5	26.8	27.0	31.0	31.3	28.0
Maldives	2009	28.8	29.4	28.7	28.7	25.4	28.1
Nepal	2011	31.1	28.1	28.2	26.4	22.0	27.0
Pakistan	2006/07	31.1	27.4	26.5	19.9	20.2	24.9
Philippines	2009	28.2	22.7	21.0	19.5	20.5	22.3
Samoa	2009	46.8	47.7	48.1	43.6	41.1	45.6

Source: Latest DHS data for the countries⁴⁹

their early stages and unable to fill this increased demand or address concerns related to health and side-effects. Over time, contraceptive use increases among the wealthier quintiles and the pattern reverses.⁵²

3.2 Unsafe Abortion

An estimated 21.6 million unsafe abortions took place globally in 2008, 10.8 million of them in Asia,⁵³ constituting 40% of all induced abortions. There was considerable variation across sub-regions, and almost no abortions performed in Eastern Asia were unsafe, as compared to 60-65% in the rest of the Region.⁵⁴

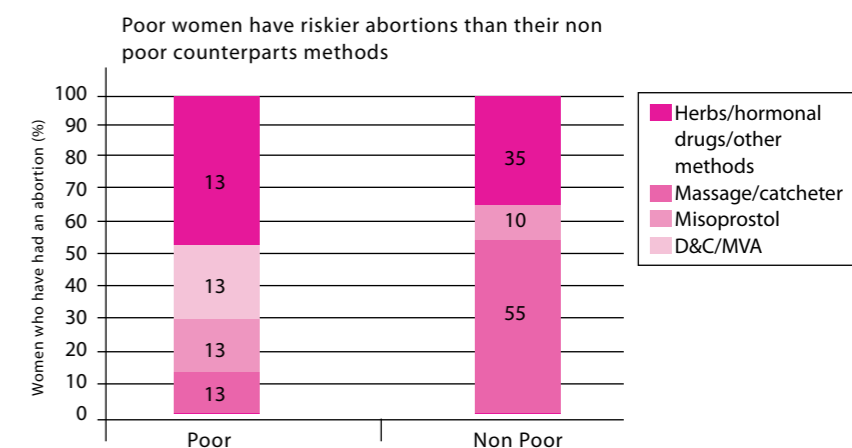
Poverty, unemployment, and inability to afford additional children were among the second most common reason women have induced abortions, according to a 27-country study published in 1998.⁵⁵ Studies from the Latin American Region have reported that there is a steep socio-

economic gradient in the probability of having an unsafe abortion, with the poorest having the highest probability. For example, in Mexico, an analysis of data on 14589 pregnancies showed that those from the lowest wealth quintile were 2.5 times more likely to have an unsafe abortion as compared to the richest, while indigenous women 5.4 times more likely to have an unsafe abortion.⁵⁶

Likewise, poverty and ethnicity increased the risk of a woman having an unsafe as compared to a safe abortion among a vulnerable population in Sao Paulo, Brazil.⁵⁷

Studies from several Asian countries, most of them small-scale, highlight the higher risk of unsafe abortion among poorer women. Women from marginalised communities are especially vulnerable to being forced to terminate a pregnancy due to economic compulsions and resort to unsafe abortions because of legal restrictions on safe abortion services.

Figure 13. Methods of abortion among poor and non poor women in the Philippines, 2004



Source: Singh, S., Juarez, F., Cabigon, J., Ball, H., Hussain, R., & Nadeau, J. (2006). *Unintended pregnancy and induced abortion in the Philippines*. New York: Guttmacher Institute.⁶⁰

Table 15. Proportion of births with skilled attendance by wealth quintiles, selected countries of the Asia-Pacific

Country	Year	Proportion of women attended by a skilled provider for delivery (% women age 15-49 who had a live birth in the 5 years preceding the survey, most recent pregnancy)					
		Low	2 nd	3rd	4th	High	Pop. Average
		Afghanistan	2010	11.7	21.2	32.7	40.7
Bangladesh	2007	4.8	6.7	12.1	22.5	50.9	18.0
Cambodia	2010	48.7	63.7	74.5	86.5	96.7	71.0
India	2005/06	19.4	31.8	49.0	67.2	88.8	46.6
Indonesia	2007	43.8	66.4	78.8	87.3	95.4	73.0
Kiribati	2009	75.9	82.5	71.4	81.6	93.2	79.8
Maldives	2009	88.6	92.6	95.4	98.4	99.3	94.8
Nepal	2011	10.7	23.7	35.9	53.0	81.5	36.0
Pakistan	2006/07	16.1	24.7	35.5	52.1	77.3	38.8
Philippines	2009	25.7	55.6	75.8	86.0	94.4	62.2
Samoa	2009	95.4	97.5	98.5	96.9	98.0	97.2

A skilled provider is a qualified doctor, nurse or midwife.

Source: Latest DHS data for countries⁷³

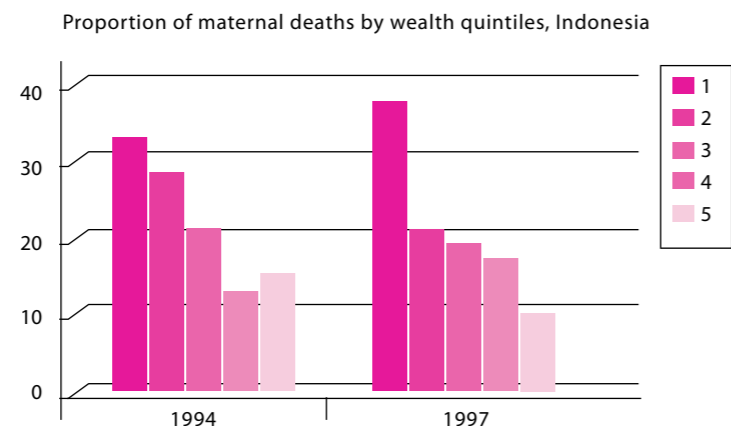
This is the situation of Burmese women living along the Thai border in Thailand: *"I stopped my last pregnancy when I was four months. I did it because my parents said that I had no job and my husband had no job. [They said,] 'You will have many problems and why weren't you more careful?'"*⁵⁸

In the Philippines, a national survey carried out in 2004 showed that more than two-thirds of abortion seekers among the poor had unsafe abortions using risky methods such as herbal and hormonal drugs and massage as compared with less than 50% of non-poor women.⁵⁹

More than 70% of the women who had used massage or inserted a catheter experienced serious complications as

compared to the 13% recorded among women who had terminated their pregnancy through Dilatation and Curettage (D&C).

Figure 14. Differentials in maternal mortality across wealth quintiles, Indonesia 1994 and 1997.



Source: Graham, W. J., Fitzmaurice, A., Bell, J. S., & Cairns, J. A. (2004). The familial technique for linking maternal death with poverty. *The Lancet*, 363, 23-27.

Pakistan is another country where safe abortion is legally restricted to circumstances where the woman's life is at stake. A higher proportion of poorer Pakistani women were reported to experience post-abortion complications as compared to their better-off peers (45% vs. 31%), a difference arising probably from their greater likelihood of using unsafe abortions.⁶¹

Economic barriers to safe abortion exist also in countries with relatively liberal abortion laws. According to the Demographic and Health Survey of Cambodia (2005), 12% of all abortions had taken place at home and 13% were helped by either a traditional birth attendant or relatives and friends. Limited availability or social and economic barriers may have contributed to this situation.⁶²

In India, women frequently mentioned lack of financial resources as a major barrier to accessing safe abortion services. This may be surprising, given that safe

Table 16. Non-utilization of antenatal care services by wealth quintiles, selected countries of the Asia-Pacific

Country	Year	Percentage not receiving any antenatal care (% women age 15-49 who had a live birth in the 5 years preceding the survey, most recent pregnancy)					
		Low	2 nd	3rd	4th	High	Pop. Average
		Afghanistan	2010	51.1	38.1	37.3	37.3
Bangladesh	2007	58.3	52.4	41.1	27.9	13.6	39.6
Cambodia	2010	19.7	13.8	7.5	4.4	1.5	10.2
India	2005/06	41.3	30.7	19.9	10.0	2.6	22.8
Indonesia	2007	11.5	4.7	2.7	0.7	0.4	4.2
Kiribati	2009	3.2	4.2	6.7	1.3	0.0	3.3
Maldives	2009	0.8	0.4	0.1	0.0	0.0	0.3
Nepal	2011	32.9	18.5	9.2	6.3	2.0	15.2
Pakistan	2006/07	59.0	47.3	33.0	20.5	6.4	34.7
Philippines	2009	8.2	4.1	2.6	1.1	1.5	3.8
Samoa	2009	8.1	4.1	1.8	2.8	0.4	3.6

Source: Latest DHS data for countries⁶³

abortion services are supposed to be provided free of cost in government health facilities. Studies show that the lowest cost for an abortion in a public facility was Indian Rupees (INR) 135 in the late 1990s, constituting more than half of the monthly per capita expenditure of the poorest 12% of India's population.⁶³ The median cost of abortion in a private facility in one state was reported to be INR 1293.⁶⁴ which exceeded the total monthly per capita expenditure of 81% of the population in 2004-05.⁶⁵

Those who cannot afford the cost of an abortion in a health facility are forced to seek the services of unqualified providers at considerable risk to their lives and wellbeing. In a rural Tamil Nadu district with a wide network of abortion service providers, 12 of 97 abortion seekers included in a study used unqualified and

unsafe providers. Eight went to M..., who had only secondary level education and had learned to perform Dilatation and Curettage as assistant to a medical doctor because she charged only Rs 200-300. This was despite her poor track record, of three deaths and numerous instances of serious post-abortion complications during the five years preceding the study. Four of the poorest women went to a traditional abortionist who used even less safe methods.⁶⁶

The interaction of poverty with education and awareness may also contribute to unsafe abortion among women from the lowest wealth quintile. In Nepal, the abortion law was liberalized in the early

Table 17. Comprehensive knowledge of AIDS among women by wealth quintiles, selected countries of the Asia-Pacific

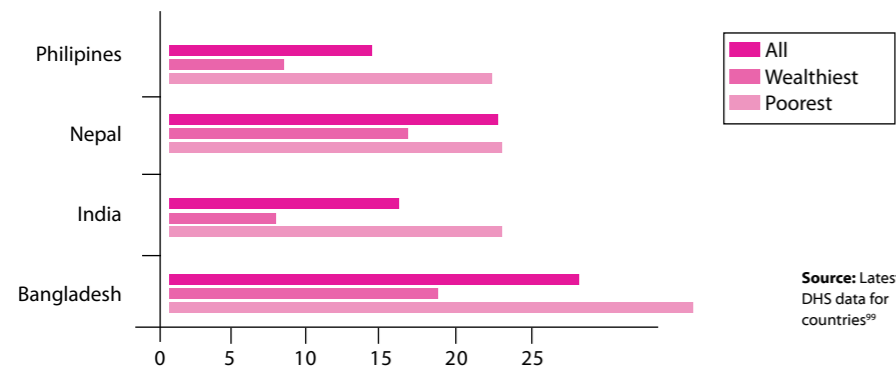
Country	Year	Percentage of women with comprehensive knowledge of AIDS					
		Low	2 nd	3rd	4 th	High	Pop. Average
		Bangladesh\$	2007	1.2	2.4	3.1	7.9
Cambodia	2010	25.7	32.3	36.9	47.2	56.7	40.8
India (HIV/AIDS)	2005/06	2.5	5.2	10.6	21.4	41.4	17.3
Indonesia\$	2007	1.9	3.8	7.1	10.7	21.7	9.1
Kiribati	2009	43.4	44.9	46.6	44.2	49.7	45.8
Maldives\$	2009	32.4	36.9	39.3	45.4	52.1	41.5
Nepal	2011	5.8	11.0	14.2	25.9	40.8	20.7
Pakistan	2006/07	0.7	1.2	3.2	5.4	14.1	5.1
Philippines	2009	11.5	15.3	19.3	25.9	31.8	21.9
Samoa	2009	3.0	3.3	3.9	3.2	6.0	3.9

\$ Data refer to ever-married women

Comprehensive knowledge means knowing that consistent use of a condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about AIDS transmission or prevention

Source: Latest DHS for countries.⁶⁶

Figure 15: Life time experience of spousal sexual violence



Source: Latest DHS data for countries⁹⁹

years of the new millennium. In 2011, only 21.8% of the poorest women knew that abortion was legal in Nepal and 40% knew where to obtain abortion services. Comparable figures for the richest women were 53.9% and 70.8%.⁶⁷

3.3 Maternal Survival And Access To Skilled Birth Attendance

Experiences of countries in Europe have demonstrated the association between poverty and maternal survival.⁶⁸ However, data for developing countries comparing maternal mortality ratios across wealth quintiles is limited. A 2004 paper by Graham et al was the first time differentials in maternal mortality by wealth quintiles and by living conditions were calculated using DHS data for ten countries including Indonesia, Nepal, and the Philippines.⁶⁹

There was a significant association between survival and women's educational level, source of water, type of toilet and floor and wealth, all of which

may be considered as proxy indicators of poverty status. Further analysis was done from data for Indonesia based on the DHS surveys of 1994 and 1997. Women from the poorest quintile accounted for about a third of all maternal deaths for both data sets, and were 3-4 times more likely to die of pregnancy-related causes than their richest women (Figure 14).

Table 18: Median age at first marriage by wealth quintiles, selected countries of the Asia-Pacific

Country	Year	Median age at first marriage (25-49) (women age 25-49)						Pop. Average
		Low	2 nd	3 rd	4 th	High		
Afghanistan	2010	16.6	17.0	17.9	18.3	18.5	17.7	
Bangladesh	2007	14.3	14.7	14.9	15.2	16.4	15.0	
Cambodia	2010	20.2	19.9	19.9	20.0	21.7	20.3	
India	2005/06	15.4	15.6	16.3	17.5	19.7	16.8	
Indonesia	2007	18.7	18.5	19.1	19.9	21.9	19.8	
Kiribati	2009	19.1	19.6	20.0	20.6	21.5	20.1	
Maldives	2009	18.2	18.3	18.6	19.6	21.1	19.0	
Nepal	2011	20.4	20.3	20.3	21.9	24.6	21.6	
Pakistan	2006/07	17.7	18.7	18.9	19.2	20.7	19.1	
Philippines	2009	19.4	20.7	21.6	23.9	*	22.1	
Samoa	2009	n.a	n.a	n.a	n.a	n.a	n.a	

Source: Latest DHS data for countries.¹⁰⁶

Differentials in risk of maternal death arise from a complex interaction of poverty and other sources of deprivation including but not restricted to unavailability of maternal health services or economic barriers to accessing the services. Gender and social inequalities play a major role in increasing risk of experiencing pregnancy-related complications as well as in limiting access to essential medical care during pregnancy.

For example, in Kerala, India, which has near universal institutional deliveries, 64% of maternal deaths in the district of Wayanad in 2010-11 were among women from the tribal communities who constituted only 17 % of the population. Delay in decision to seek medical help was associated with lack of knowledge, non-availability of transportation, lack of money and of social support, lack of decision-making power as women, and fear of the formal health system.

Table 19: Childbearing among women age 15-19 years by wealth quintiles, selected countries of the Asia-Pacific

Country	Year	Percentage of women aged 15-19 years who have begun childbearing					
		Low	2 nd	3 rd	4 th	High	Pop. Average
Afghanistan	2010	14.0	12.9	12.1	12.1	10.0	12.2
Bangladesh	2007	41.5	39.6	33.8	33.5	19.7	32.7
Cambodia	2010	13.3	10.9	9.1	6.5	4.0	8.2
India	2005/06	25.3	21.9	16.3	11.7	5.1	16.0
Indonesia	2007	5.9	6.4	9.8	16.8	9.6	8.5
Kiribati	2009	(18.8)	(11.6)	14.1	7.4	5.2	10.2
Maldives	2009	3.6	1.1	2.4	1.0	2.0	2.1
Nepal	2011	18.4	20.6	22.1	14.4	6.7	16.7
Pakistan	2006/07	15.8	11.6	7.8	8.0	4.0	9.1
Samoa	2009	13.3	10.9	9.2	8.6	5.5	9.4

Source: Latest DHS data for countries.¹⁰⁸

There was also considerable delay in receiving treatment even after reaching a health facility, and women were referred from one referral unit to another before receiving definitive treatment which came too late to save their lives.⁷⁰

Data from other countries of the Region also show that women from ethnic minorities are particularly vulnerable to pregnancy-related death. The maternal mortality ratio in the Highland areas of Vietnam where ethnic minorities are concentrated was found to be almost 10 times as high as that in the lowland areas.⁷¹

The Autonomous Region of Muslim Mindanao (ARRM) has a maternal mortality ratio 320 per 100,000 live births as against the national average of 96. In the Tibet province of China, again, has an estimated maternal mortality ratio (466

per 100,000 live births) that is more than 10 times the national average of 43 per 100,000.⁷²

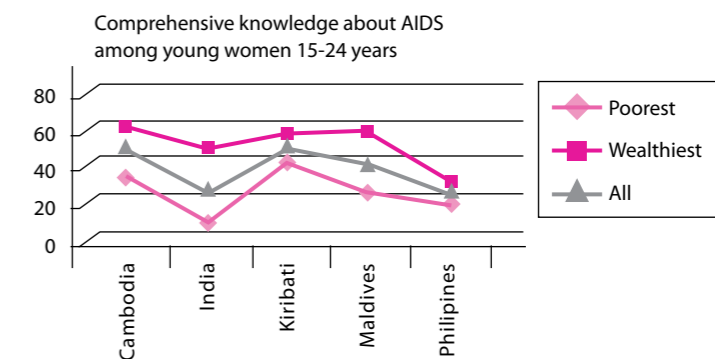
The role of skilled birth attendance in preventing maternal deaths is well known, and is one reason why the proportion

receiving skilled attendance in delivery is one of the indicators for MDG 5. There are substantial inequalities across wealth quintiles in terms of access to skilled attendance during delivery (Table 15).

Less than half of the poorest women in 8 of 11 (less than a fifth in five of these) countries had their child deliveries attended by a skilled provider. In countries of South Asia, the richest women were 4 to 10 times more likely to have skilled attendance at delivery compared to their poorer counterparts. The gap was widest in Bangladesh where less than 10% of women from the lowest wealth quintile had skilled delivery care. In Kiribati, Maldives, and Samoa, poorer women had much better access to skilled delivery care and the gaps between the poor and the rich were also much narrower.

Huge rich-poor inequalities in maternity care are not a phenomenon unique to this Region. Analysis of DHS data for 45 developing countries confirms this pattern across all the countries, and

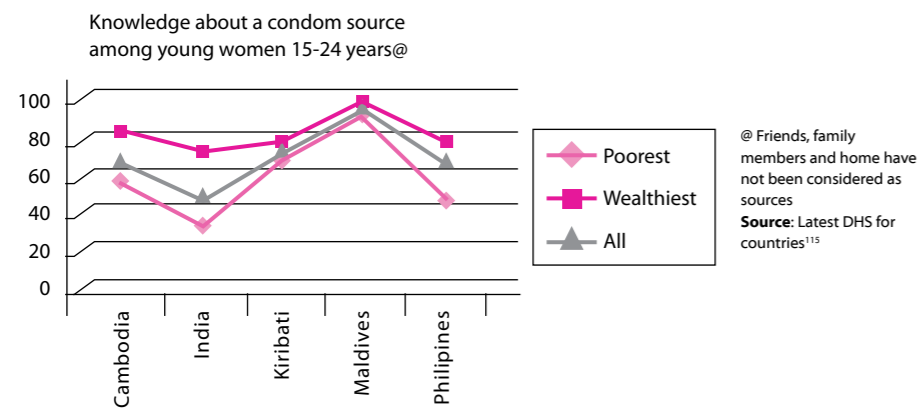
Figure 16: Comprehensive Knowledge about AIDS among young women 15-24 years



Comprehensive knowledge means knowing that consistent use of a condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about AIDS transmission or prevention

Source: Latest DHS for countries¹¹⁴

Figure 17: Knowledge about a condom source among young women 15-24 years



showed further that inequalities in access to skilled birth attendance are much larger than inequalities in access to other health services such as immunization and antenatal care.⁷⁴

Countries such as Indonesia have succeeded in narrowing the rich-poor gap through their investment in community midwives. Since 1991, when the community midwife programme was launched, the rate of professionally attended deliveries have increased at a much faster rate among the poorest (11%) as compared to the middle (6%) wealth quintiles.⁷⁵ At the same time, the barrier posed by cost in accessing skilled midwifery still persisted in some rural areas. A 2010 study in West Java, Indonesia found cost to be one of the main reasons why village women preferred to use the traditional birth attendant:

“...we don't have much money. We need to pay around 400 (400,000 rupiah ~USD 40) for a village midwife. For a traditional birth attendant...we can pay around 100

(100,000 rupiah ~ USD10)...just depends on how much we have. We can even pay them by instalments...”- FGD with mothers.⁷⁶ The use of *Jamkesmas* cards that enable poor women to access free health care was low. Reasons included misunderstanding that this could only be used with government midwives and not private ones; being ashamed of using services without paying anything; and fear that card-users will be neglected by health-care providers.⁷⁷

DHS data often report a substantial proportion of women reporting reason for non-use of a specific medical service as “no need”. A study in Dhaka, Bangladesh unravels the many nuances buried deep within this statement. Survey data showed that 86% of women who did not use SBA services during their delivery had said that it was not needed.

Further probing through in-depth interviews found that for poor women, institutional delivery was costly, the health facility – an alien and unfriendly setting – where others did not share the woman's

own perceptions of disease causation, and where the woman usually had no one by her side to support her during labour. The absence of a lady doctor was another important factor.⁷⁸

There appears to be a much wider gap in access to emergency-obstetric care (as compared to skilled birth attendance) as indicated by differentials in c-section rates across socio-economic status in Bangladesh.

A study using DHS data sets for 1991-2004 found that the c-section rate among urban women with secondary or higher education in the top asset quintile was 34.8% as compared to only 0.1% among rural women with no education in the lowest asset quintile.⁷⁹ In Indonesia, even as coverage by skilled birth attendance increased, the gap in c-section rates widened. C-section rates remained at less than 1% for the bottom two-fifths of the population while it rose to 10% for the top fifth.⁸⁰

3.4 Antenatal Care

Antenatal care is meant to prepare the woman for birth and parenthood, and also an opportunity to detect, prevent or manage complications related to pregnancy itself; previously existing health conditions exacerbated by pregnancy; and risks related to unhealthy lifestyle. Antenatal care is only effective in achieving these aims if essential evidence-based interventions are delivered during antenatal visits. However, the poorest women in the world do not receive any antenatal care. Between 40-60% of the poorest women in Afghanistan,

Bangladesh, India and Pakistan, and about a third in Nepal did not receive any antenatal care, according to the Demographic and Health Surveys carried out during 2001-10.⁸¹

While the proportions of poor women deprived of antenatal care in countries of SE Asia and the Pacific are relatively low, there were wide gaps between the poorest and richest women in terms of non-utilization, with 5-28 times more women from the poorest groups not utilizing antenatal care as compared to women from the richest groups (Table 16).

A scrutiny of the data on components of antenatal care received by women (not in the table) shows that across all countries, poor women were less likely to have their blood samples taken and urine tested for protein-urea as compared to their better-off counterparts, compromising early detection of the presence and severity of anaemia or the risk of pre-eclampsia.⁸²

3.5 Maternal Morbidity

Poor access to skilled birth attendance and especially to emergency obstetric care not only kills; those who survive may live with serious and debilitating long-term health consequences. Obstetric fistula is a serious injury associated with prolonged and/or obstructed labour which remains untreated; and with poorly performed forceps deliveries.

It is a hole in the vagina or rectum which causes urine or faeces, or both to leak. Left untreated, fistula can lead to chronic medical problems. An estimated 2 million women in sub-Saharan Africa, South Asia,

and the Arab region are living with fistula, and some 50 to 100 thousand new cases develop each year.⁸⁴

Obstetric fistula is believed to be much more prevalent among poor women than women who are better-off. Young age and chronic undernutrition is associated with a small pelvis in the mother, contributing to a higher risk of obstructed labour. Inability to access skilled birth attendance and especially c-sections are clearly more prevalent among the poorest sections of women. In turn, obstetric fistulae plunge women deeper into poverty because they face social isolation including marital breakdown; may not be able to find employment; and also because of the high cost of surgical repair of fistulae.

The Pakistan DHS (2006/07) provides some data on self-reported prevalence of fistula by wealth quintiles. The overall reported prevalence was 3% and varied between 2.6% and 3.6% across wealth quintiles, showing no specific pattern associated with wealth.⁸⁵

Utero-vaginal prolapse is another long-term morbidity associated with maternity especially when it occurs at younger ages. Studies from South Asia indicate a high prevalence of utero-vaginal Prolapse.⁸⁶ The linkages to poverty have not been systematically studied.

One qualitative study from South India among poor women who worked as agricultural labourers reported that most women ascribed the early onset (mean age: 26 years) of utero-vaginal prolapse due to heavy manual labour carried out within a week or fortnight

following delivery. Over the years, the condition caused chronic problems of the genital and urinary tract, and eventually made agricultural wage work almost impossible.⁸⁷ In Nepal, a hospital-based study of women reporting with utero-vaginal Prolapse found that teenage pregnancy, poor nutrition, unskilled assistance at delivery and resumption of work soon after delivery were all underlying factors.⁸⁸

In addition to the risk of higher physical morbidity, poorer women are also at a higher risk of psychological morbidity during pregnancy, delivery, and the puerperium. In Indonesia, depression in late pregnancy and early postpartum was related among other factors, to husband's unemployment and insufficient family income because the woman had given up work during pregnancy.⁸⁹ In India, low income, birth of a daughter when a son was desired, and lack of physical help for the mother, and poor marital relations have all been reported as risk factors for postpartum depression.⁹⁰

3.6 HIV/AIDS

The bidirectional and complex linkage between poverty and HIV/AIDS has come to be acknowledged during the past couple of decades.⁹¹ The heightened vulnerability of low-income women because of the interaction between poverty, biology and gender-based disadvantages has also been highlighted by several publications.⁹² However, there are no large data sets, for example, from national surveys that have clearly established this linkage. A 2009 review examined the interactions of financial

status and HIV with a focus on its implications for women. It concluded that poverty increased women's vulnerability to HIV. It noted that the evidence of the association between increasing wealth and poverty could not be disregarded although no clear conclusions could be reached because of methodological limitations.⁹³

A study carried out in Thailand found that people from the poorest households were the most likely to be infected with HIV.⁹⁴ While we do not have such evidence for other countries in the Region, there is sufficient data to show that they are disproportionately exposed to risks such as lack of access to critical information and services on STIs and HIV prevention; migration of self or of partner in search of employment; being trafficked or pushed into commercial sex work and intimate partner sexual violence.

There is a clear social gradient in the proportion of women with comprehensive knowledge of AIDS (Table 17). In Cambodia (2010), the proportion of women ever-tested for HIV was 17.1 in the lowest wealth quintile, and more than double of that amount (37.1) in the highest wealth quintile.⁹⁵

Violence – both at the community and at the household level – is one route through which poverty increases vulnerability to HIV in women. For example, in Nepal, the HIV prevalence in Kathmandu is reported to have increased from 2.7% in 1999, at the beginning of the Maoist insurgency, to 17% in 2002⁹⁷ and it may be reasonably assumed that those living and working in insecure conditions may be more affected.

Women from the poorer sections of the population are often at greater risk of sexual violence by their intimate partners, as shown by the most recent DHS data for four countries in the Region: Bangladesh, India, Nepal, and the Philippines.⁹⁸ This is also an example of violation of a sexual right contributing to poor sexual health.

Poorer women are also more likely to experience physical violence.¹⁰⁰ Both physical and sexual violence compromises women's ability to negotiate safe sex with their partners. For example, a study on the health consequences of intimate partner violence in Melanesia found that 27% of women in Tonga and 42% women in Vanuatu said that they had not used condoms at 'last sex' because their partners did not agree to it.¹⁰¹

3.7 Young People's Sexual And Reproductive Health And Rights

Rapidly changing economic circumstances and increasing income inequalities in the Region imply that the context in which young people make sexual and reproductive choices has also changed considerably. To begin with, age at menarche is declining while age at marriage has increased across the Region.

This increases the likelihood of sexual debut outside marriage. A 2001 study of 875 young people aged 15-24 years in Medan-Sumatra, Indonesia found that 27% of the men and 9% of the women had their first sexual experience before marriage.¹⁰²

There is great diversity across and within countries in the situation of

young people. In some countries and sub-regions of countries many young people live away from home studying or as migrant workers, living with peers rather than within a family setting. There is much greater exposure to media, better means of social networking through telecommunications and opportunities to interact with members of the opposite sex. This also exposes them to greater risks and vulnerabilities.

For example, during 2005-2009, 15% of adolescent girls in Nauru and Solomon Islands, and 9% in Lao PDR had their sexual debut before the age of 15. Data from the Philippines shows that 14.7% of adolescents who had their sexual debut before 15 years had been forced against their will, suggesting a potential association between younger age at sexual debut may be associated with greater likelihood of forced sex.

In other countries, sexual debut in adolescence happens predominantly within marriage. Early marriage and childbearing, and traditional attitudes to sexuality and reproduction continue to govern the lives and choices of young women.¹⁰³ Hard evidence is limited on the ways in which poverty impacts the sexual and reproductive health and rights of adolescents and young people in the Asia-Pacific Region.

Data sets available from Demographic and Health Surveys revolve mainly around differentials across wealth quintiles in age at marriage and childbearing, contraceptive use, knowledge about HIV, and access to condoms, and in a few instances, about risky sexual behaviour.

3.8 Median Age At Marriage

According to the latest DHS data, early marriage was closely associated with relative economic status. The median age at first marriage for the poorest women age 25-49 was below 18 years in 4 of 10 countries in the Region according to latest DHS data: Bangladesh (14.3 years), India (15.4 years), Afghanistan (16.6 years), and Pakistan (17.7 years). Across all 10 countries,¹⁰⁴ women from the lower quintiles tend to get married 2-4 years earlier than their better-off counterparts (Table 18).

Poorer households in Asia tend to marry their girls off at an early age – as seen above, well before 18 years in some countries, for a number of reasons. One is to ensure that the girl has her sexual debut within marriage and preserves the family's honour.

This is especially so in situations of insecurity such as in urban slums, and during periods of civil unrest and conflict. It is also part of the survival strategies of rural poor – bringing in a daughter-in-law means one additional hand for working the family farm, while reducing the burden on the natal family.

In societies where dowry is widely prevalent, younger women are also considered to be more marriageable and therefore, likely to cost lower dowry for the household. In turn, early marriage increases women's vulnerability to poverty because they have fewer years of education and limited personal capacities.¹⁰⁵ One immediate consequence of early marriage is early childbearing.

A clear gradient by wealth quintiles can be observed in the 10 countries in the proportion of young women aged 15-19 who have begun childbearing (Table 19).

The proportion of young women who have begun childbearing is highest in Bangladesh (41.5%) followed by India (25.3%), while Maldives (3.6%) and Indonesia (5.9%) have the lowest proportions. India and Pakistan have the widest gaps between the poorest and wealthiest quintiles – five times and four times as many young women from the poorest groups respectively have begun childbearing as compared to those from the wealthiest group. The survival and morbidity risks associated with childbearing is much higher for younger than older women, and the interaction with poverty and limited resources would further accentuate this risk.

Young women living in poverty may not have much of a say in deciding whether and when to begin childbearing and also whether or not to continue with a pregnancy. A qualitative study of young women living in Dhaka (Bangladesh) slums clearly illustrates the many forces depriving women of control over fertility.

About 72% of 153 women reported that they were coerced into childbearing soon after marriage. Because of the prevailing situation of high unemployment among men and substance-use, marriages were not stable and women went along with the pregnancy if their husbands insisted, for two reasons.

One was that a child could make the man more responsible in terms of earning a living to provide for the child; and the

second was that a child would ensure that the woman got financial support even in case the marriage broke-down. Bearing a child was also seen as having fulfilled an obligation and therefore, women could demand more of their husbands. Termination of pregnancy was also a choice that was not entirely the woman's own. Some women living in extreme poverty were pressured by their families to terminate a pregnancy so that they could keep their jobs and continue to bring in an income.¹⁰⁷

Poverty has also been found to be a driver of risky sexual behaviour. In a study among young women aged 12-19 years in four African countries, poorer women were more likely to initiate first sex before the age of 16 years and less likely to use condoms. According to the authors, this could have been in order to have access to cash and gifts but also because of early exposure and socialization into sexual activity among the poorer women.¹⁰⁹

In Cot D'Ivoire, young women with multiple disadvantages in terms of their own and their parents'/guardians' education and occupation were found to be more likely to adopt risky social behaviours. These included early commencement of sexual activity, multiple partners and non-use of condom. These same associations were not true for men living under the same circumstances.¹¹⁰

High risk sexual behaviour among out-of-school young men from an urban slum qualitative study is reported in a study from Jakarta, Indonesia. Young men faced considerable peer pressure to engage

in drug use followed by sex with a sex worker. Infection (STI) was not necessarily seen as 'negative' but more as evidence of "masculinity" and "sexual prowess".¹¹¹

DHS data for Kiribati shows that early sexual debut (< 15 yrs) and high risk sexual intercourse during the past 12 months were inversely associated with wealth status for young women. In the case of young men, a greater proportion in the higher wealth quintiles had early sexual debut. High risk sexual behaviour during the past 12 months was uniformly very high (above 75%) across all wealth quintiles.¹¹² Interestingly, in the Philippines while the same relationship between early sexual debut and wealth was seen for young women, high risk sexual behaviour among young women increased with wealth.¹¹³

A smaller proportion of young women from poorer households had comprehensive knowledge about AIDS and its prevention as compared to those from better-off households (Figure 17). A relatively higher proportion knew where to access condoms from, but the differentials by wealth status persisted.

Poor access to health services would make young people from deprived backgrounds more vulnerable to morbidity and mortality related to HIV/AIDS. The prevalence of HIV is generally low (0.1% or below) in most countries of the Region, including among young people. However in the Pacific Region, the proportion of young people (15-24 years) among those infected with HIV rose to 26.5% during 2000-2004 from only 19.5% during the 1990s. In Papua New Guinea,

the prevalence rate in 2009 was more than twice as high among young women (0.8%) compared to young men (0.3%).¹¹⁶

4.0 Summary And An Agenda For Action

This paper has examined evidence from Demographic and Health Surveys that links poverty to sexual and reproductive health and rights of women and young people in the Asia-Pacific Region. Poverty compromises the potential to enjoy good sexual and reproductive health throughout the life cycle – starting from low birth weight because of being born to poor mothers; growing up deprived of adequate nutrition to become undernourished and stunted women; living in low quality shelters that expose them to multiple infections; having limited opportunities for adequate educational attainment; employed in back-breaking and hazardous occupations, exposed to risk of sexual debut barely into teenage years including through sexual violence; married or cohabiting early and giving birth as a teenager with associated risks of death and disability; with limited ability to control one's sexual and reproductive life, and little or no access to quality health care.

In this paper, the examination of cross-sectional data across varied countries limits our understanding of the dynamic interaction between poverty and sexual and reproductive health, and the

cumulative impact of this on women's health and lives at various stages in their life-cycle. Longitudinal studies documenting women's sexual and reproductive histories and changes in life situations would yield a much more in-depth and substantive understanding of such dynamic interaction.

Despite this limitation, the evidence leaves no doubt that unless poverty and associated disadvantages and vulnerabilities are addressed, ICPD goals will remain a distant dream for many countries and population groups. There are some lessons for action that emerge from the data. The most important of these is that there are some not-so-rich countries, which have managed to achieve better sexual and reproductive health for their poorest women as compared to their counterparts. For example, contraceptive use among the poorest women could be substantial and not very far behind that of their better-off counterparts in countries such as Bangladesh, Cambodia, India, Indonesia, and Nepal. A similar finding is reported by a study based on 110 DHS from Asia, Africa, and Latin America covering the period 1985-2003.

The study concludes that these variations are associated with the availability of affordable contraceptive services within a country.¹¹⁷ In other words, availability of publicly financed and affordable contraceptive services is an important determinant of modern contraceptive use among the poorest populations in a country.

One observes also that in Cambodia, access to comprehensive information

on AIDS among the poorest women is much better than in many other countries, because of a strong National AIDS Control Program.¹¹⁸ It may, therefore, be hypothesized that strong publicly financed health systems that make quality services affordable will help bridge the gap between the rich and the poor in access to health care.

An expanded hypothesis would be that public policies that promote food security, invest in better living conditions; eliminating hazardous working conditions; and promoting gender equity and equality are the need of the hour if we are to achieve ICPD goals. Further research and analysis of existing data sets will help verify these hypotheses.

The second lesson is that ICPD's broad goals themselves need to be modified to include equity considerations. Thus, in addition to goals that call for increasing 'average' maternal mortality ratios and other sexual and reproductive health indicators, there should be goals related to reducing inequities in sexual and reproductive health and health care access. This in turn will encourage the collection and analysis of data by economic and social status and other axes of social inequalities.

Thirdly, more research and more funding to enable the research are needed, which will unravel the several layers of interconnections between poverty and poor sexual and reproductive health, so that policy and programme interventions are better informed and designed. There is a serious dearth of information especially about young people living in poverty,

in rural as well as in urban areas of the Region, and this needs to become a major research priority in the years to come.

These are but interim measures. Universal access to sexual and reproductive health cannot be realized without the eradication of poverty and bridging the inequality gap across population sub-groups. This would mean, in the words of the WHO Commission on Social Determinants of Health, tackling the inequitable distribution of power, money, and resources that underlie health inequities.

In turn, this would not be possible without a major structural change altering the rules of the game to enable inclusive, equitable, and holistic human development rather than economic growth at the cost of human well-being.

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Thematic paper 3:
**Navigating Borders,
Negotiating Bodies:**
Sexual and Reproductive Health and
Rights of Women and Young Migrant
Workers in Asia-Pacific Region¹

by Maria Lourdes Marin

1. Introduction

In 2010, the total number of international migrants worldwide was estimated to be 214 million persons.² Of these, Asia accounted for 27.5 million, representing close to 13% of the total global figure.³ Almost half of all international migrants from Asia (48%) are women. Approximately 37% of Asian migrants move to OECD (Organization for Economic Co-operation and Development) member countries; of the remainder, 43% migrate within the region and the rest migrate to other countries outside the region. Among the top ten emigration countries worldwide, five are from Asia, namely: China, Bangladesh, India, Pakistan and the Philippines.⁴ In the Pacific, there were approximately six million international migrants in 2010, of which 51.3% were women from ages 20-64.⁵ In 2010, Asian and Pacific countries collectively hosted 25% of the world's foreign population or roughly 53 million persons.

In today's modern world, the movement of people is an ordinary phenomenon. Mediated by a range of motivations, either by necessity or force or of their own volition, people move from their places of origin to destinations, both known and unknown. 'Forced' migration, as defined widely, refers to 'the movement of refugees and internally displaced people (e.g. those displaced by ethnic or political conflicts), as well as people displaced by natural or environmental disasters, wars, famine, or development projects,' among others.⁶

The predominant reason why individuals and families migrate is economic, either for survival among the poor or as a means to achieve more financial prosperity for

those who are in already economically stable situations.

Migration, especially in the South and South East Asian sub-regions, is dominated by labour migration, with over 1.2 million of the almost 10.2 million migrants from the region working in Malaysia alone. The Philippines is one of the countries that is most affected by global labour migration, with an estimated 3.8 million contract workers abroad.⁷

In 2010, a significant number of migrant workers from Bangladesh, Indonesia, Nepal and the Philippines were employed in Malaysia and Singapore, while Thailand remained as the major destination for migrants from neighbouring countries – Cambodia, the Lao People's Democratic Republic and Myanmar. However, temporary labour migration towards the Middle East and, in particular, the Gulf Cooperation Council (GCC) countries, represented the dominant flow.⁸

Apart from labour migration, the Asian region also saw the movement or displacement of people due to disasters and conflicts. In 2010, the estimated global number of displaced persons due to sudden-onset natural disasters was over 42 million.⁹ Asia was one of the worst hit regions by several natural disasters that affected millions of people and displaced many of them, internally. Bangladesh and Indonesia were the top two at "extreme risk" of natural disasters in the Natural Risk Index 2010. China and Pakistan experienced unusually heavy floods in mid-2010, which displaced over 15 million and 11 million

people, respectively.¹⁰ In the same year, Bangladesh, China and the Philippines also experienced severe storms.¹¹

The Pacific region has a strong tradition of mobility. Migration patterns vary from country to country, and within each country. The primary motive for migration is economic, although political, environmental, and cultural considerations also affect flows.¹²

Movements are characterised mainly by rural to urban internal migration, as well as by international labour migration across the islands. Migration for work is predominant among men, who work in the maritime and transport sector, and in the military.

With regard to refugees, in 2009, there were 3.9 million in Asia, up from 2.9 million in 2005. Asian refugees accounted for 14% of all international migrants in the region and almost a quarter of the world's refugees.¹³

2. Gender, Sexuality And Reproductive Health Issues In Migration

Migration, as a process and an experience, plays out differently for women and men. Experience shows that migration can provide new opportunities to improve women's lives and change oppressive gender relations.¹⁴ Women, who migrate successfully, can tip the power scales

in their favour, in situations when their financial contribution determines the survival or improved economic status of their families. Conversely, migration can also entrench traditional roles and inequalities, and expose women to new vulnerabilities as the result of precarious legal status, exclusion and isolation.¹⁵ This is true in the case of women migrant workers who are often employed in the most informal, irregular and unregulated sectors such as domestic and entertainment work.

Women, who migrate, have to negotiate and restructure their household arrangements, especially if they have male spouses or partners and children. This may entail having their male partners assume the 'reproductive role', e.g. managing the household and taking care of the children, while they assume the 'productive' role of earning an income for the family. This arrangement may not be without problems. Studies about how a feminized migration has altered concepts and expressions of masculinities of male spouses and partners, who are left behind, have been documented in a number of places.¹⁶

Labour migration has particular gender dimensions, beginning with the demographic profile of migrants leaving for overseas employment. In the Philippines, domestic and household workers make up the single largest group of newly-hired overseas contract workers at any given year. Almost 80% of all Indonesian migrant workers are women and 88% work in the informal sector.¹⁷ In Sri Lanka, 42% of all overseas workers in 2010 were female domestic

workers, mostly deployed to Middle East countries.¹⁸

In some countries in South Asia, such as Bangladesh, Pakistan and Sri Lanka, women who move are regarded as transgressing cultural norms. In Sri Lanka, the repercussions for women migrating are severe and can include poor reputations within families and communities, marital disputes, inability to marry, and physical and sexual abuse. Despite their economic contributions, they are seen within Sri Lankan families and wider communities, as well as within national discourses, to be women with loose morals.¹⁹

The gender dimensions of migration are nowhere more pronounced and evident than in the area of sexual and reproductive health and rights (SRHR). Reproductive health, as contained in the framework documents of the International Conference on Population and Development (ICPD), is defined as:

[the] state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so... It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.²⁰

Conceptually, SRHR encompasses the totality of a person's sexual and gendered existence, involving a range of domains, which include identity, beliefs, attitudes, expressions and behaviour. Its complexity is even more heightened in the case of migrants who straddle a transnational existence and simultaneously live multi-located selves. When migrant workers get transported into another location, they maintain their familial and social connections and ties to their places of origin while, at the same time, they renegotiate and establish a new set of social linkages and relationships in their places of destination.²¹

This has implications on their sexual and reproductive health, and implies the necessity for them to navigate the boundaries of a temporary existence and remote location vis-à-vis their bodily desires, behavioural intentions and subsequent actions.

Sexuality is an area of human behaviour, emotion, and understanding which is often thought of as "natural" and "private" even though it is simultaneously an area of constant surveillance and control.²² In national and global discourses around human development, human rights, health and gender equality, sexual and reproductive health and rights are among the most contested domains. Most countries enforce policies and laws that regulate the sexual and reproductive health and rights of their citizens. These include laws and policies pertaining to family planning, population management, maternal and child health, HIV and AIDS, and access to comprehensive SRH services, among others.

In the case of migrant workers, their sexuality and reproductive health are subject to state regulations and policies. Migrant workers are expected to conform to these rules and any infraction could cost them their jobs, legal status, liberty and in extreme cases, their life. These controls and restraints begin even before they leave the country of origin. Those who go through regular channels, i.e. with fully authenticated documentation of their identities, have to comply with requirements imposed by both their country of origin and destination.

For example, migrant domestic workers are compelled to undertake tests for pregnancy, sexually-transmitted infections (STIs) and HIV as a requirement for overseas work in the Gulf States and in Asian countries such as Singapore and Malaysia. As an added feature, there are recruitment agencies that give women contraceptives such as birth control pills or injectable medroxyprogesterone, commonly distributed under the brand name Depo-Provera to prevent pregnancy.

In Sri Lanka, birth control medications are administered at the request of the hiring agent to reduce the number of women who go abroad and have to return due to pregnancy.²³ While this enables women migrant workers to have access to contraception, it is administered without their consent and thus, violates their right to privacy and bodily integrity.

In some countries, pre-departure trainings become a tool to teach the workers how to be a "good worker", which means being subservient, obedient and "not creating

trouble". This is also where gender norms are emphasized, including the proper way of dressing (e.g. not wearing sexy or revealing clothes) and grooming. Information about rights is not very forthcoming, nor are there substantial discussions pertaining to provisions in their work contracts.

Pre-departure seminar providers in the Philippines are mandated to provide information on the destination country's culture and laws, much of which deal with prescribed conduct and behaviour of foreign workers. Despite this, there are still many reports of migrants who get arrested, incarcerated, punished, and in many cases, deported, for violating the foreign country's laws or policies against immorality, indecency and the like.

In recent years, pre-departure programmes in countries such as Sri Lanka, Indonesia and the Philippines have touched on SRHR issues, but these are specifically focused on HIV and AIDS, and STI prevention. However, the modules only include basic HIV education and put too much emphasis on individual agency and behaviour change. This does not always bode well for women migrant workers who are often placed in vulnerable situations, which are beyond their control.

An assessment of the Indonesian HIV education in the pre-departure programme notes that "a migrant woman's vulnerability to HIV does not rest solely on her own actions and, as such, the programme tends to 'blame' these women rather than raise the levels of protection."²⁴

3. Factors That Influence Sexual And Reproductive Health Behaviours And Outcomes Of Women Migrant Workers

Migrants travel with their epidemiological profiles, their level of exposure to infectious agents, their genetic and lifestyle-related risk factors, their culture-based health beliefs, and their susceptibility to certain conditions.²⁵

They also travel with their sexual histories and SRH notions and practices. In many areas of the world, it has been demonstrated that the availability of and access to health and medical services can have major impact on health outcomes.²⁶ When populations are able to access and avail health services, diseases are prevented or their progression is delayed and the overall cost of treatment for such diseases does not overburden the public health system. However, migrant workers, who are on temporary status, often fall within the cracks of the health system, in both countries of origin and destination.

Once migrants move to the country of destination, their overall status is mediated by a combination of determinants: their legal status; economic condition; social connectivity (both in the new and home country); education levels; psycho-emotional state; and, physical

health, among others. In particular, their employment situation is of utmost consideration as this often defines the boundaries in which they can navigate the contours of their new environment. There are occupations that do not permit days-off, e.g. domestic or household-related work. Some jobs involve a higher degree of exposure to sexual harassment, such as female seafarers in male-dominated vessels or entertainment workers. Even those who belong to professional work categories are not without problems, as they are still subject to norms and practices that may take considerable adjustment and adaptation.

In order to grasp the SRHR realities of migrants, it is important to locate them where they are most vulnerable and potentially at-risk. There are numerous studies that probe into conditions of migration work and the situation of migrant workers, particularly women, however, these have dealt more with issues around employment, such as living and working conditions and experiences of violence, exploitation and abuses, including trafficking. While there are clear linkages between gender-based violence, e.g. those experienced by women migrant workers, to SRHR, these connections have also not been explored or addressed.

There are very few studies conducted in the region that have specifically investigated the SRHR status of migrants and most of these are focused on women migrant workers' vulnerability to HIV. However, as HIV and AIDS are inherently linked and within the scope of SRH, these studies also explored, to some extent, knowledge, attitudes and practices in

relation to broader SRHR realities of migrant women workers.

3.1 Knowledge About SRHR

A study conducted by Action for Health Initiatives (ACHIEVE), Inc. among 302 Filipino women migrant domestic workers in 2006 revealed that despite the relatively higher level of education of women migrant domestic workers compared to their local counterparts, one out of every five of those who joined this study (n=61) had absolutely no knowledge of when, in a woman's monthly cycle, will sexual intercourse most likely result in a pregnancy.²⁷

Similarly, another study that was done onsite among Filipino women migrant domestic workers in Hong Kong noted that while there was early exposure to SRHR issues in the education system or from seminars they have attended, the knowledge was still generally low. A considerable number of participants, for example, did not know how to track their fertility cycle.²⁸ Other misconceptions they mentioned were:²⁹

- Wearing a wired bra is bad for the breast.
- Breast cancer can be the result of one's breasts never having been touched upon reaching adulthood.
- The Pap smear is for "cleaning" the vagina.
- Pap smear is not good for those who are sexually active because the results will be "unclear".

Traditional beliefs and societal expectations about women's bodies,

functions and roles were also expressed by the study participants. For example:

- A Pap smear can “de-virginise” a woman.
- A hysterectomy will render a woman “useless” because she can no longer conceive.
- Getting married, and having sexual relations, will cure irregular or painful menstruation; having children will achieve the same result.

Meanwhile, in a study among female migrant domestic workers in Sri Lanka, over 50% of the women believed HIV could be transmitted by mosquitoes, over 25% did not know that condoms could provide protection from HIV, and a majority believed that someone with HIV or AIDS could not look healthy.³⁰

A related issue with regards to knowledge about SRHR is where migrants get their information. It is very common among them to rely on their peers when it comes to “conventional wisdom” about SRHR, especially since for the most part, they do not have easy access to information about these matters and secondly, they are embarrassed or shy to bring up these matters with their own families or even with health care providers. A study among migrant beer promoters in Cambodia, Vietnam and Laos noted that Laotian beer promoters often relied on their mother’s advice for health problems, as they were shy to discuss their health issues with a physician.³¹

It is common for migrant workers to pass on various kinds of information to their compatriots and even to migrants of other

Box 1: Young, Mobile and Sexy

Globally, there are 33 million international migrants under the age of 20 and they account for 15% of all international migrants. Asia hosts 12.9 million international migrants under the age of 20, representing 39% of the total.³³ The Pacific hosts a much smaller number, roughly 680,000. In both regions, half of these migrants under 20 are female.

The age of the majority matters for purposes of migration because it generally determines the moment at which a person is entitled to seek admission into another country on his or her own right, without being necessarily a dependent of someone else. There are specific age restrictions on some categories of migrants, for example, among contract workers, and these vary according to country.³⁴ In the Philippines, for instance, the law mandates that a person must be from age 23 onwards to be able to work abroad as a domestic worker. However, countries such as Hong Kong and Singapore legally allow foreign domestic workers from age 18 onwards.

For young people, the decision to migrate is often related to important life transitions, such as obtaining higher education, starting work or getting married.³⁵

Young people who migrate are even more disadvantaged when it comes to access to SRHR knowledge and services. In a study of young Nepali rural-urban factory workers, a substantial number indulged in risky sexual behaviours, which included early sexual experimentation, having sex with multiple partners, and low and irregular use of condoms. Despite these higher risk behaviours, relatively few young people considered themselves to be at risk of getting STIs or HIV due to misconceptions and lack of knowledge.³⁶

While structural issues create significant barriers to the provision of reproductive health services across all the settings and populations, adolescents in particular, face additional difficulty in gaining access due to the attitudes of the community. In a study among Burmese refugees and migrants working in Thailand, young people are reportedly ‘shy’ and apprehensive about procuring reproductive health information and family planning services.³⁷ What further aggravates the situation is that young people, who are regarded to have breached community norms such as engaging in sexual relations before marriage, are shamed and punished.

nationalities. This includes information on popular health remedies for various ailments and conditions. In Hong Kong, for instance, misoprostol, more popularly known by the brand name, Cytotec, a drug that can treat gastric ulcer, but also induces labour and terminates pregnancy (in combination with mifepristone), is very popular among migrant workers. However, there is no information about correct dosage and there have been anecdotal accounts of fake versions of the drug being sold in the migrant community. It is so popular that even Indonesian women migrant workers have also started using it, upon hearing about it from their Filipino friends.³²

It must be noted that unsafe health-seeking behaviours is not solely a factor of migration. Economic constraints, the fear of knowing a confirmed illness or disease, and the widespread availability of medication or cures (either alternative or chemical) influence people to self-medicate or to seek medical attention only when their situation has worsened. Among migrants, this is compounded by fears of possible termination from their jobs, if their employers find out that they suffer from ill-health or disease.

3.2 Employment Labour Conditions And Legal Status

A crucial determinant of migrant workers’ SRH status is their employment status. In many countries, the legal status of migrants is contingent on their employment status, i.e. they are allowed to stay legally in the country if they have a valid work visa or permit. Thus, in order to remain legally in the country, they have

to remain employed and avoid getting terminated. In cases where migrants encounter problems, e.g. abusive working conditions or employers, they may opt to file a complaint with the country’s labour ministry, in order to avoid compromising their legal status. Thus, they are able to stay in the country while their case is pending. However, this is not an ideal situation because the justice system in many destination countries is not enabling for migrants and they are often not permitted to work or earn an income until their case is resolved. In some situations, this could take months or even years.

Employment contracts spell out entitlements and benefits, which in an ideal situation should include fair wages, health insurance, work leave privileges, decent accommodation, and the like. However, there are many incidents of contracts being substituted upon the migrant’s arrival in the destination countries and this is experienced even among those employed in professional categories. The enforcement of the contract is crucial to the stability and security of a migrant worker. Any violation or infraction can have consequences. There are situations where migrants are forced to resort to other measures in order to fulfil their financial obligations to their families left behind and this includes not spending for their own health needs.

Undocumented or irregular migrants, by their very status, are even more deprived and disadvantaged when it comes to access to health services and information. Already vulnerable to exploitation, abuses and violence, and lacking in social and

legal protection, they run the risk of arrest and deportation, especially if they end up accessing public health systems. Thus, they are forced to seek private health service providers, which entail steeper costs or self-medication in situations when they encounter health problems. Other migrants, who are already practicing indigenous or alternative medicine, opt out from seeking medical attention altogether.

3.3 Access To Health Services Including Srh Services

The extent of access to RH information and services of migrants is dependent on several factors. Apart from what is legally provided in their employment contracts, one major consideration is the attitude of their employers. In Hong Kong, for example, employers of migrant domestic workers are required by law to ensure that their workers have a valid Hong Kong ID card, which allows them access to government hospitals and medical services at very affordable rates (HK\$100). However, a domestic worker, though in possession of this ID card, may not be able to readily reach any health facility if her employer does not allow her to leave the house at any other time except on Sundays.³⁸ In a study among Sri Lankan domestic workers, the majority of respondents reported being administered Panadol (paracetamol) by employers for common colds and illnesses.³⁹

In some countries in the Middle East, household workers are included in the insurance package of their employers. Thus, migrant workers are unable to go to the health service provider of their choice.

In situations where they need to undergo medical check-up or examination, their employers are automatically informed of the results, violating their right to confidentiality and privacy.⁴⁰

The fear of job termination is also a major barrier for migrants to proactively attend to their health needs. Thus, they endure ailments that they consider minor and self-medicate whenever possible. This makes early detection of preventable RH-related life-threatening illnesses, such as cervical and breast cancer, which have been found to occur among migrants, difficult.

Another crucial factor in accessing RH services is cost. The inclusion of insurance in work contracts is not a guarantee that it will be provided by the employer. And even if it is provided, migrants are often not aware of the conditions in which they can avail of this insurance.

For example, gynaecological exams such as Pap Smear, contraceptive counselling, treatment of STIs, pre-natal care (in the event that they get pregnant), and abortion services are often not covered by health insurance. In some occasions, migrants have been able to avail of operations, like removal of cysts or hysterectomy and even chemotherapy for cancer, but these are not common experiences among migrants.⁴¹

Apart from cost-related factors, migrants also hesitate to seek services due to cultural and communication barriers. If migrants can access health services, they may find it difficult to communicate symptoms or understand treatment

instructions due to language barriers. This is a situation frequently complicated by different cultural constructs of illness causation and management, or unfamiliarity with a formalized health system.⁴²

For instance, women migrants who have to consult on matters they consider sensitive, such as STI treatment or unwanted pregnancy, may have a harder time explaining the symptoms in a foreign language, especially when the attending physician or health personnel is a man. For migrants in Thailand, structural barriers, including security, distance, language differences, and resource shortages often limit their access to available reproductive health resources.⁴³

It is also important to consider the availability of health services when these are needed by the migrant workers. Even in situations where insurance is provided and the cost is reasonable, the waiting period for public health facilities can be long, as locals also utilize the same services. Thus, in order to avoid the queue, migrants are forced to seek private health services, which they may not necessarily be able to afford, if their employers do not pay for such services. Other barriers impeding access to health services, facilities or goods for migrants include: health providers' and migrants' lack of information regarding legislative measures concerning access by migrants; ambiguously or imprecisely defined entitlements; time-consuming administrative reimbursement procedures; and, lengthy and complex application processes to obtain regular access to health care, among others.⁴⁴

4. Sexual And Reproductive Health Outcomes

Women migrants experience sexual and reproductive health issues in the countries of destination, which are often a result of their day-to-day life at work, as well as from their social and sexual interactions with people they meet. Migrants do not leave their sexual and reproductive lives once they cross the immigration border.

For newly arrived and first-time migrant workers, dealing with loneliness and homesickness is a common experience. Even frequent migrant workers who have had to leave their families and partners for countless times also experience "homosexness" periodically.

It is common knowledge that in cities with a bustling migrant population, there are specific areas where migrants congregate, interact and seek opportunities for social and sexual interaction, whether with the opposite or the same sex. Public parks, popular shopping centres, restaurants and even churches transform into meeting points and social spaces for people whose only "reward" or consolation from a week or a month's heavy work is physical warmth, touch and connection with a fellow human being.

What happens next is a confluence of their own self-awareness (or lack of) of SRH, their personal beliefs anchored on cultural norms (including religious beliefs), their emotional feelings and expression of desires.

Even in restricted settings, migrants are able to find creative solutions to meet their sexual needs. While days-off are prohibited in many countries in the Gulf States, for instance, there are ways in which domestic workers may engage in sexual relations, either with partners back home or with those they meet abroad.

For those who are allowed to keep their mobile phones, they can engage in virtual interaction through text messaging, which makes a cell-phone load a necessity. Physical contact with the opposite sex is difficult and potentially dangerous, but there are domestic workers who get involved with male household workers, utility repairmen, delivery crew and even male members of the household they are employed in.

Women migrant workers, particularly those working in the service sector, are vulnerable to violence and abuse. Sexual abuse of domestic workers by male members of the household is a common problem in the Gulf States and in other countries of destination in Asia.

If a woman migrant gets raped, but does not have access to emergency contraception or safe abortion services, she could get pregnant or get infected with an STI. In countries such as Saudi Arabia and the United Arab Emirates, this could mean a jail sentence or worse, capital punishment.

In cases where the father of the child is a national of the country, women migrants may lose custody of their children and are forced to return to their countries of origin without them.

Box 2: Transgender Women Migrants

There is little systematic research on health issues of migrant transgender women in the region. Deemed as highly mobile, their common narratives speak of movement across borders to escape discrimination, abuse and violence from their home communities. Moving away from their places of origin also gives them the freedom to express themselves, away from the shackles of family and community. However, their places of destination can be equally unaccepting and hostile and thus, they find themselves with limited opportunities for employment, housing and social services, including health.

Before Japan enforced strict regulations concerning the entry of migrants in entertainment work sometime in 2006, it was a popular destination for transgender women from the Philippines and Thailand. In fact, it also became a destination for those seeking a sex reassignment surgery, such that transgender women who worked in Japan also saved up their earnings to undergo the costly procedure.

However, with stricter work visa requirements, the numbers of migrant transgender entertainers have decreased in recent years.

In more current times, migrant transgender women have taken to providing escort services and sex work in Hong Kong. This has inadvertently resulted to stricter immigration scrutiny of transgender persons in general. Of late, there have been cases of arrests of foreign 'lady boy' sex workers (deemed to be illegally working) or detention and refusal of entry into the territory by immigration personnel.

There are countries where cross-dressing can get a person arrested and punished by religious or police authorities. In June 2009, 72 Filipino men were arrested in Saudi Arabia for 'wearing women's clothing' in a private party. Individuals caught even wearing just one article of women's clothing could face three to six months of imprisonment and suffer between 50 to 100 lashes. They also have to face trial and could get deported if found guilty. Homosexuality, which does not pertain necessarily to gender identity, is expressly prohibited by Saudi Arabia's Sharia Law and when it is deemed to challenge state authorities, the maximum penalty is public execution.

Without correct knowledge and behavioural intent to protect themselves from possible negative consequences of their actions, they could end up experiencing a host of SRH-related problems. In places where contraception is not readily accessible, available or affordable, migrant women, who engage in unprotected penetrative sex, run the risk of getting pregnant or contracting an STI, including HIV. Currently, there is no data on the numbers of migrant women getting pregnant. If this is available, only the state authorities, who conduct arrests and deportation of pregnant women, hold this information, which they are not likely to divulge or release.

Even more hidden is the rate of unsafe abortion that happens among migrants. Even in places where abortion is legal, if the women cannot afford to pay the cost, they will resort to backdoor procedures, which can put their life and legal status at risk, once the authorities find out.

5. Policies And Legal Frameworks Affecting Migrant's Health

The call for recognition of the human rights of migrant workers has been made globally. This is also the anchor in which the right to health of migrant workers is framed. The 1990 UN Convention on the Protection of the Rights of Migrant Workers and Members of their Families, which was enforced in July 2003, contains

Box 3: Lesbian Migrant Workers SRH Concerns

There is no systematic documentation on the situation of lesbian migrant workers in the region. However, there have been anecdotal accounts on Filipino and Indonesian lesbian migrant domestic workers in Hong Kong. Working in a country that enforces mandatory days-off for migrant workers is enabling for lesbians who are able to form their own associations and support groups.

As minorities, the protections in the Race and Sex Discrimination Ordinances are also extended to them. In Hong Kong, they are able to congregate in public spaces and express themselves visibly.

In the study done by ACHIEVE, one of the most common concerns raised by the Filipino lesbian respondents is their hesitation to seek SRH services. None of the FGD respondents have gone through a pap smear or any gynaecological exam, even though most of them are sexually active with their partners.

And while some of them expressed willingness to undergo such a procedure, they are hindered by their own body-image issues, i.e. they are ashamed of their bodies or of being physically and sexually exposed. They also do not want

to be reminded of their biological "femaleness" and they cannot deal with the idea of another person seeing and touching their "private parts", especially if it is a male, foreign doctor. Such feelings are not uncommon especially among self-identified butch lesbians, i.e. lesbians who identify themselves as masculine or male, but have not yet explored or embraced the concept of a transgender or transman identity.

Interestingly, gender constructs of femininity and masculinity play out strongly in the work environments of lesbian migrant workers. While there have been accounts of lesbians terminated because of their masculine looks or being made to "feminize" their appearance, especially those who were taking care of young children, there were also accounts of those who had employers who "preferred to hire them because they were perceived to be able to do anything."

Another reason they were preferred was because their employers assumed that "they would not get pregnant or leave work due to marriage."

very few provisions that specifically addresses health issues of migrant workers. Article 43 states that "Migrant workers shall enjoy equal treatment with nationals of the State of employment in relation to...access to social and health services, provided that the requirements for participation in the respective schemes are met (Sec 1e)". Another provision, Article 28, provides that migrant workers and members of their families have the right to receive any medical care that is urgently required, regardless of their legal status.

While the 1990 Convention is adhered to by 46 States Parties, the signatories come mainly from origin countries of migrant workers. Furthermore, the strength of UN conventions can only be measured if these are translated into national legislation and policies. Policy coherence across migration and health sectors presents numerous challenges. This is further compounded by intersecting realities of immigration controls and labour policies, which are often not harmonized with health policies. A migrant worker's legal status is determined by his or her employment status, which in turn, is subject to requirements, including medical fitness. Traditional policies and regulations focus on disease control, emerging public health issues both globally and in the hosting community, and the cost implications of addressing migrant health needs.⁴⁵ Such approaches often run counter with a more rights-based approach on health, which focuses on accessibility, acceptability and quality of health services for migrants. This so-called debate between 'public health versus human rights' has permeated

Box 4: Policies related to migrant health in Singapore

Some of the policies related to migrant health are an outright violation of sexual and reproductive rights such as prohibition against pregnancy, childbirth and marriage.

This also includes compulsory testing for sexually transmitted infections, including HIV and AIDS. Workers, who are ascertained to have committed these violations, have their work permits revoked and are placed in the immigration watch list for deportation.

These policies do not only exhibit a racial bias, but also target migrants who come from lower income brackets such as domestic workers. The Singapore Employment of Foreign Manpower Act explicitly illustrates this point.

Employment of Foreign Manpower Act (Chapter 91A)
Conditions of Work Permit/Visit Pass for Foreign Worker
Ministry of Manpower, Singapore

Employment

6. The foreign worker shall undergo a medical examination by a Singapore registered doctor as and when directed by the Controller. If the worker is certified medically unfit, his/her Work Permit shall be revoked.

Conduct

9. The foreign worker shall not go through any form of marriage or apply to marry under any law, religion, custom or usage with a Singapore Citizen or Permanent Resident in or outside Singapore, without the prior approval of the Controller, while he/she holds a Work Permit, and also after his/her Work Permit has expired or has been cancelled or revoked.

10. If the foreign worker is a female foreign worker, the foreign worker shall not become pregnant or deliver any child in Singapore during the validity of her Work Permit/Visit Pass, unless she is a Work Permit holder who is already married to a Singapore Citizen or Permanent Resident with the approval of the Controller. This condition shall apply even after the Work Permit of the foreign worker has expired or has been cancelled or revoked.

11. The foreign worker shall not indulge or be involved in any illegal, immoral or undesirable activities, including breaking up families in Singapore.

the discourse on migrant health, with destination countries using health indicators to impose controls over entry, residence and stay of non-nationals.

Arguably, this issue has been elevated globally when the international community and nation-states began weighing on the merits of travel restrictions in relation to HIV status. Today, there are still a number of countries in the world with permanent bans on the entry of people living with HIV, on the grounds of preventing or mitigating its spread, a policy that the United Nations has already deemed to have no public health rationale.⁴⁶ In the Pacific region, six countries (Australia, Marshall Islands, Micronesia, Papua New Guinea, Samoa and Tonga) currently impose HIV related restrictions on entry, stay and residence of people living with HIV.⁴⁷

The economics of health care for migrants is a fiercely debated issue, i.e. who bears the financing for migrant health services. Nationality or residence are frequently associated with elements of requirement or regulation, designed to control or balance the allocation of associated privileges or access to services.⁴⁸ Yet, the framework of health rights promotes universal access and this is not just confined to curative or treatment services, but also preventive health care.

There are a number of countries in the region, who have begun to take proactive steps to address health issues of migrant workers. These include the development of policies, implementation of programmes, and creation of structures or mechanisms. Thailand hosts more than

two million workers, but less than half of them are officially registered under the national verification process. Those who are registered are entitled to basic health insurance and in some cases, even migrants living with HIV can have access to treatment. In Sri Lanka, the government established an inter-ministerial body that addresses migration and health concerns, which is housed in the Ministry of Health.

6. Platforms And Opportunities

As the migration process connects countries of origin, transit, destination and return, it is futile for countries to have a purely national approach to migration and health issues.⁴⁹ Through bilateral, multi-country and multi-sectoral dialogues, collaboration and partnership, health responses can be harmonized, including policies and programmes.

Addressing SRH needs of migrant workers requires strengthening multi-sectoral collaboration at the country level and strengthening cross-border cooperation between countries of origin and destination. Such an approach is enshrined in the Millennium Development Goal (MDG 8), which promotes global partnerships for development, including migration.

In the region, various regional and sub-regional platforms addressing global health challenges such as HIV and AIDS, Severe Acute Respiratory Syndrome SARS, avian influenza, and the Pandemic

Influenza caused by H1N1 virus have emerged in the last decade. The infectious and communicable nature of these diseases prompted swift actions from concerned and affected governments in Asia, however, efforts at addressing migrants' health and in particular, sexual and reproductive health, have yet to be undertaken.

Currently being utilized as an entry point in addressing migrant's SRHR issues in Asia are multi-country platforms addressing HIV and AIDS. HIV in the region is still predominantly transmitted sexually, necessitating the inclusion of sexuality and gender dimensions in the current discourse and response.

One of such platform is the Joint UN Initiatives on Mobility and HIV/AIDS in South East Asia (JUNIMA), a multi-sectoral body composed of governments (including the ASEAN Secretariat), international agencies and civil society organizations, whose mandate is to promote universal access to HIV prevention, treatment, care and support for mobile and migrant populations, mainly in South East Asia. JUNIMA has made visible the interconnections between migration and HIV in regional and global platforms, emphasizing that migration, in and by itself, is not a risk factor for the spread of the virus.

Global discussions on migrant health were formalized at the 61st World Health Assembly (WHA) in 2008, where a resolution on "Health of Migrants" was approved by member states. The resolution called upon member states to improve the monitoring of migrants'

health; share best practices for meeting migrants' health needs; promote migrant-sensitive health policies and equitable access to health promotion, disease prevention and care among migrants; and, forge multilateral cooperation, among others. It also requested the Director General of the World Health Organization (WHO) to support efforts towards the implementation of the resolution and to submit a report on its implementation in the 63rd WHA in 2010.

In March 2010, WHO and the International Organization for Migration (IOM) convened a global consultation, which brought together representatives from governments, international agencies and CSOs to develop an operational framework on migrants' health.

This framework outlines four key pillars of migrants' health, namely: monitoring of migrants' health; migrant-sensitive health systems; policy and legal frameworks; and, partnerships and multi-country frameworks. Understandably, the consultation aimed to encompass the broad landscape of migration to include all forms of migrants, e.g. temporary and permanent, refugees, IDPs, asylum seekers, students and trainees, and those in 'irregular' situations. The report on the consultation was presented during the 63rd WHA as a follow-up report to the 2008 Resolution.

Taking off from the WHO-IOM global initiatives in migrants' health, JUNIMA members led by the United Nations Development Program (UNDP) Regional Office, Coordination of Action Research on AIDS and Mobility in Asia (CARAM-Asia),

IOM and UNAIDS convened a High Level Multi-stakeholder Regional Dialogue on Migrant Workers' Health and Access to HIV services in the ASEAN Region in 2011.

This dialogue brought together representatives from the health, labour and foreign affairs, along with civil society representatives, migrant workers living with HIV and international organizations to discuss issues affecting migrants' health, particularly in the area of prevention, treatment and control of HIV. It also called for regional cooperation in addressing the issues, bearing in mind the 2007 ASEAN Declaration that sought to promote the human rights of migrant workers.

Paradoxically, while HIV has been the traditional entry point to discuss migrants' health, it has also been contested by governments who have consistently quelled efforts to address the cross-border dimensions of the pandemic. In particular, the subject of mandatory HIV testing as a requirement for overseas employment, the accessibility of prevention services for migrants and access to treatment of those infected, are issues that have remained unresolved in these sub-regional platforms.

Thus, in recent discussions, the issue has been strategically broadened to "migrants' health" to divert undue attention to the sensitivities brought about by HIV and AIDS.

For its part, the South Asian Association for Regional Cooperation (SAARC) developed a regional strategy on HIV and AIDS, which covered the period,

2006-2010. Under its Policy and Advocacy Component was a specific activity to "promote regional dialogue on cross border issues relevant to HIV/AIDS". The outcomes identified for this activity were: i) Member States address safe mobility issues; and ii) National Government policy on HIV/AIDS reflects key issues related to safe mobility and displacement. Currently, there is no information on the status of implementation of the regional strategy and whether there was an assessment following its completion in 2010.

While the issue of mobility and HIV is acknowledged in the Pacific and there have been some activities with specific groups, there has been no comprehensive focus on this area and further attention is needed.

The Pacific Regional Strategy on HIV and Other STIs (2009-2013) includes migrant and mobile populations in the key populations that need to be addressed but targeted and tailored prevention programmes for mobile populations still need to be further developed.⁵⁰

While it is laudable and commendable for these regional and global platforms to create opportunities that address migrants' health issues, it remains to be seen whether these discussions will translate into concrete actions at the country or inter-country level.

The vigilance of CSOs in tracking the progress of resolutions and recommendations resulting from these processes is critical in order to sustain the momentum started by these dialogues and consultations.

7. Moving Forward And The Agenda For Action

Over the next few decades, international migration is likely to transform in scale, reach and complexity, due to growing demographic disparities, the effects of environmental change, new global political and economic dynamics, technological revolutions and social networks.⁵¹ In terms of population size, international migrants as a whole could make up the fifth largest country by population size in the world.

The sheer magnitude of the movement and flow of persons in the region, and throughout the world, necessitates a critical discussion on the health aspects of migration. Depending on the situation and location, it has been observed that the health of migrants may have important implications for the populations from which they originate from, transit to or travel through, and live and work. At the same time, aspects of migrants' health are influenced and affected by where and how they travel, reside or settle.⁵²

Addressing migrants' health involves integrating key human rights concepts into sound public health approaches. The key principle is to eliminate disparities in access to health services, facilities and goods between migrants and host populations, bearing in mind the financing implications into existing health systems. It also means creating

an enabling environment for migrants to enjoy and fulfil their health rights, including sexual and reproductive health and rights.

However, this action must be accompanied with or situated alongside strategies or proactive action to address the totality of migrants' human rights. At the practical level, it should translate into the integration and inclusion of health needs of migrants into rights-based national plans, policies and programmes.

Countries of origin and destination must endeavour to promote migrant-friendly health policies and work towards the development of mechanisms that enhance social protection, health and safety of migrants. Policies that restrict or hinder migrants from accessing health services must be reviewed and repealed if necessary. In the area of SRHR of migrants, it is important to continue generating more evidence that could enhance existing SRHR programmes and services.

This includes further investigation and analysis of trends and patterns in the SRHR status of migrant workers; mapping of existing SRHR services, policies and information; and identification of good practices in addressing SRHR needs of migrant workers, among others.

The gathering, dissemination and utilization of information must take into account issues around human security, as disclosure of sensitive data or information about migrants could put them into a precarious situation. This is especially true in the case of irregular or undocumented migrants. SRHR responses need not be

treated as stand-alone strategies but they can very well be integrated in existing programmes and services for migrants.

For instance, countries which require pre-departure or post-arrival trainings for migrants can integrate SRHR topics in their curriculum so that migrant workers, particularly women, are provided adequate and non-biased information to be able to handle SRHR issues, especially onsite.

Capacities of health care providers must be built and enhanced to enable them to render culturally competent, gender-sensitive and migrant-friendly health services. Whenever possible, networks of migrants can also be mobilized and trained as volunteer health workers, in order to complement services provided by health service providers and professionals.

Lastly, migration, especially cross-border or inter-country movement, necessitates the cooperative involvement of countries of origin or return, transit and destination. Where possible, bilateral agreements and or memorandum of understanding in the area of migrant health should be explored and mutually arrived at.

At the national level, it is crucial to encourage and foster collaboration between immigration, health, foreign affairs and interior ministries in order to arrive at harmonized migrant-friendly policies and a cohesive response.

SRH and migrants' rights advocates should also utilize platforms such as the framing of the post-2014 sustainable development goals (SDGs) that would

complement a revised set of MDGs. In addition, the International Conference on Population and Development (ICPD) will also mark its 20th anniversary on 2014, which would entail renewed discussions on issues related to SRHR and development.

At the regional and global level, existing bodies and platforms that address migration and health, such as the UN, WHO, IOM, ASEAN, SAARC, and the Secretariat of the Pacific Council should be constantly monitored and pushed to address the issues and engage civil society organizations and migrant workers associations in the response.

Endnotes

- 1 This paper is an attempt to explore the intersections of migration and sexual and reproductive health and rights (SRHR) of women and young people in Asia and the Pacific. Because migration covers a broad and expansive landscape, this paper will focus mainly on international labour migrants, with specific discussions relating to women migrant workers. The dearth of data on the SRHR situation of mobile and migrant women and young people in the Pacific region has resulted in undue emphasis and focus of this paper on the Asian context.
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Thematic paper 4:
**Climate Change and Sexual
and Reproductive Health
and Rights of Women
and Young People in the
Asia-Pacific Region:**
Affirming Rights, Refuting
Dubious Linkages

by Jael M. Silliman, Ed.D.

1. Introduction

It is now widely accepted that higher global temperatures, induced by natural phenomena and human activities, have contributed to Climate Change (CC). Climate-heating carbon emissions set a record high in 2011, with an increase of over 3.2% over the previous year.¹ Atmospheric concentrations of greenhouse gases continue to increase to levels which will push global temperatures to more than 2°C above the pre-industrial average. The threats of climate change include more frequent heat waves and severe storms, shifts in rainfall patterns, rising sea levels, ocean acidification, and threats to freshwater supply, agricultural productivity and human health.² The effects of CC on health will affect most populations in the next decade, especially women and young people, and exacerbate inequities between rich and poor countries, and rich and poor people within countries.

*“While climate change is a global phenomenon, its negative impacts are more severely felt by poor people and poor countries. They are more vulnerable because of their high dependence on natural resources, and their limited capacity to cope with climate variability and extremes.”*³ It is estimated that 70% of those living below the poverty level will be disproportionately affected by CC.⁴

The effects of CC will be felt most acutely by segments of the population that are already vulnerable owing to geographical location, gender, age, indigenous or minority status, and disability.⁵ The Asia Pacific encompasses some of the world’s most vulnerable regions such as the Ganges/Brahmaputra valleys,

Bangladesh, the Maldives, the Marshall Islands, and Tuvalu. The region is home to many small island states, features arid and high mountain zones as well as densely populated coastal areas that are considered particularly vulnerable to CC. Rising sea levels are a particular threat to islands that are at risk of being submerged. Increasing deforestation is another cause of CC and the region is home to many tropical and temperate forests. For example, Indonesia has lost 28 million hectares of forest due to logging. Nepal and parts of Northern India and Pakistan have also lost a great deal of forest cover. They have experienced landslides and Pakistan has already been confronted with heavy flooding and unusual weather patterns.

1.1 Climate Change: Women and Young Girls

Gender inequality and the low status of women persist in the region and CC exacerbates these inequalities. “The unequal distribution of rights, resources and power, as well as repressive cultural rules and norms – constrain the ability of many women to take action on Climate Change.”⁶

The United Nations Development Programme (UNDP)’s 2007 Human Development Report underlines the importance of considering poor women and men in the context of CC, taking into account the underlying causes and intensifiers of inequalities including poverty, gender power imbalances, HIV/AIDS, food insecurity and conflict to understand how CC intersects with and exacerbates these and other inequalities

and vulnerabilities, including gendered ones. Due to the efforts of the global women’s movement, the international research and policy literature acknowledges and demonstrates a better understanding of the relationships/ inter-linkages between CC, poverty, and gender. Men and women are differently impacted by CC, because their roles and responsibilities are differently constructed. For example, CC in many instances impacts agricultural production, negatively, leading to the out-migration of men in search of employment, and increased workloads of women who must take on the men’s tasks, too. Similarly, as women are primarily responsible for collecting fuel and water, CC means that with the drying up of natural resources, their workloads increase.

There is also a growing consensus that in order to mitigate and adapt to changing climate conditions, women need to be empowered, so that they can take action to enhance environmental protection, and use technologies that are less polluting/ energy intensive.

In the policy arena, there are entry points for taking gender into account, as in the Bali Action Plan created at the United Nations Framework Convention on Climate Change (UNFCCC) Conferences of the Parties (COP) 13, 2007, and the UNFCCC Secretariat, in 2008, has included the need for gender specific recommendations in conference documents.

There are a few pilot programmes underway to reduce gendered vulnerabilities and empower women

to take action to resist CC. However, there is still need for further research, policy development, and intervention in this critical development arena, so that women and their gendered vulnerabilities will be adequately represented.

Young girls are also particularly vulnerable. In many parts of the developing world and in the region, young girls assist or carry out household tasks alongside their mothers, or undertake women’s roles and responsibilities at a very early age, and many of the CC related health issues impact them as well.

For example, the dwindling forest and water resources mean that they have to walk further to collect these resources, or if their mothers are away longer, they are to take on the household tasks.

This often means they drop out of school to carry out essential household tasks. Contaminated and polluted water also has negative impacts on their health and so does reduction in household food intake.

For socio-cultural reasons, girls and women, who are least valued in their families, their food intake is reduced to meet the needs of other family members. In times of natural disasters that become accentuated through CC, adolescent girls are vulnerable to sexual violence and abuse.

The region is also home to many indigenous peoples who will also be made more vulnerable by CC especially because of their greater dependence on forests and other natural resources to meet their

subsistence and livelihood needs. The region is already home to climate change refugees, also known as climate change forced migrants, who have to shift to other places to secure their livelihoods in increasingly tenuous circumstances.

1.2 Climate Change and MDGs

Adverse weather has induced changes, which have led to increasing concerns that CC can have an adverse impact on realizing the Millennium Development Goals (MDGs). Weather induced changes such as the reduction in the quality and quantity of drinking water, the spread of water-borne illness through floods and droughts, and food insecurity leading to increased malnutrition.

All of these impact the achievement of MDG5 on improving maternal health. During times of climate stress, women and girls are typically the ones to care for the home and fetch water, fodder, firewood and food, which exacerbate the already existing gender inequality impacting the achievement of MDG3 on gender equality.

The African Development Report suggests the best way to address CC impacts on the poor is to integrate adaptation responses into development planning to achieve the over-arching MDG goal of halving extreme poverty by 2015. Adaptation measures seek to reduce vulnerabilities to current and projected climate risks. It requires the shifting of livelihood strategies under stress, and requires developing support systems that are resilient and flexible enough to respond to the impacts of CC.

In the policy arena, the full and successful implementation at the national level of key international conventions, declarations and conferences such as the Rio Declaration on Environment and Development and Agenda 21 (1992), United Nations Framework Convention on Climate Change (UNFCCC) in 1992, The International Conference on Population and Development – Programme of Action (ICPD POA) in 1994, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)(1979), and the Beijing Declaration and Platform for Action (1995), is an essential first step. Governments in recent times are compromising on long-term and agreed international agreements mentioned above on gender equality and women’s human rights including sexual and reproductive health and rights (SRHR).⁷ “The Future We Want”- the outcome document of the Rio+20 Conference on sustainable development, which took place in Rio de Janeiro, Brazil in June 2012, was weak on issues of gender, and sexual and reproductive health. The document lacks references to sexual and reproductive rights, and falls short of making meaningful commitments to address sustainable development.

To date, some population control and environmental groups have made simplistic links between CC and population growth. They argue that with the increase of the human population, more green house gas emissions (GHGE) are released and this exacerbates global warming. This paper continues feminist challenges towards the simplistic linking between population growth and CC that can undermine women’s SRHR, and it has

failed to take a comprehensive approach to reducing CC, as well as reducing funds for this critical development challenge.

The paper treats women’s SRHR as a subset of women’s health issues and further teases out the varied ways in which CC impacts women’s SRHR.⁸ The indirect ways in which CC impacts SRHR is further elaborated to ensure the necessary resources, and appropriate development policies are put in place to promote and protect women’s SRHR in the context of CC. Given the obvious gender inequalities that exist in the Asia and Pacific region, coupled with the fact that the region will be severely impacted by CC, it is crucial to understand these risks and put in place those policies, processes and programmes to reduce them.

2. Climate Change And Population Growth Connections

Almost twenty years ago, at the International Conference on Population and Development (ICPD, Cairo, 1994), a global movement of feminists and their allies successfully debunked population control as a legitimate development strategy. While the United Nations (UN), and other credible developmental and environmental organizations also negate simplistic links between population growth and CC, there are population control advocates who seek to regain ground and capture new resources by

taking advantage of international concern about CC.

At the United Nations Climate Change Conference in Copenhagen, for example, Optimal Population Trust proclaimed “Contraceptives are the greenest technology!”⁹ President Zhou promoted the environmental benefits of China’s draconian family planning policy – 400 million fewer births result in 18 million fewer tons of carbon dioxide (CO₂) emissions a year. In the same vein, some environmental activists argue that human beings act as *climate changers* and suggest that population stabilization policies are more politically feasible and cost-effective than other ways of reducing carbon emissions.

Although the UN refused to link issues of population and climate change in the Copenhagen Accord, this has not stopped population control advocates to continue making this dubious linkage. Due to their zeal, in leading up to Rio+20, the zero draft document and the revised document represent a disturbing return to Neo-Malthusian arguments which link population with food and climate crises. Some UN agencies claim that “early stabilization of world population would make a crucial contribution to realizing sustainable development”. Demographers are claiming that “slowing population growth, makes many environmental problems easier to solve and development easier to achieve.” These statements represent a serious regression from the Rio, Cairo, and Beijing agendas that negate the link between fertility increases and environmental decline.¹⁰

Other groups are also finding population control a useful vehicle to advance their particular interests in the context of CC. Anti-immigration organizations urge reduction in birth rates to avoid the threat of “*climate refugees*”. Their coded radicalised message resonates in foreign policy circles in Europe and the US.¹¹

Military and industrial stakeholders, who want to deflect responsibility for CO₂ emissions, blame population growth for climate change, making population control the “obvious” solution.¹²

The dangers of undue emphasis on population reduction to address climate change are clear: it jeopardizes decades of work to advance multifaceted, rights-respecting, environmentally sound and equitable development models.¹³ A narrow focus on reducing birth rates ignores the other demographic factors that are integral components of the population-climate change equation. For example, urbanization trends, immigration patterns and, perhaps most importantly, per capita resource consumption.

All of these interact with population size, which affect the environment. From a demographic perspective, it makes no sense to single out only one factor – birth rates – as the problem and the solution. Indeed, the other demographic forces eclipse birth rates as the drivers of environmental decline. Climate change strategies that do not address these other factors are, thus, too limited and doomed to be ineffective.

One-sixth of the world’s population

lives in countries with extremely low rates of consumption, including energy consumption. These countries are also countries with higher rates of population growth and hence, are the target of population control advocates who insist that it is the large and growing populations of these countries that threaten CC. Climate justice advocates insist that equitable climate change strategies should not displace responsibility for carbon emissions upon those least responsible for them. According to the UN Framework Convention on Climate Change (UNFCCC), the largest emissions of GHGE (both historical and current) originate from developed countries. The military industrial complex is a primary source of emissions, similarly, large scale corporate practices ravage and pollute the environment on a grand scale, and emit a huge share of GHGE.

Industrialized countries with 20% of the world’s population are responsible for 80% of the accumulated carbon build-up in the atmosphere. By contrast, per capita emissions in developing countries are low. Total emissions of CO₂ in developed countries have increased by nearly 8%, and although the per capita emissions have declined in the developed countries by 18%, these are still 10 times higher than those of developing countries. Developed countries have also benefitted from the significant shift in production compared to developing countries, and this has contributed to the declining domestic emission in the developed countries.¹⁴

For instance, according to the World

Development Indicators Database CO₂ emissions (metric tons per capita) within 2008, in the United States (US), it was 18.0 metric tons per capita, compared to 0.3 metric tons per capita in Bangladesh. In parts of the developing world such as sub-Saharan Africa, where population growth rates are high, CO₂ emission rates are very low. Due to the low levels of consumption, the impact on climate is negligible.

A “Fair Share Level” (FSL) approach to CC integrates equity and consumption considerations. FSL determines a particular global average of emissions per person. Countries mired in energy poverty are differentiated from those living above that level. In fact, FSL strives to move people out of energy poverty while addressing the consumption of high-level consumers. Addressing energy poverty and its consequent negative health outcomes, FSL proponents advocate for convenient fuels and greater access to electricity.

Population control strategies, or a narrow focus on reducing fertility through family planning programmes, have inevitably led to abuses, coercion and the violation of women’s fundamental rights. The Asian-Pacific Resource and Research Centre for Women’s (ARROW) 2009 ICPD+15 monitoring study shows that these violations persist. In 9 of 12 population policies examined, fertility levels were considered as ‘too high’; policies aimed at lowering them focused narrowly on birth control, with the burden of contraceptives mostly falling on women.

An Empowerment Approach, which provides women with greater access

to education and employment, gives them greater say in household and community decision-making, increases access to quality sexual and reproductive health services, and brings assurance of the future prospects for their children; therefore, fertility rates inevitably decline. As a matter of human rights, women's right to control their own fertility should not be sacrificed to protect the environment. Nor is that sacrifice necessary.

Cutting CO₂ emissions through reducing militarism, insisting on corporate environmental regulations and more responsible use of resources, new energy saving technologies and changed consumption patterns would do a great deal more to protect the climate. These interventions would have a far more direct and immediate impact on reducing climate change than reducing birth rates, especially the birth rates of the lowest level consumers.

Respect for women's rights, including their SRH rights, mandates women's control over their fertility, i.e. to determine whether or not to have children. The aim of family-planning programmes must be to enable 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 to ensure they make informed choices with the availability of a full range of safe and effective methods.

It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents.¹⁵

This is as crucial as other rights, such as women's rights to bodily integrity, to pleasure and to express gender and sexuality. Since the 1992 Rio Conference on Environment and Development, and through subsequent conferences such as ICPD, and the 1995 Beijing Fourth World Conference on Women, women's rights advocates have insisted on policies that give women greater control over their SRHR and well-being. This includes access to quality contraceptive services to determine their own fertility, amongst other things. Women's bodies should not be the vehicle for climate change solutions, but concern for the impact of climate change on women should prompt effective as well as rights-respecting efforts to control GHGE. Thus, there is a clear recognition and consensus that undue emphasis on population reduction to address CC would jeopardize decades of work to advance and respect multi-faceted rights with respect to environmentally sound and equitable development models.

The National Adaptation Programmes of Action (NAPAS) are important documents for developing countries to plan for and fund their response to CC. They encourage debate about the links between human induced CC and the dynamics of population change, providing the opportunity to shift from arguments of over-population towards more nuanced understandings of SRHR.¹⁶

Population growth rates are not a causal factor for CC, nor are they a key factor leading to CC. They show that it is necessary for countries to conserve and better manage natural resources

such as land and water, address issues of migration, and empower women so that they can be environmental protectors and better resource managers. Empowering women as well as providing access to family planning and better SRHR are an important end in itself. A narrow focus on family planning alone to address CC would not address the complex ways in which population and CC interact.

National Adaptation Programmes of Action (NAPAS) offer opportunities for advancing sexual and reproductive health and rights in respective countries, and encourage debates over links between effects of human induced climate change and the dynamics of population change, providing the opportunity to shift from arguments about "overpopulation" towards more progressive understanding of SRHR. Unfortunately, the issue of overpopulation has entered the debates in the formulation of some Pacific NAPAS which have been highlighted in the *ARROWs For Change* (AFC) on climate change, and some of the misguided responses have focused narrowly on family planning.¹⁷

The challenge for NAPAS is to recognize the different order of complexity in the links between SRHR, gender equality and climate change, and NAPAS can then provide opportunities for investments in SRHR of women and young people.

While there is a better understanding of gender and CC linkages, and a broad rejection of population control as a mitigation strategy for CC among credible environment and development organizations, the issues of CC and the

SRHR of women and young people in Asia and the Pacific requires further exploration.

ARROW has used the scattered references in the literature on gender, environment and CC to develop an analysis of the links between SRHR and CC. The next section of this paper captures, brings together and probes these references further, to provide the missing SRHR response with adaptation efforts.

3. Key Sectors Impacted By Climate Change And Effects On Sexual And Reproductive Health And Rights Of Women And Young People

Climate sensitive sectors particularly impacted by CC include: **Agriculture and Food Security, Energy, Water, and Forests**. Women are key providers of food, fuel and water, and are leaders in environmental struggles. Thus, they can play a key role in fashioning locally appropriate and viable solutions to CC. The literature on gender, environment and development underline the ways in which environmental destruction and CC adversely impact women, and this calls for women's particular vulnerabilities to be

addressed. Here the work on gender and CC is extended to highlight the impact on SRHR.

3.1 Agriculture and Food Security

Climate Change has serious ramifications on food security: it affects food availability, food accessibility, food utilization, and food stability. It is predicted to reduce crop yields and food production in some regions, especially the tropics. Women farmers currently account for 45-80% of all food production in developing countries, and two thirds of female labour in these countries are engaged in agricultural work. In the context of CC, traditional food sources have become more scarce and unpredictable. Women face the loss of income and reduced harvests due to climate change.¹⁸

In the Asia region, women are responsible for 56% of household food production. The shrinking of agricultural resources and lands, thus, would have a very negative impact on their access to this important resource that provides food for their families. Related increases in food prices make food more inaccessible to poor people, in particular to women and girls whose health has been found to decline more than the health of males in times of food shortages.

Reduced food intake would make pregnant women particularly vulnerable and can affect maternal health. It could lead to babies with low birth weight and higher risks of child mortality. Without adequate adaptation, the International Food Policy Research Institute estimates

that by 2050 there could be an additional 25 million malnourished children.¹⁹ It is, therefore, essential to address the social and cultural factors that lead to differential access to food, especially in the South Asia region, that could only be exacerbated during times of food shortage and price rise.²⁰

The lack of/or reduction of food quantity/quality, and poor nutrition are especially critical for adolescent and young girls, and pregnant and lactating mothers as these can lead to poor reproductive health outcomes. Thus, food security is a critical component of women's SRHR and is also important as food security provides the basis for women to be able to exercise their right to have children. Food security is an enabling condition for meeting women's SRHR. Climate Change will heighten people's vulnerability to diseases caused by poor nutrition.²¹

3.2 Water

Climate Change dries up water resources, further reducing the potable drinking water available. In the last century, expanding global economies and the industrialization of agriculture have exacerbated fresh water demand. As a result, many water sources are contaminated; in developing countries 90-95% of all sewage and 70% of all industrial wastes contaminate surface water.²² As the primary collectors of water, women are more dependent on less reliable sources of water. Poor quality of water leads to an increase in vectors and more favourable conditions for spreading viruses associated with temperature and heat.

Pregnant women are more susceptible to water borne diseases and malaria. Pregnant women are particularly vulnerable to malaria, as they are twice as “appealing” as non-pregnant women to malaria-carrying mosquitoes.²³ Malaria leads to anaemia that is indirectly responsible for one quarter more increases in maternal mortality.²⁴

Clean basic water and sanitation, which are often disrupted due to CC stress, are critical in improving maternal and newborn health.²⁵ Poor menstrual management due to lack of proper water and sanitation can contribute to irreversible and cascading health and wellbeing outcomes impacting their ability to attaining great health.²⁶

As water resources have also become more unreliable and erratic as a result of climate change, women have to walk further to fulfil their household water needs. Carrying heavy burdens for long periods can cause uterine prolapse among women.²⁷ Travelling further distances to collect water is also a risk factor for girls and women as their vulnerability to sexual assault and harassment increases when further away from their homes. This is even more so in areas of conflict. Given the high density of conflict zones in the Asia Pacific region, this is a particular SRHR concern.

3.3 Forests/Energy

The Asia Pacific region is rich in forest cover and large sectors of the population depend on forest resources, especially indigenous peoples. Climate Change also has a very negative impact on natural

resources and the accessibility to these resources could pose vulnerabilities. This is particularly true in the case of seeking resources in which poor women have to go long distances to collect food and fuel that are considered their responsibility. Women are the primary users of household energy.

As the availability of traditional fuel sources and energies becomes increasingly commoditized and scarce, the feminization of poverty is exacerbated. As women venture further away from their homes, women are also more vulnerable to sexual harassment that can greatly impact their SRHR.

There is also evidence that longer walks with heavy loads have a negative health impact on women. In Uttaranchal, India, the heavy loads that women carry over long distances in search of firewood has led to a 30% higher rate of miscarriages compared with national averages.²⁸

The loss of medicinal plants, which are found in forests to treat ailments, particularly affects the availability of resource of poor women who rely on these plants for various treatments. Many of these plants are used to treat SRHR issues of women and girls.

While this section of the paper has focused on the health concerns that stem from the impacts of CC, there are also health consequences that arise from the causes of CC. Fossil fuels cause pollution which in itself leads to numerous health consequences that are well documented. In the area of SRHR, high levels of pollution have resulted in birth defects.

The Government of China has acknowledged there have been higher rates of birth defects due to pollution. The impact of pollution and SRHR needs to be further examined. There is also a need to examine the links between meteorological conditions and SRHR. For example, some studies have found increased incidence of eclampsia in pregnancy during climatic conditions characterized by low temperatures, high humidity or high precipitation.²⁹

4. Climate Change Induced Disasters And SRHR

The Asia Pacific region is one of the most disaster prone regions in the world.³⁰ Along with CC comes increasing exposure to disasters such as floods, tsunamis, and heat waves. Several studies have indicated that disaster mortality is higher for women because of differences in vulnerability.

A 2006 study of 141 natural disasters by the London School of Economics found that when women do not enjoy economic and social rights equal to men, more women than men die in disasters. It also found that boys are likely to receive preferential treatment in rescue efforts, and in the aftermath of disasters.³¹

The differing experiences of various countries illustrate how gender operates in the context of disasters. Following the 2004 Asian Tsunami, Oxfam found that in many villages in Aceh, and in parts of

India, females accounted for 70% of the dead. In the 1991 Bangladesh cyclone that killed 140,000 people, 90% were women and girls.³²

Increased harassment and abuse, both in the home and relief shelters, have been widely reported. Moreover, health care and proper hygiene are often inadequate in shelters, particularly for pregnant, lactating and menstruating women.³³ There is a high incidence of mortality among mothers during disasters and an increase in infant mortality. There is a lack of access to essential services after a disaster, especially contraception and SRHR services, which results in higher risks of mortality among pregnant women.

Women and girls are more sexually vulnerable in times of natural disasters as the protection they get from their partners and families is in disarray. Whereas for post disaster vulnerabilities that female folks encounter, there is an increase in girls getting married at an early age, school dropouts, sexual harassments, trafficking and prostitutions, and more risks of transmission of Sexually Transmitted Diseases (STDs).³⁴

*“Studies during Pakistan’s emergencies show that Gender Based Violence (GBV), and Sexual and Reproductive Health and Rights violations occur side-by-side. For instance, a rapid assessment following the 2005 earthquake in Pakistan revealed that GBV has an impact on women and girls through forced sex, increased risk of unwanted pregnancies, STIs, sexual abuse, harassment, kidnapping, torture and forced marriage.”*³⁵

Violence against women, both from

intimate partners and unknown men, rises after disasters.³⁶ To protect women and girls SRHR in disasters, it is necessary for primary health care centres to have ambulances and instruments for emergency obstetric care, and an effective outreach strategy to reach pregnant women in remote areas, and have strategies in place to deal with GBV and sexual assault. The attention to the particular vulnerabilities of people of diverse gender, and sexual identities in times of disasters is a critical call for their rights and needs to be addressed by SRH service providers.

A failure to address the SRHR of all women and girls, people of diverse gender and sexual orientation in disaster situations is a violation of the rights of women and girls to non-discrimination in health as guaranteed by CEDAW and other international human rights instruments.³⁷ As a result of the impact of CC on natural resources and due to displacement as a result of disasters, there is an increasing number of climate induced migrants and climate refugees who often find themselves in unsafe circumstances that make them more vulnerable to sexual harassment.

5. Programs Underway In The Asia Pacific Region

There are several programs underway, globally and in the Asia Pacific region, that enable women to better adapt to

CC. These programmes are small in scale and scattered. None of them directly deal with issues of SRHR but indirectly address some of the issues associated with CC that has an impact on women’s SRHR. To illustrate the kind of programmes underway, a few examples are mentioned below. In the Philippines, to maintain food security the National Coalition of Rural Women is creating seed banks and planting indigenous seeds to take control over their food crops rather than relying on commercial companies for seed.³⁸

An Action Aid Project in Nepal has taught women to capture on video the ways in which they are coping with the impact of CC. They record how their local institutions are being built and adapted to deal with drought and flood.³⁹ The women in the project are put in touch with policy makers to have a voice in the development of appropriate CC policies. CARE is working in Bangladesh with women to empower them and to help them build climate resistant livelihoods such as duck rearing to maintain and sustain livelihoods under increasingly precarious climatic conditions.⁴⁰ However, while such programmes and projects are important as a start to the efforts of addressing gender issues in CC, they are very small in scale and do not directly address women’s SRHR.

6. Analytical Tools

There are tools to understand how best to address vulnerabilities that people face in the context of CC. For example,

the Vulnerability Capacity Index is a tool designed to measure the various elements that lead to vulnerability.⁴¹

While it examines vulnerabilities from a gender perspective, it would be useful to see how this tool can be extended to measure the vulnerabilities of pregnant women, women of child-bearing age, and children in particular. Similarly, Oxfam's Participatory Capacity and Vulnerability Analysis (PCVA) is designed to understand the hazards faced by a population and the factors that make them vulnerable to those hazards. In this tool, too, the particular vulnerabilities of pregnant women, and women with HIV and other debilitating STDs, could be considered as a separate category so that their particular vulnerabilities could be addressed and appropriate services could be delivered.

7. Moving Forward And The Agenda For Action

A set of recommendations is put forward here to ensure that the Sexual and Reproductive Health and Rights of women and girls are included in research, advocacy, policies, and service delivery.

7.1 Research

1. Develop evidence based linkages between CC and SRHR;
2. Carry out further research on the causes of CC, pollution from fossil fuels, and the impact on women's SRHR;

3. Clarify the underlying causes of CC, which includes a sharper focus on the roles that corporations and the military industrial complex play as primary contributors to CC.

7.2 Policy

1. Identify the key policy, resource, and institutional gaps to ensure that issues of SRHR and CC are a priority in the future;
2. Incorporate the SRHR effects of CC in NAPAS across sectors of government. More NAPAS should include greater access to rights based family planning that prioritizes the empowerment of poor communities affected by CC.
3. Ensure that adaptation strategies are responsive to gendered vulnerabilities.
4. Encourage a multi-sector collaboration: An integrated approach requires cooperation between development, environment and health organizations at both national and international levels.

7.3 Services

1. Increase investments in Rights-based Sexual and Reproductive Health Services including contraception that uphold the ICPD POA principles to enable 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 to ensure informed choices, and make available a full range of safe and effective methods. It also includes their right to make decisions concerning reproduction that is free of

discrimination, coercion and violence, so that women and their gendered vulnerabilities in the context of CC will be adequately represented.

2. Ensure that disaster relief resources, strategies, and tools include and address gender based violence (GBV) and SRHR for women and girls as well as for people of diverse gender and sexual orientation

7.4 Advocacy/Outreach

1. Support civil society interventions that empower women to hold governments accountable for the types of policies they develop and to ensure that mitigation and adaptation strategies address and include the SRHR of women and girls, people of diverse gender and sexual orientation.
2. Ensure that all national plans addressing climate change adaptation and mitigation plans include the provision of comprehensive SRHR services for all, delivered in the context of primary health care and not just narrowly targeted family planning.
3. Ensure that the particular vulnerabilities of adolescents are addressed so they do not drop out from school, face an early marriage or are not more vulnerable to sexual violence as a consequence of CC.
4. Support women's leadership in multi-faceted climate change responses.
5. Refute and challenge discourses that blame women's fertility for CC.

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Thematic paper 5:
**Religious Extremisms
and its Impact on Sexual
and Reproductive Health
and Rights of Women and
Young People in the
Asia-Pacific Region**

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1. Introduction

Religious extremisms have commonalities when it comes to views on, and regulations of, a woman's body and conduct.

This is demonstrated by the control and imposition of strict patriarchal interpretation of religious texts and their respective regulations and practices. When we talk about patriarchy in this context it refers to societal, cultural and individual institutions where power is located in males, and there tends to be an underlying belief in the inequality of men and women.

Religious extremists' concept of a good and noble society is particularly reflected in the control of women's bodies as a way of 'guarding their honour'.

This can lead to many types of harm for women, especially when religious extremism is allowed to gain space and voice of authority in social, civil, political and cultural institutions at all levels of society while being supported by political forces. This paper aims to give a brief overview of the many ways in which religious extremisms interact with women's sexual and reproductive health rights (SRHR) in the Asian region. The paper also endeavours to highlight the work being done to resist religious extremisms by women's rights NGO's and put forward recommendations for a way forward.

Considering the sizeable nature of both the topic and the region covered this paper should by no means be considered exhaustive, rather, it aims to spotlight different aspects of the issues involved.

What are Religious Extremisms?

Although fundamentalists are inherently conservative and wedded to the past, their ideas are essentially modern and highly innovative, says leading 20th century religious scholar Karen Armstrong.¹ This is evidenced by the fact religious fundamentalisms tend to be wedded to political agendas. Principles that respect gender equality and women generally can be found at the core in many if not most major religions, but it is not these principles that are emphasised. Rather it is principles that preserve traditional power structures and privilege.²

Fundamentalism as a term emerged from the North American protestant Christian context and implies the return to a singular religious text as being inerrant truth to live by. This is then not appropriate for other religions where religious doctrine comes from as number of different sources³ For the purpose of this paper, religious extremisms and religious fundamentalisms are used interchangeably.

According to Martin E. Marty and R. Scott Appleby, authors of the book series, *The Fundamentalist Project*, which compared Protestant Christian, Jewish, Sunni Muslim, Shia Muslim, Hindu, Sikh, Buddhist, Confucian and Shinto fundamentalisms 'fundamentalisms' followed certain patterns:

1. An embattled form of spirituality, emerging as a response to a perceived crisis;

2. Engaged in a conflict with enemies whose secularist policies and beliefs seem inimical to religion itself, which they deem as a war between good and evil;
3. Fear of annihilation, thus they try to fortify their beleaguered identity by means of a selective retrieval of certain doctrines and practices of the past;
4. To avoid contamination, they often withdraw from mainstream society to create a counterculture, yet cleverly absorbing the pragmatic rationalism of modernity to create an ideology that provides them with a plan of action.⁴

Additionally, Danguilan makes the point in reference to Marty and Appleby that "fundamentalists are totalitarian as they seek to remake all aspects of society and government on religious principles."⁵ It is important to note that forms of government do not determine the extent of influence of extremisms, and religious extremism can be found thriving in liberal democracies as well as in totalitarian or authoritarian contexts. Claiming that fundamentalisms are simply rejections of modernity is reductive and unhelpful.⁶

2. Religious Extremisms and Women in the Asian region

Religious extremism found its ground in the Asian region in the political and economic crises of a modern world after

most nations gained independence. As modern liberal democracies in many nations were established and so called 'westernisation' took place on a social and cultural level, reactionary religious protest groups emerged as conscious rejections to 'westernisation' and a way of protecting what was seen to be traditional values that were under threat.⁷

The Asian-Pacific Resource and Research Centre for Women (ARROW) have identified religious extremisms as being a major obstacle to the fulfilment of sexual and reproductive rights as human rights in the region.⁸

ARROW goes further in stating that religious extremism 'promotes stereotypes about women based on inequality between the two sexes, and religion is used also in the political arena to deny women full recognition of their rights.'⁹ Further to this evidence based monitoring of the ICPD Programme of Action in the Asia-Pacific region in 2009, pointed to religion as a barrier to contraception and abortion access in Indonesia, Malaysia, Philippines, and Pakistan.

Freedman, a leading figure in the world of health and human rights argues that religious extremism uses "women to map its territory and construct its borders." Women's sexuality and reproductive capacity are viewed as points of vulnerability and opportunity within the heightened concern about 'authenticity' and 'purity' of race or religion; therefore, women must be policed. Specifically, women's wombs need to be controlled to produce the 'pure' heirs of their race

or religion.¹⁰ This can be seen in various strains of religious extremism in the region.

According to Norani Othman, Islamic extremisms have one common feature among the diverse Islamist movements, namely that their discourse, agenda and projects affect women the most in terms of their status, rights, roles and responsibilities as members of the family and community. Women are most often considered as subordinate and second-class citizens.¹¹

Dasgupta has described Hindu fundamentalism as having its roots in the nationalist project of Hindu revival and reform that started in the 19th century. Women's empowerment was strictly confined through mythological references, overlooking more concrete reform measures of education, raising age of marriage and improving the status of widows. Women's sacrificial protection of their own chastity was lauded as courageous, as in the case of medieval Indian women who committed suicide rather than fall into the hands of Muslim invaders, or of women who burnt alive as Sati at the funeral pyre of their dead husbands.¹²

The development of Catholic Church ever since Christianity came to the Philippines in the 16th century has also seen some conservative interpretations of the Christian texts by Catholic leaders. According to Aguilin-Pangalangan, this has affected Filipino women in three main areas – divorce, abortion and contraceptive access. Not mentioned by Aguilin-Pangalangan but also

strongly affected are youth sexual and reproductive rights and sexual rights of persons of diverse sexual orientation and gender identities. Such restrictive interpretations of the Bible show unmitigated belief in absolute religious authority although more progressive views on these issues do exist.¹³

According to Khuankaew Buddhist teachings that originated 2,500 years ago did not discriminate against women. Over time due to the cultural influence of societies that were, before the advent of Buddhism (and still are) heavily patriarchal, a lot of misinterpretation has filtered into the teachings. In many forms of Buddhism it is now part of the doctrine to believe that being born a woman is the result of a previous bad karma and is a misfortune. An example of how this operates on a practical level can be seen when a woman experiences violence in her family. The violence believed to be the result of a bad karma from a past life and she has to accept it by making merits in her present life.¹⁴

3. Religious Extremism – Its Impact on Sexual & Reproductive Health & Rights on Women and Young Women

In this section, the paper will look at some of the crucial sexual and reproductive health and rights issues that women and youth are facing when religious extremisms are allowed to influence laws and policies. These issues include sexual and gender based violence, moral policing, barriers to accessing contraception and family planning, and restrictive family laws.

3.1 Sexual and Gender-based Violence

Religious extremisms often result in sexual and gender based violence either because some types of violence are deemed to be permissible according to religious doctrine such as female genital mutilation (FGM), or because violence is considered a logical consequence for not behaving in line with religious doctrine, such as honour killings. Below we elaborate on some specific types of gender based violence and how it impacts women.

Female Genital Mutilation

While there is no strict obligation or social demand for a boy or a man to remain a

virgin until he marries, many religious and socio-cultural identities in the region lay great importance on the 'purity' and 'chastity' of a girl or woman.

For example, FGM (Often referred to as female circumcision by those who defend it), is the practice which the World Health Organisation defines as including procedures which "intentionally alter or cause injury to the female genital organs for non-medical reasons,"¹⁵ has been condoned as a religious or traditional practice in order to 'cleanse' or control a young girl's sexuality, and to preserve her virginal state and preparation for 'adulthood' until the right time comes i.e. marriage.

The practice of FGM has health risks including but not limited to: "severe bleeding and problems urinating, and later cysts, infections, infertility as well as complications in childbirth and increased risk of newborn deaths."¹⁶ Furthermore the practice violates the right of young girls and women to decide what is best for their own bodies, as FGM is usually conducted at a young age without the consultation of the person it is being performed upon.

There are no direct religious texts that prescribe FGM, but cultural and traditional beliefs remain firm in allowing this practice to continue often because religious and cultural leaders claim there is a religious mandate for the practice, even though the evidence for this is tenuous. The United Nations 2009 report has listed India, Indonesia, Malaysia and Sri Lanka as countries where FGM has been documented in Asia.¹⁷

In Indonesia, although FGM was banned in 2006, two of Indonesia's Muslim organizations, including the largest and mostly moderate Nahdatul Ulama, ultimately condone the practice advising "not to cut too much". As a result, many continue to perform the procedure.¹⁸ In 2009, the Fatwa Committee National Council of Islamic Religious Affairs Malaysia decided that female circumcision is part of Islamic teachings and it should be observed by Muslims (obligatory or 'wajib'). However, the circumcision can be exempted if the practice brings harm to the person. .

A qualitative study done in Malaysia by Beatrice Letitia Haffner on Cultural Traditional Practices: Implications for Reproductive Health pointed out that female circumcision is a major health hazard affecting between 100 and 140 million women worldwide¹⁹. Her study concluded that female circumcision may lead to reproductive health hazards such as infections, pelvic inflammatory diseases, Bartholin's gland abscess and chronic vulvar ulcer and infertility.²⁰

The pressure on girls to remain a virgin until marriage has led to the shameful act of virginity testing in some countries. There was a CNN report in 2009 that virginity tests were conducted in Madhya Pradesh state, India which was then controlled by conservative Hindu nationalists who are members of the opposition Bharatiya Janata Party. The National Commission for Women (NCW) said they received reports that some 150 brides-to-be, mostly tribal women, were subject to 'virginity tests' before their mass wedding as part of a state

government scheme. This was however, denied by the state authorities, claiming that they were "just clinical examinations" aimed to keep the event free from any fraudulent entries -- like women already married, but wanting to get free wedding goodies.²¹ The Human Rights Watch report in 2010 also mentioned of abuses against Minors in Aceh where there have been cases of the Shari'ah police forcing female suspects to submit to virginity tests, which violated the rights of women and girls to physical integrity and privacy. Such tests are also unnecessary, as there is no legitimate medical or forensic rationale for such tests and it is discriminatory toward women and girls.²²

Honour Killing

The consequence of having sex outside marriage can be fatal, as in the case of honour crimes or honour killings. Extremists from religions of Hinduism, Judaism, Christianity and Islam have used honour killings to propound the idea that women and girls as property with no rights of their own and it is upon the men or leaders of the tribe to decide their fate, and to justify killing them if they bring 'shame' or 'dishonour' to the family or tribe.

According to women's rights advocates, the concepts of women as property, and of honour, are so deeply entrenched in the social, political and economic fabric of Pakistan that the government mostly ignores the regular occurrences of women being killed and maimed by their families."²³ At most, such deaths are sometimes recorded as suicide or deaths by accident. In 2005, the average annual

number of honour killings for the whole nation was stated to be more than 10,000 per year.²⁴ In 2008, the media reported that three teenage girls were buried alive by their tribe in a remote part of Pakistan to punish them for attempting to choose their own husbands, in an "honour" killing case.²⁵

In Amnesty International's 2011 report, gender-based violence, including rape, forced marriages, "honour killings", acid attacks and other forms of domestic violence, was committed with impunity as police were reluctant to register and investigate complaints. According to the women's helpline Madadgaar (based in Pakistan), 1,195 women had been murdered as of late November 2011. Of these, 98 had been raped before they were killed. These Madadgaar figures showed a total of 321 women raped, and 194 gang-raped.²⁶

Furthermore, most honour killings are encompassed by the 1990 'Qisas and Diyat' Ordinance, which permits the individual and his or her family to retain control over a crime, including the right to determine whether to report the crime, prosecute the offender, or demand *diyat* (or financial compensation). Since most honour killings are committed by a close relative, if and when the case reaches a court of law, the victim's family may 'pardon' the murderer, or be pressured to accept *diyat* (financial compensation). Once such a pardon has been secured, the state has no further writ on the matter although often the killers are relatives of the victim.²⁷

According to the Honour Based Violence

Awareness Network, particular issues in Hindu communities are caste and *gotra* (patriline). Marriage opportunities are very restricted and there may be particularly fierce (and violent) opposition to any contact between a woman and a male of lower caste; marriages within a *gotra* are condemned as incestuous. Panchayats (small local council) have actively policed *gotra* restrictions and called for the deaths of couples who have contravened such norms.²⁸

In some cases, young men in the LGBTIQ community suffer a similar fate. United Nations High Commissioner for Refugees state that “claims made by LGBT persons often reveal exposure to physical and sexual violence, extended periods of detention, medical abuse, threat of execution and honour killing.”²⁹

3.2 Moral Policing

In Malaysia, moral policing that applies only to Muslims, is regulated under the Syari’ah Criminal Offences Act (SCOA) 1997. It exists to control ‘moral conduct’ turning what are otherwise personal religious obligations into legal obligations which can be prosecuted under the SCOA. It is the replacing of personal values with ‘state values’ that have the force of law. Both Malaysia and Indonesia are seeing the growth of morality policy sanctioned by the state at different levels.

In 2009, a Shari’ah High court in the state of Pahang, Malaysia sentenced Kartika, a Muslim woman with maximum penalty of a fine of RM5,000 and 6 lashes after she plead guilty to drinking beer in public.

Sisters in Islam together with the Joint Action Group for Gender Equality (JAG) voiced strong opposition to the caning and submitted a memorandum to the Prime Minister of Malaysia, raising several issues on shari’ah and constitutional grounds, sentencing guidelines, and Malaysia’s commitments to international human rights instruments.

While the Kartika case was given huge media coverage and outcry from human rights groups from local, regional and international levels, the Home Ministry since (year) announced that the Prisons Department has caned three Muslim women for committing illicit sex and giving birth to babies out of wedlock.

Sisters in Islam questioned the government’s motive in proceeding with the caning of the three Muslim women, and doing it surreptitiously implies that the government wanted to hide this degrading and unjust treatment from public scrutiny. Sisters in Islam also questioned whether the men involved were also found guilty for illicit sex and similarly sentenced and caned.³⁰

Malaysia and Aceh in Indonesia have what is known as ‘khalwat’ (close proximity or seclusion) laws that are used to prosecute Muslim men and women who are accused of being together without any family connection or legal marriage, there is a supposition that illicit sexual relations or activities leading to illicit sexual relations may occurred between the parties. Sisters in Islam have protested and said that khalwat raids should not be carried out in a way that degrades human dignity and the practice of barging into people’s

houses and bedrooms in particular, clearly violates an individual’s right to privacy and human dignity protected by the Quran.³¹

There are serious violations of human rights in Aceh when the Shari’ah police are accused of power-abuse and raping suspects detained under the Seclusion Law.³²

3.3 Abortion and Contraception

Abortion

Many religious extremist views deem abortion to be killing of an innocent life, which they consider a grievous sin and although there have been progressive interpretations of religious texts, both Catholic and Muslim, the overwhelming objection to abortion has made even some professionals such as doctors and those working in Family Planning centres to be reluctant to carry out legal abortions.

Most of the Malay women interviewed in Malaysia in 1993 as part of the IRRRAG study regarded abortion as a sin only permissible for serious health reasons and not for unmarried women, although the women were aware of traditional methods of abortion.³³ Their actual practice however differed from their belief.

According to the 2005 report by Asian-Pacific Resource and Research Centre for Women (ARROW), the constitution of the Philippines recognizes life from the moment of conception and criminalises abortion except to save the life of the

mother. In countries where the procedure is legal, governments have failed to ensure that accessible and safe abortion care services are available to women.³⁴

The Reproductive Rights Advocacy Alliance Malaysia (RRAAM) believes that in spite of the 1989 liberalisation of Malaysia’s Penal Code to allow abortion for physical and mental health reasons, the law was not widely known.³⁵ Religious barriers have been cited due to the misconception of service providers on Muslim fatwas (legal opinion) on abortion and the prohibition of the Vatican on abortion.

Although in 2002 the National Fatwa Council in Malaysia (legal advisory under sya’riah law) issued a fatwa declaring that an abortion after 120 days gestation is considered murder unless the mother’s life is in danger or there is fetal impairment, this was not publicized or adopted by states.³⁶ There are additional restrictions for minors under 18 years seeking abortion, such as parental consent requirements that undermine the ability of young people to make independent decisions about their own health, and making them vulnerable to abuse.

Magdalena Lopez and Luz Chua of the Catholics for Reproductive Health, Philippines mentioned that some of the arguments with respect to abortion used by Catholic religious leaders state that all life is sacred and abortion is murder and a mortal sin. According to them, abortion violates the constitution, which equally protects the life of the mother and the life of the unborn, therefore abortion

is illegal under any circumstances. This understanding translates that the unborn child’s life is of greater importance than that of the mother’s.

According to Aguiling, Philippine law provides an exception to the abortion ban which can be inferred from the duty of the physicians to save the life of their patients. However, criminal liability for abortion is not only confined to the woman who procures the abortion, but extends to the physician and midwife, the parents of the pregnant woman who consent to the abortion, and the pharmacist who dispenses prescriptions. This makes doctors extremely unwilling to risk providing abortions which could be contested later.³⁷

Abortion is a taboo subject in Pakistan although it does take place fairly often in rural and urban areas. The popular perception is that abortion is illegal when in reality it is legal in specific circumstances, including where the health of the mother is in danger. Although abortion is permissible for rape victims and underage violations, the government will not publicly admit or acknowledge that these are happening. There is progressive opinion that abortion and medical abortion is allowed (120 days is permissible) and a girl does not need to inform her parents. Sex outside marriage is considered illegal thus is kept hidden and not made public.³⁸

Contraception

In Malaysia, contraception is allowed for spacing purposes but not for permanent use for Muslims unless for health and

welfare issues, and only made available widely in Ministry of Health services for married couples. Young people selectively are provided with contraception from government services. Contraceptive Prevalence Rate (CPR) has stagnated for the past 25 years due to low policy and service priority, as well as increasing religious influence very little research done on the deeper reasons for this. Some services require the permission from a husband for IUD or ligation.

There needs to be a concerted effort by women’s rights groups to conduct dialogues and meetings with policy makers and seminars with service providers. Reproductive Rights Advocacy Alliance Malaysia (RRAAM) is organising state level seminars on reproductive rights, contraception and abortion, and has covered over 1,000 since 2007. As of now, direct contact with religious officials has not been established, only with selected Muslim leaders who are considered as allies.³⁹ According to Zaitun Kasim, sexual relations and pregnancies outside of a ‘legitimate’ heterosexual marriage are generally deemed unacceptable in most parts of the Muslim world.

In the Philippines, where 83% of the population is Roman Catholic, religious fundamentalism backed by political power has become a formidable barrier to women’s access to family planning. Catholic forces have gained considerable influence over the policy-making process and have used their influence to push forward a conservative agenda and RH programme that focuses upon only natural methods of family planning.⁴⁰

Rev. Vincent Joseph Lachina from Planned Parenthood, USA has laid out six reasons for the rise of religious fundamentalism – the decline of economic justice, the ongoing battle for power, the generational divide, decline of the moderate church, the loss of media control and the absence of a strong progressive leader.

He also stressed that the religious extremists have been loud in giving misconstrued information that contraceptives will promote increased sexual activity, and the ‘dangers’ of population control.

Sex education is seen as a tool to promote promiscuous behaviour and the sole method that should be taught is through ‘abstinence’. Rev. Lachina also argued that religious extremism gains its importance in the renewed rise of the patriarchal system and religious sexism, where men are redefining the role of women and demonizing family planning organizations. He also mentioned that there is a connection between religious fundamentalism and politics.

In countering the religious extremism, Rev. Lachina said the pluralistic approach is important which implies that there is ‘One God, Many Voices’.

In Pakistan, the MMR is 260/100,000⁴¹. There are 75 registered Muslim sects and 95% of those are Sunni. Access to family planning services is only for those who are married. The contraceptive prevalence rate for modern methods in Pakistan is a mere 21.7% according to the Pakistan DHS (2006-07).

3.4 Family Laws and State Policies

In Malaysia, a proposal to recognize marital rape as a punishable offence was dropped from a national Domestic Violence Act because of opposition from religious conservatives (Muslim) in Parliament.⁴² The Islamic Family Law Act (1984). Zaitun “Toni” Mohamed Kasim, a leading human rights, sexual rights and women rights activist, stressed that, in matters of marriage and divorce, women are constantly reminded of their subordinate positions in the home and are warned of the dire consequences of challenging this. Zaitun listed ways in which this occurs include the following:

- The presence of a wali (male guardian) to ‘give the woman away’ in marriage is still a legal requirement in many countries with Muslim populations
- Polygamy has become synonymous with Islam, although its origins predate Islam. The verse in the Koran on polygamy is almost always interpreted and codified as the sole right of a Muslim man, although progressive interpretations of the same verse is taken as restriction towards polygamy, leading towards a total ban as in Tunisia since 1956.
- Domestic violence is underreported, as some women and men believe that Islam gives men the right to beat their wives.
- Women still face great difficulty in accessing divorce while men are given full right to divorce at will, sometimes through SMS/text messaging.
- Impact on sexual minorities: Transgendered and transsexual

persons are often vulnerable to social persecution and violence as well as legal prosecution. Transsexuals can be detained under either Civil Law as well as the Shari’ah Laws. However, Muslim transsexuals, in particular male-to-female transsexuals, are more often arrested under the SCOA for ‘wearing women’s clothes for immoral purposes’ and can be fined and/or imprisoned. Sex-reassignment surgery for Muslim transsexuals is illegal in some Muslim majority countries, like but legal in Iran or Egypt.⁴³

Elizabeth Aguilung-Pangalangan, professor at the University of the Philippines (U.P.) College of Law mentioned that there are only two Catholic countries in the world, where divorce is not recognized – Malta and the Philippines. Except for the recognition of foreign divorce decrees and Muslim divorce, the Philippines has no divorce law.

When there is a breakdown in marriage, Filipinos avail instead of a declaration of nullity of marriage based on psychological incapacity (Article 36 of the Family Code). A serious consequence of the no-divorce but pro-nullity stance in the Philippines is that it allows for abuse of the Article 36 and the petitioner in the nullity cases to present a psychiatrist or clinical testimony to nullify the marriage. According to the Office of the Solicitor General, petitions for civil annulment increase by 15% every year.

Also to be noted is the evidence of the perception that marital violence contradicts the very foundation of marriage. The 2003 report of the

Philippine National Police shows that wife battering accounted for 53.6% of the total 8,011 cases of violence against women. The constitutional intent is for the Philippines to remain a secular state. But the failure of the government to introduce true reforms to directly improve the lives of people has led to distrust and cynicism.

Thus, Filipinos turn to religious institutions for guidance. The Church’s interpretations and selective literalism of what it claims to be the core Christian teachings is rarely questioned. This has caused suffering for many, especially women, on which the non-recognition of reproductive and sexual rights disparately impacts.

The Philippine experience in the area of sexual and reproductive rights undeniably confirms that the state favours Catholicism and the government encourages the imposition of Roman Catholic Church teachings on all civilians, irrespective of the actor’s own religious beliefs or non-beliefs.

The right to gender equality and the protection of women’s rights enshrined under the Constitution and the Women in Development and Nation Building Act are likewise ignored. Aguilung-Pangalangan concludes that to allow the predominant church to direct public policy and government to apply it equally to Catholics and non-Catholics alike is to ignore human rights protected by the Constitution and other laws.

It dilutes the role of free will and perpetuates the discrimination of women and the continued subjugation of their rights, freedoms and identity.⁴⁴

4. Countering Religious Extremism by Women’s Group in Asia Pacific

Despite the difficult circumstances a lot of positive work has been done by women’s groups in resisting religious fundamentalisms across the region on a variety of different levels.

In the state of Gujarat in India, Sahiyar a women’s rights organisation has worked against Hindu fundamentalism through the unique use of *Garba* (folk dances) which have allowed them to convey complex messages about women’s rights in ways everyone can understand. They also provide training and capacity building for women so that they have the tools to respond to local situations⁴⁵.

In Indonesia student union groups have found success in creating publications that are accessible to all to make people think about pluralism as an alternative to fundamentalism.⁴⁶

In Pakistan the women’s rights movement has advocated for clear rules of law rather than looking to the principles of equality within Islam. Those in power are able to leverage their particular interpretations of Islam so the women’s movement has looked to advocating for clear laws that protect women.⁴⁷

5. Conclusions and an Agenda for Action

Religious fundamentalisms present a difficult climate for women accessing their SRHR and achieving gender equality. However women’s groups have responded to the challenge utilising a diverse range of tactics that challenge people’s attitudes and reinforce women’s autonomy.

There have, however been setbacks in the advances of women’s rights in countering the effects of religious extremism, especially under the SRHR due to governments’ pressure to respond to the demands of religious authorities or conservative political parties, and a more religiously conscious electorate.

Laws have been amended to reflect the more conservative religious roots, as what can be seen happening in Iran, Malaysia and Aceh in Indonesia. Multi-religious Singapore and Malaysia, Muslim women have been excluded from gender-sensitive reform processes in civil law, where non-Muslim women are enjoying far greater rights of gender equality.

Women’s groups that push for law reform come into conflict with traditional religious authorities and extremists who accused them of being Western feminists and a threat to the existing patriarchal and traditional religious values, that have been made to believe as the only rightful interpretation and practice of one’s religion.

In order to counter such religious extremism, Norani Othman has put forward the following women's rights activities to formulate strategies to promote such rights in the form of:

- Networking – building alliance to promote the awareness of SRHR, even working with women Member of Parliaments. Sisters in Islam in Malaysia is engaged with other civil society movement, especially in the area of women's and human's rights, to push for reform within Islam. In Iran, secular and Islamist feminists work together in their advocacy.
- Reclaiming the religion – It is important that SRHR issues are looked within the context of religion in the interpretive process, codification or implementation by building knowledge from progressive and rights perspective, and women from Iran, Malaysia and Indonesia are at the forefront in engaging with the religion and challenging patriarchal and extremist interpretations of Islam.
- Working with media – Mass media is crucial for women's rights groups to be heard, especially with the usage of social media in creating an active public space and discussion on SRHR to engage with the 'silent majority' that are mostly afraid to speak out for fear of backlash from religious extremists.
- Reforming curricula in education institutes to promote progressive understanding of religion and SRHR – Indonesia is at the forefront in reforming its curricula to produce critical and progressive Muslim graduates.
- Writing and Publications of easy-to-

read materials – In order to break the dominance of religious books from classical texts and traditional interpretations, women's rights groups have to make an effort to counter with simple booklets especially on right to equality and issues of domestic violence, polygamy, child marriage, abortion and family planning.(ex. SIS booklets)

- Participation of Men – As the shift within a patriarchal society is still in the making, men's voices have more influence and impact, especially in matters of religion. Women's rights groups need to engage with progressive men and get them to speak on women's issues and SRHR.

Overall a multi-dimensional approach must be taken that works both from inside religion as well as outside it. Women's rights groups cannot simply hope to change society in order to change legal frameworks, both these sites of action must be worked upon simultaneously in order to achieve functional change that protects women at the soonest possible eventuality.

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Outcomes Of The Regional Meetings

The extensive discussions and conversations at the two meetings led to concrete outcomes including a call to action that is aimed at the governments in the region urging them to prioritize SRHR to realistically address the grave issues in the region; a regional action plan for advocacy in the lead up to the ICPD global review in 2014 and lastly, a partnership was formed to bring our knowledge, experiences, efforts and spirits together for coordinated and persistent efforts in prioritizing women, young people, other vulnerable and marginalized groups and ensure their sexual and reproductive health and rights are protected in the next development framework beyond 2014.

Outcome 1:

KUALA LUMPUR CALL

TO ACTION

Asian and the Pacific NGOs Call for Sexual and Reproductive Health and Rights for Sustainable Development¹

3rd May 2012;
Kuala Lumpur,
Malaysia

Who We Are

We, 121 cross-generation activists, advocates, and representatives of NGOs from diverse social movements from 27 countries in Asia and the Pacific, have gathered in Kuala Lumpur, Malaysia to revitalise the sexual and reproductive health and rights (SRHR) agenda for sustainable development in the region, drawing from the commitments made in the Programme of Action of the International Conference on Population and Development (ICPD PoA) and the Millennium Development Goals (MDGs).

As we face a world in multiple crises, we call for the inclusion and prioritisation of women and young people's SRHR in new development frameworks that take stock

of current consensus documents and move beyond them to fully achieve our human rights.

Why This Call?

Asia and the Pacific, where we live and work, is a diverse region of inequalities and paradoxes, ranging from small island states to populous sub-continent. Home to 61.3 percent of the world's people, as well as 60.4 percent of all women and 62.6 percent of youth,² the region has two-thirds of the world's poor,³ 62.5 percent of the world's hungry,⁴ and 42 percent of maternal deaths³ with as high as 27 percent of these maternal deaths resulting from unsafe abortions.⁵ Even as many countries in the region are becoming classified as middle-income countries and thereby no longer a priority for aid, drastic inequality and inequity remain. Despite great need and demand, in 2010 alone, the funding gap in the region for SRHR was US\$6.73 billion.⁶

While there have been some important gains, almost 20 years after ICPD and the Beijing Platform for Action, we continue to face challenges in the region, such as lack of SRHR services resulting in maternal mortality and morbidity, women's anaemia and malnutrition, and lack of access to contraception and family-planning, as well as early age of marriage and pregnancy.⁵ Lack of access to comprehensive sexuality education, and rights-based information and services for vulnerable groups is a concern across the region.⁵

Women and young people who are poor,

have limited formal education, live in remote and/or rural areas, from tribal groups, from ethnic minorities, from lower castes, are LGBTQI people,⁷ are displaced, migrants or refugees, are in sex work or live with disabilities, face greater difficulties in accessing comprehensive sexuality education and services, and making decisions about their own bodies. Policymaking and programme development relegate sexuality to reproductive functions, and shifting the paradigm to an affirmative sexuality framework is a challenge.

These include the lack of focus on sexual pleasure; the lack of access to comprehensive sexuality education; the lack of recognition of the concepts of marital rape, sexual harassment, sex-work, and the sexual and reproductive rights of people of diverse sexual orientations and gender identities.⁵

Various forces impede the SRHR agenda globally and regionally. The ICPD PoA has become sidelined in the development agenda, and the concept of SRHR has been narrowed down. The language of rights and development has become appropriated by forces that push for political, religious, and neoliberal/market fundamentalist agendas.

Challenges include the return of population control discourses, imposition of regressive aid conditionalities, market-based approaches to health and food provision, aggressive trade policies that hinder access to health services and healthy food systems and food security, disasters, militarism, conflict, climate change, religious fundamentalism, as well as the food, fuel, and finance crises.

Our Call

We call on our governments, international organisations, including UN agencies, development partners, and other duty bearers to take the following actions:

1. Recognise that gender equality, equity, and sexual and reproductive rights are central and integral to sustainable development.

Achieving sexual and reproductive rights must be placed within a broader frame that includes fulfilling basic rights to education, health, food, nutrition, housing, livelihood, political participation, and freedom of expression; addressing various inequities and inequalities, including between and within nations, communities and families; and achieving social justice.

2. In reshaping the international political and development agenda beyond the ICPD PoA and MDGs, ensure a comprehensive and holistic SRHR agenda. Such an agenda should include abortion rights, adolescents and young people's sexuality, affirmative sexuality, including the right to seek pleasure and other sexual rights.

3. Review, amend, and implement laws and policies to address the needs and realities of women, young people, and LGBTQI persons, and to uphold human rights, including sexual and reproductive rights. This includes amending laws and policies that deny access to SRHR information and services, such as those that require parental or husband's consent, as well as those that criminalise

abortion, HIV transmission, sex work, diverse sexual orientation and gender identities. Affirming laws that uphold the human rights of sexual and gender non-conforming persons should be enacted and implemented. Laws to address human rights violations, including gender-based violence, early marriage, early childbirth, homophobia and transphobia, and discrimination against people living with disability, need to be drafted and implemented. At the minimum, laws and policies need to be underpinned by international human rights law, and affirm sexual and reproductive rights.

4. Ensure that accountability mechanisms are in place and adhere to the highest standards of transparency in order to monitor progress in achieving SRHR, social equality and equity, and universal access for all. Regional inter-governmental bodies of ASEAN⁸, Pacific Islands Forum, and SAARC⁹ should promote the institutionalisation of these mechanisms.

5. Fulfil the right to universal access to a continuum of quality care and comprehensive sexual and reproductive health services, supplies, and information, through all levels of healthcare and public provisioning. This would include provision of the full range of contraceptives (including emergency contraception), services to ensure maternal health and nutrition, emergency and comprehensive obstetric and postnatal care services, interventions for maternal morbidities including uterine prolapse, services

for safe abortion and management of abortion complications, infertility treatment, access to medication and treatment for STI and HIV and reproductive cancers, and appropriate referral systems. Services and programmes for SRHR, HIV, and gender-based violence need to be interlinked, and disability-friendly, and available even in times of conflict, disasters, migration, and displacement.

6. Provide universal comprehensive sexuality education (CSE) in formal and non-formal education systems, as well as in out-of-school and workplace settings, which is age-appropriate, gender-sensitive, disability-friendly, evidence-based, context-specific, and acknowledges the evolving capacities of young people. Provide 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. 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. We acknowledge the successful outcomes of the 45th session of the UN Commission on Population and Development in this regard.

7. Conduct and support ethical, gender-sensitive research that provides the evidence for

policymaking and programming related to SRHR and its linkages with other issues. Data should be disaggregated according to age, sex, and other socio-economic indicators. Implement civil registration and vital statistics systems, conduct regular health surveys and studies and make information and analysis accessible to the public. Address significant data gaps in monitoring and reporting on ICPD PoA and MDGs. In the forthcoming review and reporting processes, meaningfully engage NGOs and progressive social movements, and recognise the validity of qualitative studies, case studies, and experiences from the field as evidence.

8. Unequivocally endorse, sustain and scale up domestic resources and official development aid (ODA) for the implementation of comprehensive SRHR interventions in the region. Increase domestic resources and national health spending, including on SRHR. Commit to and implement rights-based approaches to poverty reduction that are interlinked with health strategies, as long-term investments. Address financial, supply and demand side barriers to universal access to SRHR, including by implementing an efficient tax-revenue-based funding that aims at universal access, not only coverage. Developed countries, including in this region, must meet their ODA target commitments of 0.7 percent of gross national income (GNI). Bilateral and emerging donors should be encouraged to channel more funds to SRHR. The ODA to Asia and the Pacific must be increased to match needs; and the share for the health sector and

SRHR must also be increased. The total allocations needed for SRHR in the Asia and the Pacific is US\$25 billion by 2015.

9. Address the impact of religious extremism on SRHR for women, young people, LGBTQI persons and other vulnerable groups, including by removing legal and policy barriers based in political and cultural conservatism. Harness all forms of media, including social media, to promote the empowerment of women and respect for human rights.

10. Address the increased vulnerabilities of women and young people due to migration, climate change, disasters, conflict and displacement, and adopt concrete measures to mitigate their impacts, including on SRHR. Addressing SRHR among communities affected by these vulnerabilities requires eliminating disparities in accessing resources and SRHR services. Comprehensive SRHR responses must be integrated in existing programmes and services for migrants and displaced people. Women's bodies should not be the vehicle for climate change solutions, but concern for the impact of climate change on women should prompt effective as well as rights-respecting efforts. Climate change particularly affects small island states and disaster-prone areas of the region, which disproportionately impacts women and other vulnerable groups. These complex problems should be addressed using a gendered, intersectional approach, situating sexuality and rights concerns within

macroeconomic, environmental, and livelihood issues.

11. Abolish global and regional trade and financial policies that perpetuate food insecurity, malnutrition and interlinked SRHR concerns. Recognise that food security and nutrition greatly impact SRHR, particularly of women, young people and other vulnerable groups. In times of food insecurity, women bear the greater burden of work in meeting the gap of nutrition for the household, often leading to dangerous work, unsafe food sources and malnourishment of women and girls. Inequalities along the global food chain greatly exacerbate these vulnerabilities. Local food supply chains, particularly the role of women producers, should be supported. Unfair trade policies also affect access to lifesaving medicines and must be abolished.

12. Meaningfully engage NGOs and progressive social movements from the global South, particularly women-led and youth-led groups, as equal partners in development at all levels, and ensure an enabling environment for their work. Involve them in international development agenda-setting, implementation, and review processes.

Our Principles

We believe in the principles of bodily integrity, personhood, respect for diversity, and equality. All people are equal, regardless of their age, marital

status, sex, gender and gender identity, sexual orientation, economic status and livelihood, citizenship status, race, caste, ethnicity and religion, social and political opinions, geographical location, disability status, and HIV status, amongst other social factors.

We believe that all people have the right to sexual well-being, and to live lives free from discrimination, fear, coercion, violence, and sexual and reproductive ill-health. Women and youth have the right to be able to decide on reproductive matters, including avoiding unplanned, unwanted pregnancy by having access to contraception and to safe abortion services. Everyone has the right to comprehensive education and information on sexuality, sexual and reproductive health, and the right to high-quality, accessible, gender-sensitive, youth-friendly and non-judgmental comprehensive SRHR services.

We believe that sustainable development cannot be achieved without sexual and reproductive rights, and without addressing inequity, inequality and social injustice within and between countries, related to gender and class, amongst others. Additionally, sexual and reproductive rights are vital to achieving health, well-being, and gender equality.

We believe that SRHR is closely intertwined with HIV and AIDS and gender-based violence. SRHR is interlinked with other development issues, including poverty, food security and nutrition, education, labour, migration, democracy struggles, conflict, climate change, and the environment.

To support this Call, volunteer to translate it in your language, or get print copies for distribution, please get in touch with any of the following ARROW staff: Maria Melinda (Malyn) Ando (malyn@arrow.org.my), Rachel Arinii Judhistari (rachel@arrow.org.my) and Suloshini (Sulo) Jahanath (sulo@arrow.org.my). Or access it online: www.arrow.org.my/APNGOs/KL_Call_to_Action.pdf.

1. The Kuala Lumpur Call to Action is the outcome document of the ARROW-organised regional meeting, Beyond ICPD and MDGs: Strategizing for Sexual and Reproductive Health and Rights in the Pacific and the subject of this report. To know the members of the drafting team, see the Acknowledgement page of this report. See Annex 3 for the names of the independent activists and representatives of groups who participated in the conference and supported this Call.
2. World Population Prospects: The 2010 Revision, <http://esa.un.org/wpp/Other-Information/faq.htm>
3. United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), Asian Development Bank (ADB), and United Nations Development Programme (UNDP). 2010. Paths to 2015: MDGs in Asia and the Pacific.
4. Food and Agriculture Organization. 2010. The State of Food Insecurity in the World 2010: Addressing Food Insecurity in Protracted Crises.
5. Thanenthiran, S. & Racherla, S. 2009. Reclaiming & Redefining Rights – ICPD+15: Status of Sexual & Reproductive Health & Rights in Asia. Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).
6. Gil, M.B. 2010. Making SRHR Count: Asia Pacific Resource Flows Project 2010. Bangkok: Asia Pacific Alliance for Sexual and Reproductive Health and Rights (APA).
7. Lesbians, gays, bisexuals, transgender, transsexual, queer, and intersex people.
8. Association of Southeast Asian Nations.
9. South Asian Association for Regional Cooperation.

Outcome 2:

Kuala Lumpur Plan of Action To accelerate the achievement of SRHR in Asia-Pacific

Participants from 27 countries across the region sat together, discussed the key issues facing the region, and looked at the key opportunities that may arise in the next few years with the upcoming review processes for ICPD, MDGs, and the Beijing Platform for Action, and put together sub-regional plans of action which then were included into this regional plan of action.

Key Issues

Key issues that emerged in the sub-regional discussions were the need to build the momentum for SRHR in a world where the MDGs is the governing paradigm for development and that comprehensive agenda of the ICPD, especially in the key area of sexual and reproductive rights, has been ignored. Additionally, the aggregated overall reporting figures continue to mask inequalities and inequities between and within countries. Gender inequality and inequity remains a critical issue despite educational attainments.

Universal access to comprehensive quality SRH services, supplies, and information for all, continues to be a challenge. More specifically, there is a lack of services for

the prevention, screening and treatment of all forms of reproductive cancers; a lack of comprehensive sexuality education and youth-friendly services; and access to safe abortion services. The recognition that sexuality is diverse and that there is a life-cycle of sexuality in addition to a life-cycle of reproduction is an emerging paradigm. Migration and climate change bring new challenges to the SRHR field, while perennial issues such as gender-based violence continue to persist.

A renewed cultural-religious rights framework continues to impede the achievement of SRHR of all people. Meaningful engagement and leadership of NGOs and progressive social movements from the global south as equal partners in development, particularly women-led and youth-led groups, is seen as a critical working methodology that lacks attention and investment.

It is essential to also engage with the macroeconomic framework in order to create a more just, equal and equitable world where every human being enjoys his/her full SRHR.

Actions

A broad range of actions from macro-level interventions to interventions at the global, regional, and national levels were discussed.

Macro-level Interventions

- ▶ Create visibility of the issue; demand creation
- ▶ Look at new spaces and create new spaces that are not UN-driven
- ▶ Creating a research agenda for the lesser explored issues
- ▶ Cross movement work to expand the SRHR agenda
- ▶ Use of media for visibility of our issues
- ▶ Do our homework with regards: who is with us/against us across all stakeholders

Global Interventions

- ▶ Participation at the hi-level fora
- ▶ Participation in global meeting venues
- ▶ Monitoring of private-public partnerships and the impact of privatisation of health on the achievement of universal access to SRHR
- ▶ Work with special rapporteurs on Health, Cultural Rights, VAW etc.
- ▶ Organise side events during key global events
- ▶ Women and young people from global south to lead global processes

Regional Interventions

- ▶ The creation of a regional advocacy campaign and regional advocacy materials
- ▶ Regional and sub-regional advocacy capacity building workshops
- ▶ Sharing of resources and capacities across organisations across the region
- ▶ Identification of events to participate and intervene in

- ▶ Advocacy dialogues with regional stakeholders on a proactive basis
- ▶ Create a regional/ sub-regional list-serv in the lead-up to 2014/2015
- ▶ Have a sub-regional meeting to build coherence on sub-regional issues
- ▶ Organise side events at regional processes

National Processes

- ▶ Create national level network of NGOs to facilitate and push the ICPD agenda, with perhaps the formation of a national level steering committee
- ▶ National level advocacy during key days and events
- ▶ National dialogues with governments on the issues/educating new leaders in government on SRHR and the ICPD
- ▶ Documentation of good/effective advocacy practices
- ▶ Create an NGO summit at the national level to build the momentum for SRHR
- ▶ Meet, connect, and link with UNFPA at the national level
- ▶ Create and sustain national level momentum

Opportunities

Some of the key advocacy opportunities in the next 3 years (2014/2015) include:

1. ASEAN People's Forum
2. Global Parliamentarians meeting (2012; Istanbul)
3. VAW meeting (2012; Sri Lanka)
4. APCRSRHR (2014; Manila)
5. Youth Global Forum (December 2012; Bali)
6. Asia Pacific Population Conference (2013)
7. Rio + 20 (June 2012)
8. SEAHRN (Oct 2012; Jakarta)

9. ESCAP Regional Review (June-Sept 2013)
10. Women Deliver Conference (May 2013; Kuala Lumpur)
11. CPD (April 2013/April 2014)
12. UNGASS on ICPD
13. CSW (March 2013/March 2014)
14. ASEAN & SAARC interventions
15. PIC interventions: health ministers meeting
16. Global HR meeting of UNFPA (Netherlands)
17. Global Women's Health meeting of UNFPA
18. MDG Global processes
19. World Conference on Women
20. United Nations World Youth Conference (2014; Sri Lanka)

Outcome 3:

Kuala Lumpur Plan of Action Asia-Pacific Partnership For SRHR And Sustainable Development

Concept Note

Introduction

By 2014, the landmark international agreement document of the Cairo Programme of Action (ICPD PoA) will reach specific time-bound goals, and similarly, in 2015, we will reach the target date for achieving the Millennium Development Goals (MDGs). These conferences and time-bound goals have been significant in placing women's sexual and reproductive rights in the global development agenda. However, a number of reasons have contributed to the reversing of the accomplishments over the years.

These include limited funding resources and competing agenda, lack of leadership, shift in government commitments and responsibilities in providing health care, and the growing opposition groups to sexual and reproductive rights. In addition, persistent development issues such as poverty, food security and nutrition, access to sexual and reproductive health; and emerging issues such as climate change, increasing

displacement and migration, and the aforementioned rising religious extremism threaten to further derail progress.

This year is also critical as at the Earth Summit (Rio+20) the global development agenda and a plan for sustainable development for the future will be deliberated and drawn up. In the lead up to 2014-2015, it is critical that civil society and the people from the Asia-Pacific region are able to articulate their demands, and to ensure that upcoming development agendas of governments, inter-governmental organisations and donors are in tandem with the needs, realities and experiences of the Asia-Pacific region. There is also a need to redefine the development agenda in the wake of current global challenges and to mitigate the risk of losing the gains that governments have committed to in the ICPD Programme of Action.

The Beyond ICPD & MDGs: NGOs Strategising for SRHR in the Asia-Pacific Region meeting was organised with the objective of strategising and defining a comprehensive SRHR agenda for the region within the new development framework. It will bring together close to 100 activists, academics, researchers, development practitioners, parliamentarians, and donors/development partners from over 25 countries in the region and globally.

The participants will discuss critical SRHR issues that are inter-linked to broader developmental as well as region-specific pertinent issues of Universal Access to

Sexual and Reproductive Health, Poverty, Climate Change, Displacements and Migration, Food Security and Religious Extremism. The meeting came up with key recommendations and advocacy strategies for prioritising SRHR in the new development framework post-ICPD and MDGs.

Why a SRHR and Sustainable Development Partnership?

To ensure the action-oriented follow-up of the meeting, ARROW proposes the formation of a regional coalition/partnership, of the participating organisations. This partnership/coalition functions in order to keep the momentum going up to and beyond the ICPD and MDGs.

The rationale to form a partnership comes from the basic belief that:

- ▶ Building a coalition of individuals and organisations within and across movements will strengthen not only the SRHR movement and agenda from within but other movements as well, such as Youth, HIV/AIDS, VAW, Environment, Population, Economic and Trade to name a few
- ▶ SRHR is an integral part of comprehensive health, and human rights and is linked to all other development issues and therefore it should be integrated into every aspect of the development agenda
- ▶ Health outcomes are determined by social conditions in which people

are born, grow, live, work and age, including the health system, and therefore the social determinants of health are important issues that need to be incorporated fully into the development agenda

- ▶ Young people constitute 60% of the world population, and are critical in taking the development agenda forward, yet are not fully engaged or solicited in shaping the development agenda
- ▶ Advocacy and shaping of policies around SRHR should be based on evidence from the ground in the region, that reflect the lived realities of people
- ▶ A collective approach to lobbying and advocacy can step-up the pressure on policy makers and governments to be accountable and deliver on the commitments made
- ▶ The perspective, needs and experiences of the region need to be taken into the global processes and to influence the setting of the global development agenda
- ▶ An emphasis on human rights is needed to ensure that the most marginalised and vulnerable groups' needs and rights are addressed in policy and programme development and implementation

For all these reasons, ARROW believes that a strong coalition/partnership needs to be formed among organisations and individuals in this region as well as the global South, committed to securing the SRHR needs and rights of all women, especially for the marginalised and socially excluded on the basis of age,

ability, gender, socio-economic and political conditions, and geographic location; and that SRHR is an integral part of sustainable development.

Proposed Principles that the Partnership will Uphold

These are: equity, equality and justice; human rights and women's rights; respect for diversity; meaningful participation; transparency and accountability.

How will the Partnership Work?

Membership: All organisations and individuals committed to the goals of attaining SRHR for all and the core principles are invited to be members of the coalition/partnership. Individual and organisational allies will be asked to sign up to be part of the coalition.

Working Modality: The operations of the coalition/partnership will be managed by a Secretariat. This will be on a rotational basis, with each term being three years.

Decision-Making: Based on the core principles, the decision-making will happen through an open process. An electronic list will be set up to enable communication and all decision-making will be done through a transparent policy, where every coalition member has the opportunity to fully participate in the decision-making.

Please send your responses and feedback to:
Nalini Singh: nalini@arrow.org.my



Annex

Annex 1

Concept Note of the Regional Meetings

Introduction and Background

The coming three years are critical to the Sexual and Reproductive Health and Rights (SRHR) agenda. In three years, by 2015, the target date for achieving the Millennium Development Goals (MDGs) will have been reached. At the same time, the Beijing Platform of Action developed at the Fourth World Conference on Women and the Cairo Programme of Action, developed at the International Conference on Population and Development (ICPD) will have reached their tenure.

In 2010, the MDGs reached their 10 year turning point, but progress towards MDG5 has been unacceptably slow. The main reason is that target 5b: “Universal access to reproductive health”—a critical intervention to reduce maternal deaths—was only adopted 5 years on, and its relevant indicators were ascribed only in 2007. This meant that the SRHR agenda ‘lost’ 7 years of political prioritisation by both national governments and international donors.¹ Additionally, hostility to several dimensions of the SRHR agenda has grown throughout the Asia-Pacific region and at the international policy-making arenas, thereby reducing political and financial commitment to the issue.

The MDGs were a strategic call in the year 2000 that rallied the international community behind common goals and a common vision. However, the current global scenario demands a more holistic and critical take on the development agenda. There is a need to develop a forward-looking vision and a clearly delineated and clearly articulated agenda with regards to the new development framework which will emerge in 2015.

This regional SRHR agenda needs to take stock of current realities and anticipated future trends in the Asia-Pacific region. Some of the key current trends are enumerated below:

- ▶ Climate change, which will affect the region’s poor disproportionately²;
- ▶ Global economic, financial, and food crises, which will impact sexual and reproductive health (SRH) achievements especially for the region’s poor³ and the region’s least developed countries disproportionately;
- ▶ Migration trends, which highlight new SRH service needs as well as new definitions of ‘couples’;
- ▶ New aid architecture and financial and health sector reforms underway in the region, which impact SRH service provision;
- ▶ Human rights approaches and mechanisms, which support access to health services and SRHR;
- ▶ New and emerging challenges such as disaster⁴, conflict, and fragile states;
- ▶ Continuing challenges in age-old SRHR issues such as maternal mortality and access to contraception and family-planning, which continue to hamper

the region’s SRHR achievements and progress⁵;

- ▶ Rising religious conservatism (negatively impacting the women’s SRHR) and the concertisation of the power of religious conservatives within the state;
- ▶ Inter-sectionality of individual identities which exacerbate social and health inequities;
- ▶ Regionalisation of the UN which will see regional forums and regional meetings as a critical advocacy space to further the SRHR agenda.

There is also an urgent need to revitalise the role of NGOs, nationally, regionally, and globally, within the development community:

As development partners;

- To monitor and hold governments accountable to their national and international commitments;
- To continue advocating for (a) issues that are either new and innovative (such as sexuality rights) or necessary but perceived as contentious (culture/country specific gender inequality issues such as child marriage; and (b) access to comprehensive sex and sexuality education and access to safe abortion services) to help improve MDG5 outcomes.

This meeting will bring together a broad array of academics, activists, policymakers, donors, and civil society representatives across the broad spectrum of SRHR issues and different movements: human rights, migration, environment and climate change, poverty, women’s rights, progressive, faith-based, and sexuality organisations.

The meeting will bring together participants across 23 countries in Asia and the Pacific (**South Asia:** India, Bangladesh, Nepal, Pakistan, Bhutan, Maldives, Sri Lanka, and Afghanistan; **Southeast Asia:** Malaysia, Indonesia, East Timor, the Philippines, Thailand, Vietnam, Lao PDR, Burma, and Cambodia; **East Asia:** China; **Central Asia:** Iran; **Pacific:** Fiji, Kiribati, Papua New Guinea, and Samoa) to ensure that the agenda developed is grounded in reality.

Objectives

The meeting on “Beyond ICPD and the MDGs: NGOs strategising for sexual and reproductive health and rights in the Asia-Pacific region” aims to:

- Ensure the Asia-Pacific SRHR agenda and its interlinkages with other development issues are clearly defined in order to inform the ICPD+20 and the post-MDG development framework ensuring that the region is a priority for development investment
- Develop recommendations to inform policies and programs of the Asia-Pacific agenda.
- Bring together key organisations, networks, governmental and inter-governmental bodies, and individuals to form an alliance/coalition which will revitalise the agenda and will be able to place SRHR within the development and funding framework regionally and internationally.
- To share ICPD and Beyond 2014 Global Survey processes with the NGO stakeholders.

Participants

The meeting will involve participants from all identified 23 countries in the region. It will also bring expert paper writers, discussants, reviewers, rapporteurs, and moderators to facilitate and provide input into the meeting processes.

Outputs expected

This meeting will define and discuss the comprehensive SRHR agenda of the Asia-Pacific region and will chart the avenues for advocacy and effective engagement for NGOs. The meeting will also equip NGOs with necessary advocacy skills to facilitate their active engagement in all processes leading up to defining the development agenda post 2014-2015. The presentations on the thematic papers, the inputs from the discussants, and the recommendations, discussions and deliberations arising from the meetings will inform the post ICPD+20 development agenda.

1. This happened despite governments and NGOs welcoming the landmark 1994 Programme of Action (PoA) of the ICPD with its progressive, rights-based stance. The assumption was that the SRHR community would only grow from strength to strength from that juncture. Sixteen years later, there is a need to recognise that the implementation of the ICPD PoA has been chequered.
2. Climate change will affect almost all of the Pacific countries and many of the Asian countries with large populations such as Bangladesh, Thailand, and Indonesia.
3. It is estimated that two-thirds of the world’s extreme poor live in the Asia-Pacific region.
4. With over 50% of the total world disasters, the Asia and Pacific Islands region represents the widest and most disaster prone continent in the world.
5. With over 50% of the total world disasters, the Asia and Pacific Islands region represents the widest and most disaster prone continent in the world.

Annex 2

Agenda

Beyond ICPD and the MDGs: NGOs Strategising for Sexual and Reproductive Health and Rights in the Asia-Pacific region

2 May 2012
Kuala Lumpur,
Malaysia

8:00 am – 9:30 am | Registration

Step 1: attendance and collection of meeting package

Step 2: sign-up for World Café Sessions

9.30 am – 10.15 am | Welcome Note

Ms. Sivananthi Thanenthiran, Executive Director, ARROW

Ms. Eva Schoening, Project Advisor, Sector Initiative Population Dynamics,
Sexual and Reproductive Health and Rights, GIZ

Keynote Speech

Dr. Dina M. Siddiqi, Visiting Associate Professor at Hunter College, U.S.A

10:15 am – 10:30 am | **Moderator's Note**

Professor Datin Dr. Rashidah Shuib, Director, Women's Development Centre (KANITA),
University Sains Malaysia

10.30 am – 11.00 am | Tea Break

11.00 am – 11.30 am | Plenary 1

**Universal Access to Sexual and Reproductive Health and Rights of women and
young people in the Asia-Pacific Region**

Presented by: **Dr. Subha Sri**, Clinic Director, RUWSEC, India

Thematic paper written by: **Dr. Sundari Ravindran**, Professor of Achutha Menon
Centre for Health Science Studies, Sree Chitra Tirunal Institute For Medical Sciences &
Technology

11.30 am - 12.00 pm | Plenary 2

**Poverty and Sexual and Reproductive Health and its impact on SRHR of women and
young people in the Asia-Pacific region**

Presented by: **Dr. Manju Nair**, Faculty Member, Achutha Menon Centre for Health
Science Studies, Sree Chitra Tirunal Institute For Medical Sciences & Technology

Thematic paper written by: **Dr. Manju Nair**

12.00 pm - 12.30 pm | Plenary 3

**Food Security and Nutrition and its impact on SRHR of women and young people in
the Asia-Pacific region**

Presented by: **Dr. Marilen Danguilan**, Senior Advisor, Social Protection, UN World Food
Programme

Thematic paper written by: **Dr. Marilen Danguilan**

Thematic Papers - Beyond ICPD and the MDGs:

NGOs Strategizing for Sexual and Reproductive Health and Rights in Asia-Pacific

2-4 May 2012; Kuala Lumpur, Malaysia

12.30 pm – 12.50 pm | Q & A session

Professor Datin Dr. Rashidah Shuib, Director, Women's Development Centre (KANITA),
University Sains Malaysia

12.50pm – 1.00pm | Programme Note

World Café Sessions

1.00 pm – 2.00 pm | Lunch

2.00 pm - 4.00 pm | **Simultaneous World Café Sessions**

Group 1: Universal Access to Sexual and Reproductive Health and Rights of women and young people in the Asia-Pacific Region

Discussants for Group 1:

Dr. Sylvia "Guy" Estrada Claudio, Director of the University of the Philippines Centre for Women's Studies & Professor of the Department of Women and Development Studies, College of Social Work and Community Development, University of the Philippines

Ms. Sunita Kujur, Director, Feminist Leadership & Movement, CREA

Group 2: Poverty and Sexual and Reproductive Health and its impact on SRHR of women and young people in the Asia-Pacific region

Discussants for Group 2:

Ms. Rokeya Kabir, Member of the South Asia Alliance for Poverty Eradication (SAAPE)
Prof. Nathalie A. Verceles, Board of Trustees, Likhaan and Professor at the University of the Philippines Department of Social Work and Community Development

Group 3: Food Security and Nutrition and its impact on SRHR of women and young people in the Asia-Pacific region

Discussants for Group 3:

Dr. Narimah Awin, Regional Advisor Making Pregnancy Safer and Reproductive Health (MRH), WHO SEARO

Ms. Sivananthi Thanenthiran, Executive Director, ARROW

4.00 pm - 4.30 pm | Tea Break

4.30 pm - 5.00 pm | Reporting back

Presentation of discussions/recommendations from World Café sessions

Meeting Rapporteurs:

Ms. Rishita Nandagiri, Youth Representative

Ms. Anita Chávez-Berry, Independent Consultant

Dr. Gill Greer, Independent Consultant

5.00 pm – 5.30 pm | Wrap- up of the first day of the discussions

Professor Datin Dr. Rashidah Shuib, Director, Women's Development Centre (KANITA),
University Sains Malaysia

6.30 pm | Welcome Dinner

At the Islamic Arts Museum of Malaysia and Launch of the ICPD+15 Series Reports

Beyond ICPD and the MDGs: NGOs Strategizing for Sexual and Reproductive Health and Rights in the Asia-Pacific region

3 May 2012
Kuala Lumpur,
Malaysia

8:30 am – 9:00 am | Registration for second round of World Café sessions

9.00 am – 9.15 am | Reflections from Day One

Professor Datin Dr. Rashidah Shuib, Director, Women's Development Centre (KANITA),
University Sains Malaysia

9.15 am - 9.45 am | Plenary 4

**Climate Change and its impact on SRHR of women and young people
in the Asia-Pacific region**

Presented by: **Ms. Ambika Varma** on behalf of **Dr. Jael Silliman**, Independent
Consultant, formerly Program Officer for Women's Rights & Gender Equity in the Human
Rights Unit, Peace and Social Justice Program of the Ford Foundation

Thematic paper written by: **Dr. Jael Silliman**

9.45 am – 10.15 am | Plenary 5

**Migration/Displacement and its impact on SRHR of women and young people in the
Asia-Pacific region**

Presented by: **Ms. Maria Lourdes Marin**, Executive Director of Action for Health
Initiatives (ACHIEVE)

Thematic paper written by: **Ms. Maria Lourdes Marin**

10.15 am – 10.45 am | Tea Break

10.45 am - 11.15 am | Plenary 6

**Religious Extremism and its impact on SRHR of women and young people in the
Asia-Pacific region**

Presented by: **Ms. Ratna Osman**, Executive Director, Sisters in Islam, Malaysia

Thematic paper written by: **Ms. Ratna Osman**

11.15 am - 1.15 pm | Simultaneous World Café Sessions

**Group 4: Migration/Displacement and its impact on SRHR of women and young
people in the Asia-Pacific region**

Discussants for Group 4:

Dr. Muhadjir Darwin, Professor, Center for Population and Policy Studies Gadjah Mada
University, Indonesia

Ms. Nartrapee Wongseangchundr, Senior Programme Officer, Department of Program
Quality Development, Raks Thai Foundation, Thailand

**Group 5: Climate Change and its impact on SRHR of women and young people in the
Asia-Pacific region**

Discussants for Group 5:

Ms. Avelina Rokoduru, Research Coordinator Pacific Sexual & Reproductive Health
Research Centre (PacS-RHRC), College of Medicine, Nursing & Health Sciences, Fiji
National University, Suva

Dr. Anna Whelan, Independent Consultant

**Group 6: Religious Extremism and its impact on SRHR of women and young people
in the Asia-Pacific region**

Discussants for Group 6:

Ms. Dina M. Siddiqi, Visiting Associate Professor, Hunter College, U.S.A

Ms. Magdalena Lopez, Senior Advisor – International Program, Catholics for Choice

1.15 pm – 2.15 pm | Lunch

2.15 pm - 2.45 pm | Reporting back

Presentation of discussions/recommendations from World Café sessions

Meeting Rapporteurs:

Ms. Rishita Nandagiri, Youth Representative

Ms. Anita Chávez-Berry, Independent Consultant

Dr. Gill Greer, Independent Consultant

2.45 pm – 3.00 pm | Video Screening

Islamic perspectives on Contraception and Abortion

ARROW

3.00 pm - 3.30 pm | Tea Break

3.30 pm - 4.30 pm | Discussion on the Way Forward

Professor Datin Dr. Rashidah Shuib (Director, Women's Development Centre (KANITA),
University Sains Malaysia)

Ms. Nalini Singh, Programme Manager, Advocacy and Capacity Building, ARROW

4.30 pm – 4.45 pm | KL Call to Action

Nida Mushtaq, Programme Officer, ICPD Review, ARROW

4.45 pm - 5.00 pm | Closing Address

Dame Carol Kidu, Member of Parliament, Papua New Guinea

5.00 pm – 5.15 pm | Closing remarks

Ms. Sivananthi Thanenthiran, Executive Director, ARROW

Opportunities for NGOs at National, Regional, and International levels in the Asia-Pacific Region in the Lead-up to 2014: NGO-UNFPA Dialogue for Strategic Engagement

4 May 2012
Kuala Lumpur,
Malaysia

8.30 am – 8.45 am | Registration

8.45 am – 9.00 am | Opening Remarks

Kiran Bhatia, Gender Advisor, Asia and the Pacific Regional Office, UNFPA

9.00 am – 10.00 am | Briefing on the ICPD beyond 2014

process Kwabena Osei-Danquah, Executive Coordinator, ICPD Beyond 2014 Secretariat, UNFPA

10.00 am – 10.30 am | Engaging Civil Society and youth in the ICPD beyond 2014

process Noemi Espinoza, Civil Society Partnerships Specialist, ICPD Beyond 2014 Secretariat, UNFPA

10.30 am – 11.00 am | Tea Break

11.00 am – 12.45 pm | Dialogue between UNFPA

Civil Society and Youth on ICPD beyond 2014 process

Moderator:

Professor Datin Dr. Rashidah Shuib, Director, Women's Development Centre (KANITA), University Sains Malaysia.

Panellists:

Ms. Kiran Bhatia, Gender Advisor, Asia and the Pacific Regional Office, UNFPA

Mr. Kwabena Osei-Danquah, Executive Coordinator, ICPD Beyond 2014 Secretariat, UNFPA

Ms. Galanne Deressa, Deputy Director, Asia and the Pacific Regional Office, UNFPA

Ms. Noemi Espinoza, Civil Society Partnerships Specialist, ICPD Beyond 2014 Secretariat, UNFPA

Ms. Maren Andrea Jimenez, Chief, Social Policy and Population Section, UNESCAP

12.45 pm – 2.00 pm | Lunch & Friday Prayers

2.00 pm – 2.15 pm | Briefing on the Working Group session

2.15 pm – 3.45 pm | Sub-regional Working Group session:

NGOs breaking up into sub-regional groups to develop action plans for advocacy in the lead up to 2014

- South East Asia
- East and Central Asia
- South Asia
- The Pacific

3.45 pm – 4.00 pm | Tea Break

4.00 pm – 4.40 pm | Reporting back from the sub-regional groups

(10 mins presentation by each group)

Sub-regional group rapporteurs

4.40 pm – 5.00 pm | Way Forward – regional Plan of Action for ICPD+20 Review

Professor Datin Dr. Rashidah Shuib, Director, Women's Development Centre (KANITA), University Sains Malaysia.

Dr. Gill Greer, Independent Consultant, New Zealand

Rishita Nandagiri, Youth Officer, WGNRR

Sivananthi Thanenthiran, Executive Director, ARROW

5.00 pm – 5.30 pm | Closing Remarks

Kiran Bhatia, Gender Advisor, Asia and the Pacific Regional Office, UNFPA

Kwabena Osei-Danquah, Executive Coordinator, ICPD Beyond 2014 Secretariat, UNFPA

Sivananthi Thanenthiran, Executive Director, ARROW

5.30 pm – 6.30 pm | Evening Drinks

Annex 3

Youth Strategy Paper

As an ardent supporter and advocate of young women's SRHR for almost two decades in the Asia-Pacific region, ARROW is committed to meaningfully involve young people in its landmark regional meeting on 'Beyond ICPD and the MDGs'. ARROW has invited a number of youth organizations to participate in the meeting and have organized for their meaningful involvement throughout the meeting and its follow-up plans. There will be a total of 11 young people, representing 8 countries, leading the discussions related to young people at the meeting

(Annex I: list of participants).

Below is an overview of how and in what capacity these young people will be engaged at the meeting:

Youth Strategizing Meeting

ARROW has organized for a one-day strategizing meeting for the youth representatives participating in the meeting. The meeting will be held a day prior to the regional meeting where our young participants will meet the presenters/speakers of the session, have a media briefing by our expert media consultant, input on the draft outcome statement of the meeting and also strategize to effectively involve in the thematic discussions at the meeting. This is all to ensure that the youth perspectives are incorporated at every step of the discussions at the meeting and they are reflected well in the outcome statements/documents of the meeting. *(Annex II: Agenda of the Youth Strategizing Meeting)*

Youth in the Thematic Sessions

Each of the six themes identified for

discussions at the meeting clearly states young people as a priority group. These themes include:

1. Universal access to sexual and reproductive rights of women and young people in Asia-Pacific
2. Poverty and its impact on SRHR of women and young people in Asia-Pacific
3. Food security and nutrition and its impact on SRHR of women and young people in Asia-Pacific
4. Climate change and its impact on SRHR of women and young people in Asia-Pacific
5. Migration and displacement and its impact on SRHR of women and young people in Asia-Pacific
6. Religious extremisms and its impact on SRHR of women and young people in Asia-Pacific

ARROW has invited youth representatives with specific knowledge of the above-mentioned themes. The respective youth representatives will engage in the discussions on these themes. ARROW has prepared a resource pack including articles, blogs and book excerpts on relevant issues that will be distributed amongst the youth representatives beforehand (*Annex III: Resource Pack List*). The youth representatives will decide on allocation of themes at the strategizing meeting beforehand.

Youth as Rapporteur of the Meeting

ARROW has engaged Ms. Rishita Nandageri as the youth representative in the team of the Rapporteurs of the meeting. Ms. Rishita Nandageri will work closely with two other rapporteurs of the meeting

to prepare an analytical report of the meeting involving discussions on the thematic sessions highlighting the youth perspective in all aspects of the meeting.

Youth in the regional ICPD+20 discussions

On the last day of the regional meeting i.e. May 4, 2012, ARROW and UNFPA will facilitate a dialogue amongst the NGOs on the Asia-Pacific regional chapter of the global ICPD operational review. One of the objectives of this meeting is to ensure that NGOs on ground are aware of the ICPD operational review in their respective countries and can engage with their governments and the coordinating UN agencies to input into the review process. The youth organizations participating in the meeting will be attached to their respective national partners with whom they will work further in the lead up to 2014/2015.

Youth as an important stakeholder of the regional Alliance

ARROW has proposed that the participating organizations at the meeting form a regional alliance to further the agenda/outcomes of the meeting and effectively represent the Asia-Pacific at the global SRHR agenda-setting avenues in the upcoming years. The youth organizations thus participating in the meeting will become important stakeholders in this alliance and will engage on regional-level with other like-minded organizations to promote youth SRHR in Asia-Pacific.

The concept note and the draft statement of the Alliance will be reviewed by the youth representatives at the strategizing

meeting where we will already incorporate their feedback into it before presenting it to wider participants at the meeting.

This avenue will be utilized to advance the network's strategy and mobilize young people in the region to further involve them in this regional network while we plan for regional interventions in the lead up to 2014/2015.

Consultation for ARROW for Change (AFC) Youth Edition

AFC is a peer-reviewed journal produced periodically by ARROW on emerging themes linked to women's SRHR in the Asia-Pacific region. This year, ARROW will produce a special edition on young people's SRHR. ARROW's young staff will be in charge as guest editors of this edition of the AFC. The proposed theme is: 'Positioning young people (especially young women/young feminists) for next development agenda'.

The issue will cover the trajectory of upcoming development agenda translated into, economic power and young women (which cover employment, access to resources, entrepreneurship, and poverty); young feminists at the ICPD review; as well as the role of rampant advancement for technology and social media for young people's SRHR. ARROW will lead the consultation process with the youth representatives regarding the theme of this issue of AFC and to identify key contributors for articles for this issue.

Solidarity Dinner

ARROW has organized a solidarity dinner for our youth participants on May 1, 2012. This avenue will be utilized informally to enhance network building among the youth participant coming from diverse backgrounds and organizations in the region.

Annex 4

List of Participants

Thematic Papers - Beyond ICPD and the MDGs:

NGOs Strategizing for Sexual and Reproductive Health and Rights in Asia-Pacific
2-4 May 2012; Kuala Lumpur, Malaysia

Asia

AFGHANISTAN

Dr. Shaqaiq Ashrafi Dost
National Programme Officer, MCH
Aga Khan Health Services

BANGLADESH

Mr. Md. Mohabubul Haque
Secretariat
People's Health Movement (PHM)

Ms. Nazmoon Nahar
Member
Doorbar Network

Ms. Rokeya Kabir
Member
South Asia Alliance for Poverty Eradication
(SAAPE)

Ms. Samia Afrin
Advocacy Officer
Naripokkho

Ms. Shireen Huq
Executive Director
Naripokkho

BURMA

Ms. Naw She Wah
National Coordinator
Myanmar Positive Women's Network

CAMBODIA

Dr. Ouk Vong Vathiny
Executive Director
Reproductive Health Association
Cambodia (RHAC)

CHINA

Ms. Cai Yiping
Executive Committee member
Development Alternatives with Women
for a New Era (DAWN)

Prof. Kaining Zhang
Director
Yunnan Health and Development
Research Association (YHDRA)

INDIA

Ms. Disha Sethi
Programme Coordinator
The YP Foundation

Ms. Anjali Sen
Regional Director
International Planned Parenthood
Federation South Asia region (IPPF SARO)

Ms. Indu Capoor
Director
Centre for Health Education, Training and
Nutrition Awareness (CHETNA)

Ms. Jashodhara Dasgupta
Coordinator
SAHAYOG

Dr. Manju Nair
Faculty Member
Achutha Menon Centre for Health Science
Studies
Sree Chitra Tirunal Institute for Medical
Sciences

Dr. P. Balasubramanian
Executive Director
Rural Women's Social Education Centre
(RUWSEC)

Ms. Prabha Nagaraja
Director, Programmes
TARSHI (Talking About Reproductive and
Sexual Health Issues)

Dr. Shilpa Shroff
Programme Assistant
Asia Safe Abortion Partnership (ASAP)

Ms. Smita Bajpai
Advocacy Officer
Centre for Health Education, Training and
Nutrition Awareness (CHETNA)

Dr. Subha Sri Balakrishnan
Clinic Director
Rural Women's Social Education Centre
(RUWSEC)

Ms. Sunita Kujur
Director, Feminist Leadership & Movement
CREA

Ms. Y.K. Sandhya
Advocacy Officer
SAHAYOG

INDONESIA

Dr. Aditiana Dewi Eridani
Director
RAHIMA

Ms. Atashedertani Habsjah
Vice Chairperson
International Planned Parenthood
Association (IPPA)

Ms. Diana Pakasi
Team Member
Center of Gender and Sexuality Studies
University of Indonesia

Prof. Dr. Muhadjir Darwin
Gadjah Madja University

Dr. Ninuk Widyanoro
Chair, Advisory Board
Yayasan Kesehatan Perempuan (YKP)

Ms. Nur Hidayati Handayani
National Coordinator
Aliansi Remaja Independen (ARI)

Ms. Sri Kusyuniati
Country Representative
RutgersWPF

Ms. Yati Kaprawi
Independent Documentary Film Maker

IRAN

Dr. Kianoush Khalili
President
Iran Family Planning Association (FPA)

JAPAN

Ms. Makoto Yaguchi
Chief, Advocacy Group
Japanese Organization for International
Cooperation in Family Planning (JOICFP)

LAOS PDR

Dr. Alongkhone Phengsavan
Faculty of Medical Sciences
University of Health Sciences (UHS)

Mr. Vieng Akhone Souriyo
President
Lao Positive Health Association (LAOPHA)

MALAYSIA

Ms. Khatija Mohd Bakti
Administrative Assistant
Reproductive Rights Advocacy Alliance
Malaysia (RRAAM)

Ms. Kuek Yen Sim
Head of Programme Services
Federation of Health Association Malaysia
(FRHAM)

Ms. Lim Hwei Mian
Programme Officer
International Council on Management
of Population Programmes (ICOMP)

Miss. Manis Chen
Drop In Coordinator, Sex Workers
Programme
PT Foundation

Ms. Maria Chin Abdullah
Executive Director
Menjana Kuasa Wanita (EMPOWER)

Ms. Rashidah Abdullah
Co-chair
Reproductive Rights Advocacy Alliance
Malaysia (RRAAM)

Professor Datin Dr. Rashidah Shuib
Director
Women's Development Centre (KANITA)
University Sains Malaysia

Ms. Ratna Osman
Executive Director
Sisters In Islam (SIS)

Ms. Rodelyn (RD) Marte
Programme Manager, Community
Advocacy Initiative
Asia Pacific Council of AIDS Service
Organizations (APCASO)

Dr. Wasim Zaman
Executive Director
International Council on Management
of Population Programmes (ICOMP)

MALDIVES

Mr. Abdul Hameed
Assistant Executive Officer
Society for Health Education (SHE)

MONGOLIA

Ms. Altanchimeg Badarch
Network Coordinator
Human Development, Reproductive
Health and Rights NGO Network

Ms. Nomingereel Khuyag
Young Women for Change NGO

Dr. Oyunaa Lkhagvasuren
President
Mongolian Family Welfare Association
(MFWA)

NEPAL

Ms. Anjana Shakya
Chairperson
Beyond Beijing Committee (BBC)

Ms. Bidya Bhattarai
Advocacy Officer
Beyond Beijing Committee (BBC)

Ms. Binjwala Shrestha
Member of the Board
Safe Motherhood Network Federation

Thematic Papers - Beyond ICPD and the MDGs:

NGOs Strategizing for Sexual and Reproductive Health and Rights in Asia-Pacific
2-4 May 2012; Kuala Lumpur, Malaysia

Mr. Pradip Pariyar
President
Association of Youth Organisations Nepal
(AYON)

Mr. Punya Bhandari
Programme Coordinator
Youth Action Nepal

Mr. Sabin Shrestha
Executive Director
Forum for Women, Law & Development

Ms. Pushpa Lata Pandey
GFA Consulting Group/GIZ

PAKISTAN

Ms. Khawar Mumtaz
Executive Director
Shirkat Gah Women's Resource Centre

Ms. Nabila Malick
Director Advocacy
Family Planning Association (FPA)

Mr. Qadeer Baig
Country Representative
RutgersWPF

Dr. Sikander Sohani
Director
Aahung

PHILIPPINES

Ms. Magdalena Lopez
Senior Advisor, International Program
Catholics for Choice

Ms. Marevic Parcon
Asia Programme Officer
Women's Global Network for Reproductive
Rights (WGNRR)

Ms. Mina Tenorio
Executive Director
Likhaan Centre for Women's Health

Dr. Eden R. Divinagracia
Executive Director
Philippines NGO Council on Population,
Health and Welfare

Professor Dr. Elizabeth Pangalangan
Executive Director
The Reproductive Health, Rights, and
Ethics Center for Studies and Training
(ReproCen)

Ms. Lalaine Viado
Cairo+20 Advocacy Associate
Development Alternatives with Women
for a New Era (DAWN)

Dr. Maria Belen Jesusa J. Danguilan
(Marilen)
Senior Advisor, Social Protection
UN World Food Programme

Ms. Maria Lourdes Marin "Malu"
Executive Director
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**Beyond ICPD and MDGs: NGOs
Strategising for Sexual and
Reproductive Health and Rights in
the Asia-Pacific Region** is a regional
meeting organised by the Asian-Pacific
Resource and Research Centre for Women
(ARROW) on 2-4 May 2012 in Kuala
Lumpur, Malaysia along with partner the
Deutsche Gesellschaft für Internationale
Zusammenarbeit (GIZ) GmbH and in
collaboration with the United Nations
Population Fund (UNFPA).

The meeting brought together 127
participants from 30 countries in the
Asia and Pacific region to define and
discuss the comprehensive sexual and
reproductive health and rights (SRHR)
agenda and chart the avenues for
advocacy and effective NGO engagement
leading up to 2014-2015.

This publication presents thematic papers
on the following issues: Universal Access
to Sexual and Reproductive Health,
Poverty, Migration and Climate Change

It also presents the way forward,
through the Kuala Lumpur Call to Action,
which makes specific demands from
governments, international organisations,
including the United Nations agencies,
development partners, and other duty
bearers. It also gives the sub-regional and
regional action plans to operationalise
the call to governments and international
bodies.

**The Asian-Pacific Resource and
Research Centre for Women (ARROW)**
is a regional, non-profit organisation with
a consultative status with the Economic
and Social Council of the United Nations.
Based in Kuala Lumpur, Malaysia, ARROW
has been working since 1993 to realize
a just, equitable, and equal world where
women attain their full sexual and
reproductive rights, and to enhance civil
society capacities to hold governments
accountable to their international
commitments related to the same.

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We work with more than 30 national
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