Regional Overview

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A REGIONAL OVERVIEW

This overview is based on the eight country monitoring reports listed below and a regional NGO consultation of the ARROW coordinated project, "ICPD Ten Years On; Monitoring and Advocacy on Sexual and Reproductive Health and Rights" funded by the Foundation, New York and NOVIB, Netherlands. It also draws on: eight NGO country reports to be published in 2005 by the Centre for Reproductive Rights, New York and ARROW as "Women of the World: Laws and Policies Affecting their Reproductive Lives – East and Southeast Asia", and papers of the Initiative for Sexual and Reproductive Rights in Health Reforms, and government reports to the 2002 ESCAP Asian and Pacific Conference.

The eight country monitoring reports and NGO Partners are:

Cambodia	Cambodian Midwives Association;
China	China Centre for Population Health and Development, Peking University;
India	CHETNA & ANS-WERS;
Indonesia	Indonesia Sexual and Reproductive Health and Rights Monitoring and Policy Advocacy Group;
Malaysia	Federation of Family Planning Associations, Malaysia;
Nepal	Beyond Beijing Committee;
Pakistan	Shirkat Gah and
Philippines	Likhaan.

The ARROW team:

Co-writing and compilation:	Rashidah Abdullah, Sai Jyothi, Syirin Junisya,
With comments from:	Nandita Solomon, Rathi Ramanathan, Augusta Khew and Nalini Keshavaraj

The comments of Ranjani K. Murthy and Barbara Klugman are also appreciated.

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Introduction

Ten years after the International Conference on Population and Development (ICPD), women's lives have seen only minimal improvement. Findings from NGO country-monitoring studies in Cambodia, China, India, Indonesia, Malaysia, Nepal, Philippines and Pakistan reveal that despite agreements to achieve the clear objectives and strategies outlined in the ICPD Programme of Action (PoA), governments have not yet been successful in implementing the majority of actions promised at that landmark conference. Preventable deaths from maternal mortality have only slightly declined in these eight countries: two million women are estimated to have died in the past decade from causes related to maternal mortality with some 259,530 of these dying from unsafe abortions. Violence against women is on the rise, as is HIV/AIDS transmission for women and men. Fifty years after family planning programmes began in the region, the expressed unmet need of Asian women for contraception is still high.

ICPD implementation has been slow in all countries, despite the acknowledged need to accelerate commitment and the effort to meet women's needs and rights, known as the spirit of Cairo. While many new population and reproductive health policies have been introduced in the countries that form part of this study, they still do not clearly incorporate a human rights and women's rights framework both at the conceptual and programme levels. There is also a large gap between what is stated and the actual implementation. Required resources for ICPD implementation are yet to be fully mobilised by national governments; and there is an even larger gap in committed resources from international donor agencies.

Methodology

This Regional Overview is based on the findings from eight country-monitoring studies in South and Southeast Asia coordinated by ARROW and NGO partners. The studies especially aim to:

- Assess progress in policies, laws and services and changes in women's health, status and lives.
- Identify the main barriers and facilitating factors in implementing commitments made in the Programme of Action, ICPD.
- Analyse the differences between governments' assessment of ICPD progress and that of NGOs and women's movements.
- Recommend critical actions to be taken by governments, NGOs, donors and UN agencies.

The aims are to be met by focussing, in particular, on the following four main areas of ICPD:

- The reproductive rights and reproductive health approach introduced in Cairo.
- Reduction of maternal mortality, unsafe abortion and unmet need for contraception.
- Promoting and protecting sexual health and rights (this includes preventing and treating HIV/AIDS and reproductive cancers and young people's rights to sexual and reproductive health information and services).
- Gender equality and women's empowerment.

Research Methods and Tools

The studies are based on primary research as well as secondary data.

1. Primary research: Qualitative research included the use of unstructured exploratory techniques: statistically small samples were used to monitor ICPD implementation in the eight countries. The study made use of 202 essential indicators developed at the planning meeting held at Kuala Lumpur (29 June-2 July 2003) by ARROW with inputs from country partners, researchers and external consultants (see annexure on essential indicators). NGOs who carried out the study are committed to the implementation of the Cairo agenda and were involved in monitoring and advocacy on sexual and reproductive health rights. Most were women-headed NGO groups working with a rights-based approach. The research methods adopted by country partners included

    - In-depth interviews with individuals from the community, local NGOs and the government. Those interviewed from the community included Traditional Birth Attendants (TBAs) and community members. Government interviews included service providers at the primary health care level, bureaucrats, policymakers and other key stakeholders in the area of sexual and reproductive health. A total of 480 interviews were conducted.

    - Focus Group Discussions (FGDs) at the community level, service provider level, with NGO groups and government counterparts to assess the impact and implementation of ICPD in the respective countries. A total of 45 FGDs were held.

    - Consultations on ICPD at Ten at the national and sub-regional levels in some countries as part of the agreed-upon methodology. A total of 16 consultations were held.

    - Dissemination seminars and dialogues on the research findings at the national level also formed part of the project activities.

2. Secondary research: The following secondary data sources were reviewed:

    - Eight country reports of the 'ICPD Ten Years On: Monitoring on Sexual and Reproductive Health and Rights in Asia'.

    - Reports of the 'Women of the World: Laws and Policies Affecting their Reproductive Lives- East and Southeast Asia', a Centre for Reproductive Rights (CRR), New York, project for which ARROW is the regional coordinator.

    - Six papers from the Rights and Reforms Initiative coordinated by the Women's Health Project, South Africa, on the impact of health sector reforms in Asia.

    - Literature review of the most recent qualitative and quantitative published reports of governments in the eight countries, NGOs, UN agencies and other research organisations in the area of sexual and reproductive health and rights.

- Recent National Demographic Health Surveys in the eight countries.
- ESCAP Government reports to the Fifth Asian and Pacific Population Conference, Bangkok, 2002.

Country Contexts

Although the eight countries have diverse historical, cultural, sociopolitical and geographical contexts, they also have some common circumstances and trends, which were found to be important barriers to ICPD implementation.

Poverty: Despite progressive reduction over the decade, poverty levels are still high in all countries except Malaysia (see tables 1 & 2).

Neo-liberal development agendas: All countries included in the study now have a neo-liberal development agenda as part of the globalised economy, with governments increasingly becoming less responsible for the provision of public services, including health. Once again, with the exception of Malaysia, all countries included here are increasingly dependent on the World Bank, USAID and the Asian Development Bank for development funding and the attendant conditions, in this case the introduction of health sector reforms.

Militarism: Growing militarism and national security concerns in Pakistan, Philippines, Nepal and India have meant less resource availability for the social sector, which includes health.

Political instability: Frequent changes in political administrations in the last decade in Pakistan, Indonesia, Nepal and the Philippines have meant a lack of continuity, and different interests and priorities among policymakers.

Religious opposition: In the Philippines, the Roman Catholic Church has intensified its efforts and successfully influenced political leaders to oppose modern family planning methods, emergency contraception, and abortion services. In Pakistan, conservative politically motivated Muslim organisations that do not believe in gender equality and women's rights, frequently oppose the agenda of women's rights activists. In India, the rise of Hindu religious fundamentalism under the Bharatiya Janata Party (in power until May of 2004), negatively affected women's rights.

ICPD Framework on Human Rights

The principles of the ICPD Programme of Action are firmly grounded in universal human rights as recognised in national laws and international human rights documents. These provide that all people are born free with equal dignity and rights and have the right to life, liberty, security of person, development and education. Women's human rights are stated in chapter II as 'inalienable, integral and [an] indivisible part of universal human rights'. Key to these rights is the eradication of all forms of discrimination on the grounds of sex and the full and equal participation of women at all levels of society. Specific to health is that 'everyone has the right to the enjoyment of the highest attainable standard of physical and mental health' and universal access to health care services.

Reproductive Rights and Reproductive Health

Rights-based Approaches

The ICPD Programme of Action defines reproductive health and rights in paragraphs 7.2 and 7.3 of chapter VII as interlinked concepts, which have both a rights and a health perspective. Chapter VII, titled 'Reproductive Rights and Reproductive Health', indicates that this is the overarching framework within which the discussion on family planning, STDs, HIV/AIDS and sexuality should take place. Rights come first in the chapter title as this provides the principles for action. The ICPD PoA explains this concept as 'The rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and the right to attain the highest standard of sexual and reproductive health...' It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence (Para 7.3).

The PoA further agrees that 'governmental goals for family planning should be defined in terms of unmet needs for information and services' and that demographic goals should not be imposed in the form of targets, quotas or incentives for recruitment of clients.

Within the region the many new reproductive health policies that shift away from a population control goal to comprehensive reproductive health and in some cases even to a broad human rights approach are evidence that there has been some policy progress. In India for example, all family planning incentives and disincentives were removed in 1996. The 1997 Reproductive Health and Child Health Programme abolished all demographically determined targets and adopted 'a client-centred, demand driven and quality service approach'. China's policy has clearly stated that the reproductive rights of citizens include the right to informed contraceptive choice and the right to receive free basic services. In 1995, the Philippines adopted the reproductive health approach, going beyond family planning, and similar policies were taken up by Pakistan (1997), Cambodia (1997) and Nepal (1998).

China (2002), India (2000), Pakistan (2000) and Indonesia (2004) developed new population policies or laws after Cairo while other countries retained existing policies (see table 3). Preliminary analysis indicates that although a broad reproductive health approach with a focus on gender equality and women's empowerment informed these policies, the emphasis continues to be on reducing population growth and 'encouraging' couples to consider small families (South Asia and Indonesia) and one to two children (China).

This kind of 'encouragement', however, is not consistent with the right to choose the number of children one wants, and when enforced with incentives or disincentives, is a violation of reproductive rights. At the time of writing, the Indonesian draft Health Law No. 23/92 was under debate on the issue of whether or not it should include the concept of reproductive rights. Similarly, in India the proposed constitutional (79th Amendment) Bill envisages that a person shall be disqualified from being allowed to become a member of either house of legislature of a state if he/she has more than two children. In the words of Gita Sen, 'Although it may seem reasonable to expect those who wish to stand for office to abide by the small family norm, requiring this may be unconstitutional and ultimately coercive' (Sen, 2002).

Also of great concern is the reversal of policy progress in India and the Philippines. Following the 2000 national population policy, several states in India, including Uttar Pradesh and Bihar, have adopted independent population policies in 2001, which have demographic targets. Recently, the ruling United Progressive Alliance (UPA) announced in its Common Minimum Programme that 'a sharply targetted population control programme will be launched in the 150-odd high fertility districts'[1] across all states. Such plans are not in line with India's new national population policy formulated in 2000.

A related concern is the fact that reproductive health NGOs and women activist NGOs were not centrally involved in the formulation of new population policies in all these countries although there were some consultations when drafts were being prepared. The extent of NGO involvement in the development of new reproductive health programmes in countries, other than the Philippines and India, also needs to be assessed. This lack of involvement by women NGOs in policy formulation does not only reflect the views of governments on the role of such NGOs, but also speaks for the poor mechanisms for women NGO participation in policy development as well as the inability of women NGOs to position themselves well for effective, strategic policy influence.

In the Philippines, the reproductive health programme developed in consultation with women's health NGOs in 1995, was dismantled by the Arroyo Administration in 2002 and implementation of reproductive health policies was relegated to local governmental units. There has been increased use of the population control framework instead of an unmet need approach. In both the Philippines and India, demographic arguments for the need for population control have resurfaced in the late 1990s, again linking population development and poverty. Herrin's influential paper (2002) in the Philippines states that 'the free exercise of fertility is not consistent with the common good.'[2]At the same time, additional opposition to reproductive rights and the full range of family planning services has come from the Catholic Church, which regained its strong policy influence during the Aquino Administration. Natural family planning methods are now the focus. This is in contradiction to the informed choice principle, which the current administration insists is part of the overall family planning policy. Arroyo has also ordered that the term 'reproductive rights' be removed from the medium term development plan for women.

Weaknesses in the ICPD document have contributed to governments coming up with their own interpretation of using the rights-based approach in population policies. In the ICPD PoA, reproductive rights are explained in Chapter IV, at the service implementation level, and are discussed around the principle of informed choice and freedom. Ideally they should have also been included in Chapter III which deals with 'Interrelationships between population, sustained economic growth and sustainable development'. Instead this chapter does not clearly explain how the principles of human rights are to be incorporated in population policies.

Despite this weakness, it is encouraging to note that with the exception of the Philippines, all other governments present at the UN ESCAP's Asian and Pacific Population Conference in December 2002, appeared comfortable with the concept of reproductive rights, going to the extent of using the term in their country statements.

What was disappointing however was that ESCAP's Population Division did not play a guiding role in linking reproductive rights to population policies. The framework for the 2002 government country reports only specified reproductive

health, not reproductive rights. None of the eight governments thus reported on reproductive rights. Further, women NGOs like ARROW were also required by ESCAP to remove information and display materials that highlighted the concept of reproductive rights. As well, all information on changes in abortion laws in the region had to be removed from an expert background paper for the meeting on reproductive health. Overall, background papers on population and development commissioned by ESCAP were very demographically focused, and did not reflect any notable change in demographic thinking since the ICPD.

NGO country reports from Cambodia and the Philippines reveal that development institutions like the World Bank, IMF and donors like USAID place minimal emphasis on reproductive rights in their policy frameworks. More analysis therefore needs to be done on the influence donors and financial institutions continue to wield on population and reproductive health policies in many countries.

Reproductive Health Services

The Programme of Action agreed that 'all countries should strive to make accessible through the primary health care system, the full range of affordable reproductive health services to all individuals of appropriate ages as soon as possible.' (PoA, 7.5 and 7.6)

There has been minimal progress in achieving this objective in most of the countries in our study, other than Malaysia. However in Malaysia also, despite the good intentions expressed in the reproductive health policy and programme objectives, the Government has maintained its position since Cairo, and does not provide contraceptive services to unmarried people, including adolescents. In South Asia, even the availability and accessibility of maternal health and quality family planning services remains a problem, not to speak of the integration of infertility, abortion, RTI, STD and reproductive cancer services. With the exception of family planning services, the cost of reproductive health services has increased due to the implementation of health sector reforms in all countries.

The Initiative for Sexual and Reproductive Rights in Health Reforms also assessed that progress in service integration has been minimal.[3] Such initiatives in reproductive health were largely confined to integrating services for screening and treating STI/RTIs with family planning and maternal and child health services at community level clinics, with few countries offering abortion services, emergency obstetric care, infertility services, reproductive cancer screening or anti-retroviral drugs through these clinics. Health services for dealing with violence against women were also not available. Furthermore, the administration of different reproductive health services continues to be vertically managed in most countries through different departments.

Pilot projects in Indonesia, Bangladesh, Philippines and China, however, indicate that the integration of STI/RTIs with MCH/family planning services can have a positive impact on general client flow, utilisation and the quality of STI/RTI services and maternal survival, provided substantial investment is made in capacity building, strengthening human resource deployment, infrastructure and protocol development. The integration of sexual and reproductive health (SRH) education for adolescents with existing SRH services also benefits young people when carried out in a bottom-up manner.

The World Bank publication *Investing in Health* (1993) which outlines its proposal for health sector reforms (HSRs), places more emphasis on health financing, decentralisation and public-private partnerships, than on the integration of health services. A regional review carried out by the Initiative for Sexual and Reproductive Rights in Health Reforms revealed that of nineteen projects appraised on the basis of information documents on World Bank-supported health sector reform projects, only seven in Bangladesh, India, Philippines, Indonesia, Vietnam, Cambodia, and China include the integration of health services as a project strategy. Of the seven, the emphasis in five projects appears to be more on administrative integration (health planning and budgeting, integrated regional health planning), and inter-sectoral integration (health and education) with no focus on integration in the provision of SRH services. Further, public-private partnerships promoted under these reforms go against the integration of SRH services, as they emphasise social marketing of specialised SRH products or services (in particular contraception and condoms for HIV/AIDs prevention) rather than integrated SRH services. There is also no evidence that decentralisation promotes provision of integrated SRH services, as it depends on funds available and attitudes and priorities of local decision-makers. Cost effectiveness methods used for priority setting under reforms have also not led to the prioritisation of comprehensive SRH services

Yet another concern expressed by the Initiative for Sexual and Reproductive Rights in Health Reforms is that of the 19 World Bank-supported HSR projects reviewed in Asia, only seven listed some SRH services as a component (mainly family planning and MCH).

Recommendations: Reproductive Rights-based Policy Framework

- Clarify and advocate for a rights-based framework to be included in all population, reproductive health, and women's empowerment policies, programmes and donor funding. This begins with the inclusion of the terms 'reproductive rights and human rights', specifically the right for:

    i) Adequate emergency obstetric care services to enable safe pregnancy and childbirth;
    ii) Access to the full range of information and reproductive health services available in all public primary health care facilities including family planning, maternal health, abortion, infertility, RTIs, STDs, sexuality and referrals to include reproductive cancer and HIV/AIDS;
    iii) Contraceptive services irrespective of age or marital status;
    iv) The freedom to decide if, when and how often to have a child and to have a satisfying and safe sex life;
    v) Access to safe, effective and affordable methods of family planning of the individual's own choice as well as other methods of their choice for regulation of fertility which are not against the law;
    vi) Sexuality information and education on personal relations as well as reproduction and STDs.

Points ii, iv, v and vi come directly from ICPD paras 7.2 and 7.6

- Monitor and make public, violations of reproductive rights, using national and international legislation and policies including the CEDAW optional protocol and ICPD agreements, as well as relevant national level legislation.

- Advocate against the political collusion of religious bodies with the State in influencing reproductive rights and health policy.
- Advocate against neo-liberal ideology that calls for rolling back State financing and provisioning at a time when greater State involvement is required for promoting, protecting and fulfilling reproductive rights.

Women's Needs for Contraception

Seven of the eight countries (excluding China for which data are not available) with a significant gap between contraceptive use and the proportion of women wanting to space or limit their families (i.e. unmet need), did not achieve the ICPD objective of a 50 percent decline by 2005. The current unmet need percentages range from a large 33 percent in Cambodia and Pakistan to 19 percent in Philippines and a low 9 percent in Indonesia (see table 4).

Other major concerns are the persistently low levels of contraceptive use found in Cambodia, Pakistan and Nepal and the low use of modern methods in Pakistan, Philippines and Malaysia (see table 5). In India, there is limited choice of contraceptive methods as the Government programme provides only five contraceptive methods (male and female sterilisation, IUDs, oral pills and condoms), with female sterilisation being singled out for an aggressive campaign and services, and backed up by strong monitoring. Providers do not offer complete information about the variety of methods available and therefore men and women do not have the opportunity to exercise their right to contraceptive choice (Santhya, 2003).[4] Reports in the field from Indonesia reveal that contraceptive choice is becoming more limited due to reductions in external funding. IUDs and hormonal implants are now the main methods available. This indicates the inability of governments to address the main family planning service barriers as agreed at the ICPD, which include extending the availability and quality of family planning methods, facilities and services.

Emergency contraception is readily available on request in public facilities only in China, although some other countries reported having limited availability. In the Philippines, ultra conservative Catholic groups claiming Postinor to be an abortifacient, influenced the Arroyo administration to withdraw even its limited availability.

China is also one of the few countries with clear evidence of improvement in the choice of contraception and the quality of services. Sterilisations have decreased and reversible methods have increased with clients' rights to be informed receiving more emphasis. On the other hand, strict norms on which provinces and in what contexts women choose the number of children (in particular beyond one child) persist in China.

A demographic view may see this minimal decline in Asia in unmet need as acceptable, especially when fertility levels are decreasing due to other factors like an increase in age at marriage. However, from a reproductive rights perspective, the slow progress is unacceptable as women still continue to have more children than they want and are thus not in control of their bodies and lives. In China, the opposite is true. Women are not allowed to have the number of children they want to meet their needs. Country experiences – as for example in Iran - show that when there is political will and sufficient resources are deployed, women's voluntary use of contraceptives can quickly increase. Iran now has a contraceptive prevalence rate of 73 percent compared to the Philippines, Malaysia and Indonesia, which are

around 55 percent. This is very low, particularly for Malaysia, which has achieved a moderately high level of socioeconomic development.

The women's NGO, Likhaan, reported that the current conservative administration in the Philippines has been influenced by the Catholic Church to promote a preference for natural family planning. The impact of the GAG policy, and the reduced availability of US aid for modern contraception are very much in evidence in the Philippines. In Malaysia, the Government continues to deny that modern contraceptive use, which has not increased for 20 years, is a service problem. Speculations on the reasons behind the lack of a more proactive Malaysian family planning programme include insufficient political will for fear of a backlash from the right wing Muslim political party (PAS) and lack of commitment to a reproductive rights approach for women.[5]

Contraceptive prevalence rates and unmet need assessment continue to focus only on married couples and exclude young people and the unmarried. There is an urgent need to improve this indicator in line with the rights of individuals of all ages to use contraception. Data on contraception availability for never married women (adults), divorced, separated and widowed women and disabled women could not be found.

Government Assessment of ICPD Progress

There is considerable variation in government ESCAP reports. The Government of Philippines for example, highlights unmet needs and also service delivery as a problem whereas Malaysia does not state any problems or make any concrete assessment of progress. Neither refers to emergency contraceptive methods. None of the reports points out that current provision of contraceptive use methods excludes young and unmarried people.

Young People's Rights to Sexual and Reproductive Health Information and Services

Governments have agreed, 'to address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group.' (PoA, 7. 44(a)).

All eight countries except Cambodia have policy statements on adolescent health (China, Indonesia, Malaysia, Nepal, Philippines), which were developed in the last decade or included in the national population policy (India and Pakistan). While some address the issue of adolescent sexual and reproductive health needs (Nepal, Philippines, China), Malaysia, in particular focuses only on general health needs (see table 6).

Although primary health centres in all countries provide contraceptive services to married adolescents, only China reported that since Cairo, unmarried youth now have the right to contraceptives and other reproductive health services as part of primary health care. Malaysia stated that the provision of certain sexual and reproductive health services for adolescents rests solely on NGOs and the private sector. Cambodia, on the other hand, has no prohibition on contraceptive services for adolescents, but its programme relies on donor funding and providers appear reluctant to provide such services to adolescents.

Most NGO Country reports (Nepal, India, Pakistan, Malaysia, Indonesia) cited government reluctance to address socio-political and religious conservatism as the main barrier in providing services to unmarried adolescents. Lack of funds is another issue in most low and middle-income countries. This is despite a clear trend towards the early onset of sexual relationships. A 1986 Malaysian study[6] showed that 20 percent of 1,200 unmarried respondents aged between 15 to 21 years had sexual intercourse, while the Philippines' Young Adults Fertility and Sexuality Survey II[7]in 2000 indicates that about 2.5 million adolescents had premarital sex and around 80 percent were not using any contraceptive methods. National data in the Philippines show more than one third or 36 percent of young Filipino women aged between 15-24 become pregnant before marriage.[8]

Formal teaching of sexual and reproductive health and rights issues affecting adolescents normally termed sexual health education or sex education, can be found in some form in the school curricula. In Malaysia it is called 'Family Health Education', in the Philippines, 'Population Education', in China, 'Adolescent Health Education', and in Indonesia and Nepal, 'Sexual And Reproductive Health Education'. Sex education is also integrated into different types of subjects such as Physical Education, Biology and Moral/ Religious Studies. In countries where sex education is available, the contents vary in accordance with government perceptions of the socio-cultural values of each country. China's prime focus is on prevention of HIV/AIDS through physical hygiene, sexual psychology and sexual morality, whereas sex education in the Philippines is confined to basic anatomy, physiology and responsible parenthood. Malaysia's topics are the human body, personal and family health and religious and moral values. There is no formal sex education in Pakistan. The Pakistan NGO report stated that the demand for sex education is well documented by NGOs, and they have made efforts to disseminate materials on sexual and reproductive health and rights to adolescents.

Government Assessment of ICPD Progress

Cambodia and Malaysia made no mention of services provided since ICPD although the latter included a statement on contraceptive provision to married couples only. None of the reports - other than Indonesia - stated whether they are providing other reproductive health services (non-contraceptives) for both boys and girls (i.e. cancer screening, impotency, menstrual health, night emissions, HIV/AIDS).

Data Problems

A number of problems relating to the availability of data were encountered during the course of the study. These include:

- Up-to-date unmet need data not being easily available in all countries;
- The inaccuracy of contraceptive prevalence and unmet need data that focus only on married women and leave out young, unmarried people.
- The lack of province and state-level use data as these often present a different picture from national-level data.
- The lack of easily available data on changes in trends of contraceptive method use.
- The lack of data and reporting on the quality of family planning services.

Recommendations: Family Planning/Contraception

- Advocate that governments take the ICPD unmet needs and rights approach towards both fertility and infertility, rather than a demographic approach, with the choice from the full range of modern contraceptive methods including emergency contraception and for increased promotion of male methods for all age groups.
- Advocate for the right of women to choose whether or not to have children and also to decide on how many to have.
- Advocate against, and convincingly resist the interference of conservative religious interpretations in government family planning programmes. Advocate for governments to not be politically influenced by fundamentalist forces to the detriment of women's and young people's expressed needs and human and sexual and reproductive rights.
- Advocate that governments evaluate family planning services more closely (including women's feedback) to identify the barriers to access to quality services and take urgent steps to improve the availability of services and policymakers' commitment to take action.

Recommendations: Youth

- Advocate that governments develop a clear programme perspective on the rights of young people to a full range of accessible and affordable reproductive health information and services from the level of Primary Health Centres.
- Governments should develop and institutionalise mechanisms that ensure genuine participation of young people as partners in programme planning, implementation and evaluation. The effectiveness of these mechanisms and the outcomes of young people's participation should be regularly monitored and evaluated.
- Governments need to develop appropriate and sensitive curricula, and bring in respectful health professionals trained in ethics, human rights, confidentiality, and youth needs to provide services for youth.
- Ensure that young people themselves represent their own advocacy issues at all levels and that adults are stakeholders in such advocacy.
- Advocate at the national level for the creation, enactment and implementation of policies that address young people's SRHR.
- Implement rights–based and gender-sensitive programmes and services such as access to contraceptive services at the national level for young people, especially for marginalised youth.

Sexuality and Sexual Health

In the Programme of Action, the only specific section on sexuality is titled 'Human Sexuality and Gender Relations' and this is one of the five sections in Chapter VII on 'Reproductive Rights and Reproductive Health'. Sexuality here refers to only heterosexuality – 'Equal relationships between men and women in matters of sexual relationships and reproduction, including full respect for the physical integrity of the human body, requiring mutual respect and willingness to accept responsibility for the consequences of sexual behaviour.' (ICPD PoA, 7.34)

Governments have agreed
'To promote adequate development of responsible sexuality, permitting relations of equity and mutual respect between the genders... to ensure that women and men have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities.' (ICPD PoA, 7.36)

Actions committed to include:

- 'integral education and services for young people' (7.37).
- '...base national policies on a better understanding of the need for responsible human sexuality and the realities of current sexual behaviour' (7.38);
- 'active and open discussion of the need to protect women, youth and children from any abuse including sexual abuse ...., laws addressing those concerns should be enacted where they do not exist, made explicit, strengthened and enforced'.... (7.39).

Elsewhere in Chapter VII, it is stated that the ability to have a satisfying and safe sex life is implied as part of reproductive health and reproductive health care and this should also include information, education and counselling on human sexuality (PoA, 7.6). It is clear then, that sexuality and sexual health come under reproductive rights and reproductive health in the ICPD PoA. Although the term 'sexual rights' is not used, it is implied that the right to a satisfying and safe sex life is part of reproductive rights. ICPD NGO advocates have decided to use the term 'sexual and reproductive health and rights' to emphasise the centrality of sexual relations in determining reproductive health outcomes and the exercise of reproductive rights.

The NGO country monitoring reports found very little information on sexuality issues, especially in relation to reproductive health services. It is not known if sexuality information is included and promoted as part of the package of reproductive health services, and if such information is provided, the content is unclear.

Several government ESCAP reports show that governments do provide sexual and reproductive health information services to young people, but the actual content of this information needs to be explained. Among the eight countries, only China was reported to have moved ahead in providing both information and actual reproductive health services to young people in primary health facilities and to have integrated sex education into the school curriculum.

In Pakistan, the NGO country report notes that 'sex and sexuality are areas of silence in official discourse and also in families,' although young people themselves appear quite comfortable in discussing sexuality issues. One study found that only one out of ten married women reported that their mothers had ever discussed physical changes of puberty with them and over half the women did not consider it important to educate their adolescent daughters about physical and emotional changes (PRHFPS 2000/01). Boys have expressed a need for advice on homosexuality in another Pakistan study.

Indonesia reports that the sexual and reproductive rights of young and single individuals have been removed (for religious and cultural reasons) from the draft amendments to the law on population and prosperous families (No. 10/1992) that is currently being revised. India similarly reports that sexuality, sexual health and rights are not included in the new population and health policies.

Considerable progress has, however, been made in improving sexual violence legislation on rape, sexual harassment and trafficking of women (see table 7). All eight countries have either enacted a related new law or made amendments to existing ones. This has given a strong message that sexual offences are not acceptable and will be punished.

Sexual coercion and rape within marriage has remained a disputed area in all countries except the Philippines which had major success in including marital rape as an offence in the new anti-rape law (1997). Efforts by women's groups to have marital rape recognised as an offence have, however, not yet been successful in Malaysia and Cambodia.

Government Assessment of ICPD Progress

None of the eight government ESCAP reports included sexuality and sexual health action or inaction as a specific sub-section. China, however, reported on sex education as part of the discussion on youth and the Philippines mentioned youth sexuality.

Maternal Mortality

The ICPD+5 agreed to a very specific and serious objective on maternal mortality. 'Countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further half by 2015. Countries with highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births. ...Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed...' (ICPD+5)

Two million women are estimated to have died from pregnancy and childbirth related complications in the eight countries since the Cairo ICPD. Of these, 259,530 died due to unsafe abortions. As many as 195,420[9] women continue to die annually in these countries due to unsafe abortions or complications of pregnancy, despite 10 years of implementation of the Cairo PoA and the inclusion of reduction of maternal mortality as one of the eight Millennium Development Goals (see table 8). Further to this, maternal morbidity is estimated to be ten times the maternal mortality rate in all these countries. The largest number of women die in India (136,000) followed by Pakistan (26,000) and in China and Indonesia around 10,000 die in each country every year. Malaysia has only 220 deaths annually. Among these deaths, unsafe abortion accounts for 13 per cent of deaths in South Asia, and 15 per cent in Southeast Asia.[10]

Only China achieved 50 per cent reduction in maternal mortality by the year 2000. In the six countries with high levels of maternal mortality, ranging from 307 to 905, namely Cambodia (437), Indonesia (307), India (440), Nepal (905), Pakistan (500) and Philippines (172), the ICPD target of less than 125 has not been met. The percentage decline in maternal mortality in the above six countries varied in the range of a disappointingly low 4.3 percent (India) to 17.7 percent (Philippines). India and Pakistan show an extremely low percentage decline in maternal mortality over the decade. Maternal mortality figures in Nepal further deteriorated post-Cairo from 830 in 1995 to 905 in 2003. While China and Malaysia showed

consistently low maternal mortality rates of 43.2 and 30 respectively, comparable to the developed world, significant rural urban differentials have been observed in China. 'In 2000, the MMR in Shanghai was 9.6 per 100,000 live births, while in Tibet and Xinjiang the MMR was 466 and 161, respectively.'[11] As for Malaysia the MMR increased from 20 in 1990 to 30 in 1998, the reasons for which are not totally known but are assumed to be related to migrant workers.[12]

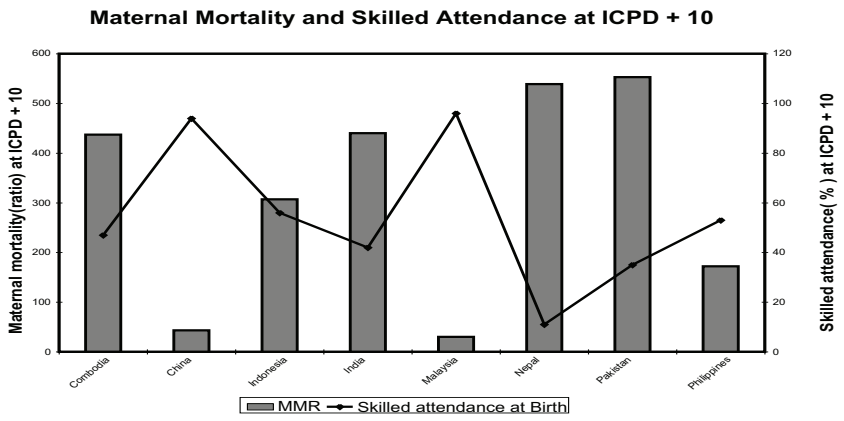
Four of the most strategic actions agreed in the Programme of Action to combat maternal mortality were: to increase prenatal and postnatal care; provisions for obstetric emergencies; family planning services and skilled attendance at birth. (ICPD PoA 8.22). Governments in the six countries (except China and Malaysia) have made minimal efforts to do the following: improve skilled attendance at delivery; improve facilities for and women's access to emergency obstetric care to treat pregnancy complications; and ensure that referral and transport systems are in place so that women with complications can receive needed care quickly. Ten years down the line, maternal mortality figures in the countries have not improved.

Ensuring Skilled Attendants at Birth

Increasing skilled attendants at birth was one of the main urgent actions identified to reduce maternal mortality. This was further reiterated in the ICPD+5 review, 'By 2005, where the maternal mortality rate is very high, at least 40 per cent of all births should be assisted by skilled attendants; by 2010 this figure should be at least 50 per cent and by 2015, at least 60 per cent. All countries should continue their efforts so that globally, by 2005, 80 per cent of all births should be assisted by skilled attendants, by 2010, 85 per cent and by 2015, 90 per cent.' (Review and Appraisal Para. 64).

Indonesia and India reached the ICPD target (set at the ICPD+5 Review) of 40 percent of all births assisted by skilled attendants (see table 9). India, however, recorded a small 10 to 15 percent improvement in skilled attendance post-Cairo. In India deliveries attended by health professionals and those conducted in institutions rose only marginally between 1992-93 and 1998-99. While 34.2 percent of births were attended by health professionals in 1992-93, there was a slight increase to 42.3 percent in 1998-99. Deliveries in institutions were only 25.5 percent in 1992-93 and rose to 33.6 percent in 1998-99 (GOI, Planning Commission, 2002). Nepal only increased to a low 11 percent from six percent in 1994 (see Table 9).

Figure 1



Source:
NGO Country reports
Human Development Report 1995 and 2003

Antenatal and Postnatal Care

WHO defines antenatal care (ANC) as 'a minimum of four quality antenatal visits for the safe and healthy outcome of pregnancy'. Of the six countries with high maternal mortality rates, none stated a significant increase in the number of women accessing the recommended four antenatal visits. India reported that only 20 percent of women received ANC services in the years 1998-99. Nepal reported 43 percent of women receiving the first antenatal visit while Cambodia reported 45 percent of women receiving antenatal care. With respect to postnatal services, Cambodia reported that a high 46 percent of women currently received no postnatal care. Consequently the majority of maternal deaths in Cambodia are a result of postnatal complications including haemorrhage, obstructed labour, sepsis, eclampsia and unsafe abortions (CDHS 2000).

Emergency Obstetric Care (EmOC)

Emergency obstetric care is undoubtedly a critical strategy to reduce maternal deaths. Though governments in the eight countries have made efforts to improve EmOC services, these remain limited and sporadic except in Malaysia and China. In Indonesia, only a few health staff have been trained, and health centres and referral hospitals have been operational in only some parts of the country. Cambodia showed an increase in the number of referral hospitals to 67, 30 percent of which now offer basic surgical procedures against the backdrop of a continuing shortage of midwives. In India, emergency obstetric care schemes have been introduced as part of the Reproductive and Child Health Programmes in some states. The UNICEF-initiated Reproductive Health Project in Pakistan, funded by the Asian Development Bank, has taken the initiative to train health personnel to identify and deal with reproductive health issues including emergency obstetric care. With only 54 percent of the rural population in Pakistan living less than 6 km from a primary health care centre, access to EmOC facilities becomes important for women. Pilot projects and programmes on EmOC have only positively impacted a few areas in these countries.

Government Assessment of ICPD Progress

Maternal mortality in the eight government reports was dealt with either in the Mortality, Morbidity and Poverty section or in the Reproductive Health section. Except for India and Philippines, unsafe abortions were not mentioned as one of the causes of maternal deaths. Quantitative data on percentage access of women to Emergency Obstetric Care (EmOC) and other key process indicators were not available in the government reports. None of the reports mentioned any critical interventions or impediments that worked or did not work to reduce maternal deaths post Cairo in their respective countries. The reports gave a more general overview of the maternal mortality situation in the respective countries.

Data Problems

- Accurate data has been a serious constraint with respect to calculating maternal mortality rates. Different agencies have come up with different maternal mortality estimates. The Philippines and Indian Governments acknowledge the serious data problems with MMR estimates. The Philippines Government report stated, 'Due to large sampling errors associated with these estimates, the observed decline [in MMR] is

considered inconclusive'. The Indian Government report similarly said, 'like most developing countries, India does not have reliable data on maternal mortality.'

- Many of the NGO country monitoring studies also reported high sampling errors in determining accurate figures.

- Collective data relating to access to emergency obstetric care are not available at provincial, state and national levels in all the eight countries. The Philippines NGO country report states that 'official government reports provide no data on quantity, quality or any other information regarding the use or non-use of EmOC.' The situation has been similar in all the other eight countries except Malaysia and China.

- Information is not readily available on what aspects of maternal care are provided free of cost and for whom, and how this affects the offtake of services.

Recommendations: Maternal Mortality

NGOs urgently need to increase their advocacy efforts to reduce maternal mortality, and specifically to recommend to their governments to:

- Ensure women's right to a level of health care that will enhance the likelihood of women surviving pregnancy and childbirth.
- Ensure skilled attendance at birth by providing skilled attendants able to prevent, detect, and manage the major obstetric complications, together with the equipment, drugs, and other supplies.
- Increase local and national budgetary allocations for EmOC to ensure geographic access to and appropriate use of EmOC, trained responsive personnel, essential equipment, supplies and drugs to ensure improved maternal health outcomes.
- Strengthen the primary health system to provide basic and comprehensive emergency obstetric care EmOC services as per WHO recommendations.
- Provide EmOC free to low income/poor women and include this service in social and private insurance packages.
- Expand antenatal and postnatal coverage, and encourage husbands and relevant male relatives to accompany pregnant women for these check ups.
- Broaden the safe motherhood package to include nutritional supplements, safe delivery, EmOC and quality family planning services.

Unsafe Abortion

'... All Governments and relevant intergovernmental and non-governmental organisations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion.... In circumstances where abortion is not against the law, such abortions should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion.' (ICPD PoA 8.25)

No national data were reported on the reduction of unsafe abortion in any of the countries. Neither was the incidence of abortion available, despite the ICPD commitment to urgently addressing this public health concern. This report thus uses WHO estimates. Asian women are known to have 50 percent or 10.5 million of the 20 million unsafe abortions women have annually (Cook and Fathala, 2003). Around 13 to 15 percent of all deaths due to pregnancy and childbirth in Asia are ascribed to unsafe abortions and many more women survive and suffer from complications related to these. Young women aged 15-19 account for at least one fourth of global abortions, but estimates for Asian young women were not available.

In the eight countries, the number of women who die from unsafe abortions annually is estimated at 25,953[13] with the highest of 17,680 deaths being in India, followed by Pakistan (3,380), China (1,650) and Indonesia (1,500) (see table 10). These figures are shockingly high when compared to only 500 annual deaths in the whole of Europe.

Progress was made in reviewing abortion laws, which was a Beijing Platform for Action agreement. Cambodia and Nepal now have new abortion laws, which allow abortion on request for any reason. This is tremendous progress for Nepal, which previously did not permit abortion for any reason and imprisoned many poor women who underwent illegal abortions. In Indonesia and Malaysia, there was review and discussion of the law among medical professionals and reproductive health advocates towards improving the law but no definite outcomes have emerged.

At present, current laws in the eight countries show the diversity of conditions under which abortion is legal (see Table 11). The Philippines is the most restrictive, followed by Pakistan, then Malaysia, which is moderately liberal (abortion is allowed for physical and mental health reasons) with Cambodia, China, India and Nepal allowing abortion for any reason. The earlier liberal abortion laws of China and India were based on demographic population reduction objectives but Cambodia's new law stated the reproductive rights of women as one of the objectives, showing the influence of the ICPD.

Despite a liberal abortion law, India continues to report a high rate of unsafe abortions. This is attributed to the lack of political will to ensure that quality abortion services are available. Clearly liberal abortion laws do not necessarily guarantee that women can exercise their right to obtain safe abortions. Implementation of the new (2002) abortion law in Nepal has been very slow, reflecting a lack of urgency to address the situation of at least 780 Nepalese women dying annually from unsafe abortions.

Countries with liberal abortion laws such as Cambodia and Malaysia report that many women service providers and members of the public do not know of the legal abortion rights of women. Partly this is due to the general lack of accurate information and partly it is because of the low priority accorded by the government to promoting women's human and reproductive rights.

In the government ESCAP reports (2002), only China reported on efforts to reduce unsafe abortion incidence and improve the quality of abortion services, as part of its reproductive health package. In the Philippines, Likhaan's abortion study (2003)[14] and Sanchez (2003)[15] found that health service providers were biased and abusive in their provision of post-abortion services, directly contravening ICPD agreements to provide humane care to women. Moralistic attitudes are a deterrent to women needing to obtain such services. More qualitative, women-centred evaluations are needed in countries like Indonesia, Pakistan, and Malaysia.

Governments with restrictive abortion laws continue to deny the reality of women's need to choose to have an abortion if there is contraceptive failure, or if poverty, gender inequality, rape, sexual coercion and socio-economic reasons make it necessary. The Philippines for example, estimates that 400,000 abortions occur annually (of which 73 percent have complications) as a result of poverty and poor access to family planning services. Teenagers represent 17 percent of the Filipino women having abortions.[16] In the other countries (India, Nepal and Cambodia), the need for unrestricted abortion services is recognised and legislation exists but the right to access safe services is still not a reality.

Government Assessment of ICPD Progress

In the government ESCAP reports (2002), only China reported on efforts to reduce unsafe abortion incidence and improve the quality of abortion services, as part of the reproductive health package. None of the other governments reported on unsafe abortion as a specific sub-section. India and Philippines acknowledged that unsafe abortions were a major cause of maternal deaths in their countries.

Data Problems

- Specific country data on unsafe abortion, derived from community studies and hospital data are scattered and governments do not monitor and report on this in their ICPD implementation reports.
- Unsafe abortion is not seen as an issue on its own, but only in relation to reduction of maternal mortality and safe motherhood goals. Young unmarried women who are not yet mothers are thus not included in unsafe abortion numbers.
- Information is not readily available on what aspects of abortion management are provided free of cost and for whom and how this affects offtake of services.

Recommendations: Unsafe Abortion

- Recognise unsafe abortion by addressing the issue openly. Document and publicise information on the number of women dying because of this, the reasons women resort to abortion and the risks and the costs.
- Advocate for rigorous abortion reduction measures, which include better access to quality family planning services, emergency contraception and better understanding of the economic reasons for abortion.
- Advocate for the urgent legal provision of abortions for victims of incest and rape
- Require quality abortion services and the full range of abortion technology including menstrual regulation and medical abortion, to be available in all public facilities as part of the reproductive health package.
- Monitor and report on negligent, discriminatory and abusive personnel providing abortion services.
- Ensure that clear information is provided for the public, for women and for service providers on women's legal right to abortion and include this in providers' training curriculum.
- Advocate for restrictive abortion laws to be reviewed and their legal conditions expanded as recommended at the Beijing Conference.

- Include training on current abortion procedures in medical and midwife training curricula.

HIV/AIDS

Reducing HIV infections

The ICPD PoA agreed 'to prevent, reduce the spread of and minimise the impact of HIV infection... to ensure that sexual and reproductive health programmes address HIV infection and AIDS;' (ICPD PoA 8.29)

In the Asia Pacific region, an estimated 7.4 million people are now living with HIV. Around half a million are believed to have died of AIDS since the epidemic began, and about twice as many, 1.1 million, became newly infected in 2003. Among these, an estimated 194,400 women might have died of AIDS, an estimated 2.85 million women are living with HIV and as many as 411,000 women have been newly infected in 2003 in the Asia Pacific region.[17]

HIV/AIDS in the eight countries ranges from low to high prevalence (see table 12). In Cambodia, the high HIV prevalence has been reduced from 3.3 percent in 1997 to 2.6 percent in 2002, but it is still regarded as a high prevalence country. The estimated number of HIV-positive cases has been on the rise since Cairo in most of the countries reviewed, and for the year 2000 the figures are: India (3,900,000), China (600,000), Indonesia (100,000), Cambodia (169,000), Pakistan (73,000), Nepal (34,000), Malaysia (42,000) and Philippines (10,000)[18](see table 12). The epidemic in Cambodia and some states in India namely Maharastra, Tamil Nadu, Karnataka, Andhra Pradesh, Nagaland and Manipur has now generalised throughout the population beyond 'risk groups' and the burden of AIDS cases on health services will be particularly high in the coming years. Malaysia, Nepal, Pakistan and some other states in India have moderate HIV prevalence rates with extensive HIV transmission occurring primarily among injecting drug users (IDU) and/or men who have sex with men (MSM). China, Indonesia, and Philippines currently have a low prevalence at 0.08, 0.09, and 0.03 per cent respectively.[19]However Cambodia, China, India and Indonesia present serious implications for epidemic levels in the future, since these countries have concentrated high prevalence areas.

Prevalence among Women: The PoA highlights the fact that women and girls are more biologically and socially vulnerable to STIs, including HIV/AIDS, and stresses the importance of meeting their needs. In Cambodia, HIV is transmitted primarily through heterosexual sex, driven by a norm of premarital and extramarital sex for men, usually with women who are paid. Men serve as bridges between sex workers and housewives, sweethearts and ultimately newborns.[20] The male to female ratio of HIV infections has increased from 9:1 in 1990-95 to 3.4:1 in 2002 in China.[21] A similar trend has been reported in the Malaysian NGO Country report. The inability of women to refuse sex with their husbands even when they know that they are HIV positive has been a major cause of transmission to women, especially in societies where men with multiple partners are tacitly condoned.[22] In India, the ability of women to negotiate is lower because sterilisation has been promoted as contraception. The epidemic's 'feminisation' is becoming more and more apparent and today the region is faced with a narrow window of opportunity to prevent AIDS from having a more severe impact on the region.

Prevalence Among Youth: The ICPD+5 Appraisal states: 'By 2005, 90 per cent of all young women and men between 15-24 years old should have access to information, education and services to develop the life skills required to reduce their vulnerability to HIV.' This is in recognition that globally half of all new HIV infections occur in people aged 15-24 and the majority of them are young women.[23]In Indonesia, more than 50 percent of HIV infections are among people aged 15-29, many of whom contract the infection before they are 20 years of age.[24] Nepal reported that 67 percent of HIV cases including AIDS are found among young people of 14-29 years.[25]

HIV/AIDS Prevention and Management

All the eight countries, except the Philippines have shown commitment to the prevention and management of HIV/AIDS. Committees, councils and task forces have been established in Cambodia, China, Philippines and Indonesia. National policies and plans of action on HIV/AIDS have been drafted in Cambodia, China, Indonesia, Malaysia, India, Nepal and Pakistan post-Cairo. Cambodia is also drafting a new law on 'Women and HIV/AIDS'.[26]

States have an obligation to take draft legislative, budgetary and administrative measures that advance the right of individuals to the highest attainable standard of health. Condoms are currently the only available means of preventing the sexual transmission of HIV and some other sexually transmitted infections (STIs). Male and female condoms provide dual protection not only from unintended pregnancies but also from STIs including AIDS. However supply shortfalls and misconceptions about the use of condoms have greatly impacted on their wide outreach and use. In 2003, the Catholic Bishops Conference of the Philippines (CBCP) successfully blocked legislation that would have authorised the use of national funds for condoms and other contraceptive supplies. Philippines further fails to provide complete HIV/AIDS information to sex workers and other high-risk groups.[27]Some local authorities, such as the mayor of Manila City, have prohibited the distribution of condoms in government health facilities.[28]The combination of high-risk sexual practices and low condom use has led experts to fear an HIV/AIDS explosion in the Philippines.

In Pakistan, blood-screening facilities are not available throughout the country; the Ministry of Health has no strict guidelines on monitoring and evaluation for doctors and dentists, rendering large sections of the population susceptible to HIV through blood transfusion.[29]

Other preventive programmes including continuous large-scale IEC campaigns, awareness generation through the media, newspapers, schools, workplaces, health facilities, education campaigns and community settings are being implemented in all the eight countries. There has been no national level assessment of the impact of these preventive programmes in the countries being studied. However, as mentioned in the Indonesian NGO country report, the impact and reach of these mass media programmes have been minimal due to incomplete, unclear and false, stigmatised messages.

Treatment and Care of People Living With HIV/AIDS (PLWHAs)

The ICPD PoA specifies that it is important, 'to ensure that HIV-infected individuals have adequate medical care and are not discriminated against.' (ICPD PoA

8.29) Access to HIV/AIDS related treatment is fundamental to the realisation of the right to the highest possible attainment of health care. Unequal and limited access to treatment however is the reality in developing countries, with less than five percent of HIV infected people having such access to HIV medicines.[30] An estimated 800,000 persons living with HIV/AIDS require anti-retroviral (ARV) treatment; but less than 40,000 in the region are currently actually receiving it.[31]All eight countries are facing the challenge of limited resources to support treatment of HIV/AIDS infected persons.

Some critical issues persist in the treatment and care of PLWHAs in the eight countries. Existing primary health care facilities are inadequate to provide a full range of integrated comprehensive services for the prevention and treatment of HIV/AIDS, including relevant information and education, adequate SRH services (including provision of condoms), access to voluntary counselling and testing, and appropriate HIV/AIDS drug treatment, as well as adequate treatment for HIV/AIDS related illnesses

The treatment of opportunistic infections and ARV therapy is bound to prove a future burden for the countries in the study. Pakistan and other countries have taken no action to counteract the deleterious effects of WTO, effective December 2004. This is likely to compromise the availability of anti retroviral drugs due to high costs.[32]The developing countries are more or less coerced into accepting this by rich countries, especially the US, and multinational drug companies who are patent holders of ARV drugs, under the pretext of WTO and TRIPS (Trade-Related Aspects of Intellectual Property Rights). This negatively affects the availability of affordable generic versions of patented drugs for HIV/AIDS.

Increasingly, pregnant women are being routinely screened. When Voluntary Counselling and Testing (VCT) guidelines are not well implemented or monitored, rights violations abound, especially among marginalised groups. The stigma attached to the disease and the regular violation of confidentiality rights by medical practitioners because of lack of knowledge about national policies and guidelines for HIV/AIDS patients are leading to obstacles in the management of HIV/AIDS.[33]The violation of basic human rights by stigmatising and discriminating against People Living With HIV/AIDS (PLWHAs) and of People Affected By HIV/AIDS (PABA) needs urgent attention. The right to equality of treatment and freedom from discrimination for PLWHAs, especially women and young people, should also be urgently attended to.

The quality of care and the poor attitude of service providers are also stumbling blocks in the treatment and provision of care without discrimination and inequality. Most governments that have an attitude of denial fail to recognise the sexuality aspect of this epidemic. Unless the critical groups of people such as those who have sex before marriage and outside marriage; men who have sex with men (MSM); people who have sex with same sex partners; and other sexual minorities, are addressed, it will be difficult to contain this epidemic.

Government Assessment of ICPD progress

All the eight government ESCAP country reports, barring Pakistan, have a chapter on the economic and social impact of HIV/AIDS. Policies and strategies in place to fight AIDS form an integral part of these reports, but less attention has been given to the implementation aspects of the various programmes. Voluntary Counselling and Testing (VCT) facilities in the different countries, access to screening, treatment and care aspects have not been dealt with. This is a matter

of some concern as these are critical if progress is to be measured and future directions mapped out.

Data Problems

- Accurate and up to date data on HIV/AIDS prevalence are not available in the eight countries. Estimates are not a true representation of the actual number of people living with HIV/AIDS.

- Ensuring the availability of HIV/AIDS data disaggregated by gender is yet another challenge. Generally data on the actual number of women infected with HIV/AIDS are unavailable.

- Surveillance is skewed as most testing is focussed on high-risk groups like sex workers, IDUs, prison inmates.

- Information is not readily available on what aspects of HIV/AIDS prevention and treatment are provided free of cost and for whom, and how this affects offtake of services.

Recommendations: HIV/AIDS

General

- To advocate for monitoring mechanisms to oversee the implementation of the government commitments to ICPD and UNGASS on prevention, treatment, care and management of HIV/AIDS.
- Advocate to governments for policies and legislation that integrate SRHR and HIV/AIDS.
- Develop a national, regional and global consensus framework for action by governments and implementing agencies. This framework's implementation should be monitored and evaluated from time to time.

Prevention

- Ensure access to preventive and treatment services, especially for women and young people. These should be reasonably priced or free, available at the primary health care level and distributed by trained and sensitised personnel/providers.
- Integrate HIV/AIDS prevention and treatment services and SRHR services at the institutional, strategic and practical levels. Information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.
- Lobby for a closer match between contraceptive methods promoted (greater use of condoms) and what is required for controlling HIV/AIDS. Promote condom use as a method of dual protection for unwanted pregnancies and HIV.
- Prohibit the mandatory HIV testing of target groups as this contravenes human rights. HIV testing should be done with the consent of the individual. Pre and post counselling must always precede such testing.

Treatment and Care

- Advocate for the development of community-based models in the treatment and care of HIV infected individuals, including the involvement of men in care. Enable people living with HIV/AIDS (PLWHAs) and people affected by HIV/AIDS (PABA) to live in dignity and equality. Stigma free centres (along with youth friendly approach) should be stressed
- Ensure adequate, accessible, affordable and acceptable supplies of essential HIV/AIDS and reproductive health related commodities, including male and female condoms and STI diagnostics and drugs. These should be available at the primary health care level.
- SRH services for men need to be invigorated at the primary health care level as men adopt high risk behaviours to a greater extent than women do. Men's shared responsibility and active involvement in responsible sexual and reproductive behaviour is a key determinant in achieving the ICPD Plan of Action, and the MDGs
- Mandatory training of all service providers is essential, with the training curriculum focussing on comprehensive management and appropriate treatment and care of PLWHAs with emphasis on service providers attitudes towards PLWHAs. The training should be linked to and covered by legislation on discrimination and the rights of people living with HIV/AIDS.

Resources

- Ensure balanced allocation of resources for care, treatment and prevention of HIV/AIDS with priority being given to positive women and their children.
- Allow countries to exercise their right to obtain generic drugs for HIV/AIDS without being politically and legally pressured by rich countries.
- Lobby with governments, the scientific community and civil society for advocacy and support of research initiatives on microbicides and other female controlled methods with greater political commitment. Promote and research access to female controlled methods, and encourage their combination with supportive strategies to educate men and women about their use and effectiveness.

Reproductive Cancers

The ICPD PoA 7.6 states '...Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required.'

Globally, increasing numbers of women are reported to be dying from reproductive cancers.[34]Despite this, estimates of mortality and the incidence of reproductive cancers are available only for a few countries in the Asia Pacific region. According to the Pakistan Reproductive Health and Family Planning Survey (PRHFPS) 2000-2001, 1.4 percent of women noticed a lump in their breast, one percent of this number were diagnosed as having breast cancer. Treatment for breast, ovarian

and cervical cancers was listed as one of the nine components of the Reproductive Health Package 1998, and is available at some of the major hospitals, but it was reported in the country monitoring study, that there are no nationwide facilities by the Ministry of Health, for early screening by Pap smear, and other means. Similarly, regular breast self-examination is not promoted.

Malaysia has made efforts to address the cancer agenda to some extent: the Ministry of Health's first Report of the National Cancer Registry (2002) indicated that a Malaysian woman had a one in 19 chance of getting breast cancer in her lifetime. Cancer of the cervix is the second most common cancer among women with an Age Standardised Incidence Rate of 21.5 per 100,000 population with a lifetime risk of 1:28. Data from the Health and Morbidity Survey (1996) show that only 26 percent of the women in the target group had ever had a Pap smear examination. This prompted the setting up of a National Technical Committee for Cervical Cancer Screening. Yet uptake of the Pap smear service averaging 350,000 to 395,000 annually between 1996 and 2001 remained dismally low with less than 40 percent of the total eligible women being covered.

The advent of health sector reforms and the introduction of social security systems have further deteriorated the access to reproductive health services in Indonesia, as such services are not prioritised in reforms and are often not part of social security packages. Insurance schemes do not even cover delivery, let alone examination and treatment of reproductive health concerns, including cervical cancer.[35] Cervical screening is an important means for preventing cancer but at present only limited screening facilities are available to women especially in South Asia. For example although 15 percent of the world's cervical cancer cases are reported in India, screening facilities are available only to a small minority of urban women.[36]

Government Assessment of ICPD Progress

Reproductive cancers were not mentioned in the eight government ESCAP reports.

Data Problems

- Lack of effective national cancer registries. This has a direct impact on the availability of reliable data on reproductive cancers.
- No NGO or government report gave figures of actual numbers of women suffering from reproductive cancers and dying annually.
- No governments reported on the availability of referral, screening or treatment services for reproductive cancers at the national level; and the costs of these services

Recommendations: Reproductive Cancers

- Generate high awareness among communities through intensified IEC and media campaigns and provide comprehensive information on early detection, screening and treatment of reproductive cancers and the right for services to be available.
- Advocate for available, affordable screening and treatment services as a priority especially for poor and disadvantaged women, as an integral part of reproductive health programmes.

- Advocate for the integration of reproductive cancers screening, detection and treatment services into primary health care services.

Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs)

'Reproductive health programmes should increase their efforts to prevent, detect and treat sexually transmitted diseases and other reproductive tract infections, especially at the primary health care level. Special outreach efforts should be made to those who do not have access to reproductive health-care programmes.' (ICPD PoA 7.30)

The global disease burden of RTIs, including STIs, is a major public health concern. In 1999, an estimated 340 million people were infected with a curable STI, such as gonorrhoea (62 million), chlamydia (92 million), syphilis (12 million), and trichomoniasis (174 million) (WHO 2001). The consequences of RTIs, including stigmatisation, reproductive impairment, domestic abuse, and abandonment, can be severe for women. Complications of reproductive tract infections can be serious. Pelvic inflammatory disease, for example, can cause infertility, ectopic pregnancy and chronic pain. Human Papillomavirus (HPV) infection is strongly linked to the risk of cervical cancer.

STI infections are among the top five conditions for which men and women seek care. Cambodia reported almost universal STI treatment in MOH clinics providing STI services in outpatient departments. Several NGOs have been involved in the provision of STI prevention and care services for both general and high risk populations (Catalla and Catalla, 2003). In Indonesia, the focus of the Government is on the treatment of infections among high risk groups and the treatment of gonorrhoea and syphilis. However, other STIs like chlamydia, which is spreading gradually among housewives, are not prioritised.

The ICPD emphasised the integration of reproductive health services to meet the needs of women, especially for STI prevention and care. The programmes in some of the countries have demonstrated that integration of RTI/STI prevention and control within existing health programmes and services is feasible. However, few ESPS have prioritised the treatment of STIs.

Government Assessment of ICPD Progress

None of the eight government ESCAP documents reported anything on the prevalence, treatment and care measures on RTIs and STIs.

Data Problems

Very few epidemiological studies have measured the prevalence of reproductive tract infections in developing countries. Those that have, have been concerned principally with infections due to Chlamydia trachomatis, Neisseria gonorrhoea, and HPV. Extensive data on prevalence, treatment and care measures on RTIs and STIs are therefore not available at the national level.[37] Further, the burden of many RTIs and STIs has not been computed, as a result of which they do not get

prioritised. This includes non sexually transmitted reproductive tract infections, uterine prolapse, urinary incontinence, vesico vaginal and recto-vaginal fistulae, menstrual disorders and infertility (except when these are the result of sexually transmitted infections). There is also little data on efficacy and costs of different interventions to address these problems (Castillo, forthcoming).

Recommendations: RTIs and STIs

- Reproductive health programmes need to increase efforts to integrate detection and management of RTIs, including STIs and to work towards prevention, care and treatment, at the primary health care level.

- Promotion and reliable supply and distribution of male and female condoms as protection against RTI and STIs should be an integral component of all reproductive health care services.

- Services providers should be adequately trained on infection diagnosis and case management and should appropriately respond to RTI and STI infections.

- STI/RTI programmes and services should be used as an entry point to step up HIV/AIDS prevention, treatment and care.

Gender Equality and Women's Empowerment

The principles of the Programme of Action (Chapter II) clearly put forward a human rights framework stating that women have equal rights to freedom, dignity, education, health, reproductive decision-making and an equal relationship with men in marriage. The gender equality and women's empowerment chapter comes early in the Programme of Action before the reproductive rights and reproductive health chapter, showing that this is an overarching concern at the heart of the ICPD paradigm shift.

'The empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself' (PoA, 41).

The chapter has three sections which deal with the following issues: a) empowerment of women b) the girl child and c) male responsibilities.

Governments agreed to:
'Act to empower women and take steps to eliminate inequalities between men and women as soon as possible' (PoA, 44), particularly in the areas of:

- Equal participation and representation in all political processes.
- Promoting women's potential through education, skill development and employment and eliminating poverty, illiteracy and ill-health.
- Eliminating all practices that discriminate against women and assisting them to establish and realise their rights including reproductive and sexual health.
- Improving women's ability to earn income and be economically self-reliant.
- Eliminating violence against women.
- Eliminating discriminatory employment practices.
- Ensuring women can combine the roles of childbearing, breast-feeding and child rearing with participation in the work force (ICPD PoA 4.4).

Change in Women's Lives

Violence Against Women (VAW)

Real achievement can only be acknowledged when women's lives improve and there is an increase in their power to make autonomous decisions in their sexual and reproductive lives, family relationships, work and health. One of the best indicators of real change in power relations between men and women is a decrease in domestic violence and rape. Although this is a key indicator, only two of the eight countries (Cambodia and Malaysia) had ever had a national prevalence survey on domestic violence (see Table 13) and these were both in the early 1990s. Without a survey, the extent of the problem cannot be accurately known and decadal change cannot be measured. Country studies stated that violence against women in all forms continues to be a huge problem, and has reportedly increased in Indonesia, Malaysia, Pakistan and also Cambodia.

In Pakistan, estimates are that a very high 75-95 percent of all women experience domestic violence, whereas the Malaysian 1990 national estimate was 39 percent and for Cambodia, it was 16 percent. Whether these data are comparable is a question, as different definitions and methods could have been used to define domestic violence. More public support and services however, are available to battered women in Southeast Asia and China due to greater government and media recognition of the issue. A number of countries like Cambodia, China, Malaysia, Philippines and Indonesia have begun or extended VAW crisis services run by government and NGOs. VAW services have been integrated into public health services fully in Malaysia or partially in the Philippines, China and India. Women's suffering from alienation and stigma due to domestic violence and rape has thus probably lessened in these countries. In all countries where violence is on the rise, women continue to be coerced, threatened, raped, beaten, murdered and trafficked. This abuse and dominance of men as part of a patriarchal society is a huge barrier to women being in control of their lives and bodies and to women's well-being and happiness.

NGO country reports from South Asia state that girls and women are still suffering from other forms of discrimination related to gender inequality. The evidence at the end of Cairo's first decade in India for example, is that the bias against females in the juvenile sex ratio and infant and child mortality rates has become worse[38] and thus more girls and women continue to die disproportionately.

Enrolment in Education

On the positive side, great strides have been made in reducing gender disparity in school enrolment (see Table 14). All eight countries have reduced the gender gap and in the Philippines and Malaysia, more girls than boys are enrolled in school. Pakistan stands out as having the lowest enrolment ratio of 61 girls compared to 100 boys while South Asian countries all have lower ratios[39] than their counterparts in Southeast and East Asia. Inequality in illiteracy rates continues in all the countries, particularly in South Asia. The very good progress in girls' school education has put women in a position in which they have more knowledge, skills and opportunities to decide on what they want from their lives. Thus one firm pillar on which to build real empowerment is more in place since Cairo.

Political Participation

Women's political participation has also improved in Indonesia, Philippines, India, Cambodia and Pakistan in the past decade. Quotas for women's political representation from local to national levels in India, Pakistan and the Philippines were one of the most effective strategies to be implemented.

Laws and Policies

In all the countries except Pakistan, there have been many new laws and policies to address gender inequality and discrimination. For example, seven of the countries have drafted, passed and/or implemented new legislation on violence against women (see Table 14) addressing the offences of domestic violence, rape, trafficking of women and sexual harassment. The most common legislation was a domestic violence law with Malaysia leading the way in 1994. The National Commission on Women in Pakistan has, since 2000, been recommending the need for legislation on domestic violence, although there has not yet been a State response to this. Women's status in Pakistan is very low due to retrogressive customs worsened by discriminatory legislation in the name of Islam, like the Hudood Ordinances 1979, that cover fornication and rape (requiring the evidence of four adult male eye witnesses for maximum punishment and excluding the evidence of women and minorities for the same level of punishment); the Qisaas and Diyat Ordinances (dealing with retribution and blood money in case of murder where the diyat of females is half that of males); and the Law of Evidence 1983 which seeks to reduce the evidence of women in business transactions to half that of men. Customary practices like killing in the name of honour, offering women to settle conflicts, and domestic violence are widespread in Pakistan. According to a July 2002 UN report, of the 2200 women in prison, most have been convicted under the Hudood Ordinance.[40]

Country reports reveal, however, that governments have been slow to implement the new laws, showing no real awareness of urgency. For example, after taking five years to draft legislation, Malaysia took another two years to implement the domestic violence law. Liberalisation of abortion laws in Cambodia in 1997 and Nepal in 2002 has been only partially implemented and women thus continue to die from unsafe abortions, and in Nepal are still imprisoned on charges of infanticide. Indeed the only people to consistently push for law reform (an agenda set long before but given additional impetus by the Beijing Conference) have been women NGOs and advocacy groups.

Most countries (Cambodia, India, Pakistan, Philippines, Indonesia and Malaysia) have also put in place national women's empowerment or women's development policies and have developed national action plans with gender equality and women's health as key areas. Although prior to Cairo and Beijing many countries had statements in their constitutions on the right of women to gender equality, these new policies and plans represent the first time the government has committed in detail to specific actions to improve women's lives within the framework of women's empowerment and gender equality rather than just improving women's status. While this is definitely good progress, there needs to be an in-depth content analysis of these policies and plans to evaluate how good they are. The extent of actual implementation also needs to be monitored and assessed.

Good progress has also been achieved in strengthening national institutional mechanisms for the advancement of women, a strategic objective of the

Beijing Platform for Action. New ministries on women have been established in Malaysia, and National Commissions or Councils on Women have been set up in Pakistan (2002), and Cambodia (2001). Again, there needs to be an evaluation of the concrete outcomes of these initiatives, as well of similar steps already in existence in other countries. Pakistan has reported for example, that their new National Commission on Women has made a number of critical legislative recommendations years ago, which have not yet been agreed to. The Commission has no decision-making power however and plays only an advisory role.

Human Rights Commissions have also been set up in many of the countries in the 1990s and they have begun to address violations of women's rights and reproductive rights. However, their tenure so far has been too short to make an assessment of the outcome of their work.

Overall, it can be said that there is now a much more conducive national policy environment for achieving gender equality in all of the eight countries, with perhaps the exception of Pakistan. The next decade will need to focus on monitoring to ensure that these laws, policies and plans are fully implemented and the outcomes evaluated. Whilst the policy and legal environment may have become more positive, social support for gender equality has not necessarily increased, as shown by the increasing incidence of violence against women and the continuing son preference in the countries studied.

International Policies

The PoA urges countries to sign, ratify and implement all existing agreements that promote women's rights as a key action (PoA, 4.5). All countries in this study had ratified the Convention on the Elimination of All Forms of Discrimination Against Women by 2004. Progress on reporting and implementation has been good but slow. Again, monitoring and evaluation is needed to determine to what extent government policy makers and women NGOs successfully use this Convention and other Declarations and Treaties to promote and defend women's rights.

Gender-sensitive Health Services

There is no evidence that health services have became gender-sensitive, addressing gender inequality and women's empowerment issues. In fact, from case studies in the Philippines and Pakistan, there is evidence that poor women are further disempowered by the disrespect and lack of care and empathy on the part of health providers in government health services. The quality of NGO reproductive health services received a much higher rating from women[41] than did government health services; but their capacities vary across and within countries.

Governments have not yet initiated any extensive gender-sensitive training for health providers. With public health services in most of the countries not yet providing basic quality reproductive health services and experiencing shortages of staff, resources, and facilities, ensuring gender-sensitive and client-centred services is a challenge.

Men's Responsibility

The ICPD PoA broke new ground in addressing men's specific responsibilities and roles in achieving gender equality and equal sexual relations, in stopping violence against women, sharing contraception and HIV/AIDS and STDs prevention, and also in pregnancy care, equal sharing of child rearing and domestic work. Governments do not report on this section in their ESCAP reports as a critical gender equality strategy. Some government reports refer to the issue of male responsibility but limit it to the use of male contraceptives methods. This is the old pre-ICPD concept of 'male involvement'. Some countries have interpreted this ICPD concern narrowly as primarily regarding men's own reproductive health needs and included this in the list of reproductive health services ideally available. Progress here is still at the basic level of clarifying concepts and strategies and conducting research to better understand masculinity. In spite of commitments on expanding male involvement in contraception, there has not been much progress in most countries. More than governments, NGOs have taken the lead in this area. A promising strategy is the formation of Men Against Violence groups in Malaysia, India, Cambodia and the Philippines.

Government Assessment of ICPD Progress

VAW indicators of incidence and changes in law, policy and services were not a focus in most government reports, nor were men's responsibility indicators addressed in any of them. This shows that governments are following the UN Gender Equality Index indicators of education and employment which are very limited and outdated now that Cairo and Beijing have emphasised not only women's public status but the equality of their personal relationships with men in private (as indicated by the incidence of domestic violence).

Of the eight government reports studied, most provide data on progress in terms of literacy rates and enrolment in education while some also deal with political participation. Only Cambodia reported data on domestic violence, while violence against women was referred to by Cambodia and the Philippines.

Where the girl child is concerned, India acknowledged increased discrimination as evidenced by the deterioration in male-female juvenile sex ratios. No governments reported comprehensively in this section on efforts to increase male responsibility towards equal gender relations. This would have included information on change in rules on paternity leave, strengthening child-support laws, school curriculum, public education on gender equality and family responsibilities as well as men's responsibility in sexual and reproductive decision-making and reproductive health. Nepal was the only country to report that school textbooks were being revised.

Data Problems

- Data on gender differentials in education and enrolment were more easily available from UN sources than from the countries themselves as there are no regular country reports on progress towards gender equality.
- Very few countries have implemented national studies on the incidence of domestic violence and rape, so these data too were not available. Few countries have systematic annual police records on domestic violence, rape and sexual harassment.

- There are few inter country studies using common definitions and methodology on violence against women; this makes comparisons difficult
- Trend data on violence against women are not yet available. Domestic violence baseline national studies, for example in Malaysia and Cambodia, in the mid-1990s have not yet been repeated.
- Data on attitudes of women and men on gender equity are lacking, posing challenges for strategies to bring about change.

Recommendations: Gender Equality

- Advocate for the faster and more effective implementation and evaluation of new legislation, policies and plans to reduce violence against women, gender discrimination and unsafe abortion.

- Advocate for governments to regularly monitor and report on progress in implementation of the national policies and plans on gender equality, including preparation of alternative NGO reports.

- Advocate for women activist NGO involvement in decision-making on new and revised laws, policies and plans on gender equality and their representation on commissions and committees on women's development, violence against women, education etc.

- Advocate for regular national and Asian prevalence studies on domestic violence and a reliable national and Asian database on various types of violence against women as an evidence base for policies and plans.

- Advocate for national indicators on violence against women to be used as basic indicators of gender equality and women's empowerment nationally as well as internationally as part of the gender empowerment indicators in the MDGs and gender indexes.

- Advocate for indicators related to changing norms and practices on men's responsibility for gender equality to be monitored and reported on as part of gender equality.

- Public and media campaigns and education against violence, discrimination and gender inequality in marriage and the family need to be intensified so that the process of changing social attitudes can begin.

- Advocate for campaigns to promote public awareness of men's responsibilities and roles in improving women's SRHR as enshrined in the ICPD.

- Advocate for school curricula that promote gender equality and socialise young people, especially boys, to be egalitarian and share SRHR responsibilities.

- Advocate for institutionalisation of shared responsibilities in family and child rearing, through improved maternity and paternity leave entitlements and benefits.

- Ensure gender-training that is based on feminist perspectives, and follow–up and monitoring mechanisms that are integrated into the training programmes in order to assess their long term effectiveness in changing behaviour and practices.

The Main Barriers

Inadequate Health Care Systems/Health Sector Reform Impact

Expanded reproductive rights and reproductive health services were supposed to be integrated into well-functioning primary health care systems. However what has instead happened is that during the ICPD decade, public health systems have weakened in China, India, Pakistan, Indonesia and the Philippines, partly due to structural adjustment programmes of the 1980s and health sector reforms of the late 1980s/1990s. India and the Philippines have reported shortages of staff, equipment, facilities and supplies. India has clinic structures but often only limited basic services are available in the poorer northwestern states. Also, health staff in Cambodia, Indonesia and India are reported to have low morale and salaries. Corruption, and poor supervision of health staff have also been cited as reasons in Cambodia, India and Nepal.

Health sector reforms, promoted and financed by the World Bank, USAID and the Asian Development Bank, which were introduced in the late 1980s/1990s to address failing health systems, have not resulted in any significant improvements in reproductive health outcomes for poor, young and other marginalised women in the last decade. The reform components have commonly included increase of user fees and expansion of social health insurance; decentralisation of decisions related to service delivery; the promotion of public-private interactions in health services, and the promotion of cost effective methods for priority-setting . It was expected that these changes would improve the efficiency, affordability, coverage, quality and community participation of health services. However, findings from this regional study and the global Initiative for Sexual and Reproductive Rights in Health Reforms[42] reveal that anticipated benefits have not occurred, and health systems have, in fact, weakened. Furthermore, some elements of reforms are anti-SRH in their orientation, notably the expansion of user fees, public private interactions involving the profit sector, and the use of cost effectiveness methods for priority setting. Reforms have, in particular, affected the availability of controversial SRH services (e.g services for abortion, complications arising out of violence against women) and low priority SRH issues (e.g infertility, which do not lead to DALYS – Disability Adjusted Life Years - saved); and services for marginalised groups such as adolescents, and the elderly. These aspects are discussed below in greater detail.

Our eight country reports suggest that government budgets for health expenditure have also declined in some countries. In China, for example, health sector reforms, which form part of the re-orientation to a market economy, have led to a decline in government health expenditure from 25 percent in 1990 to 15 percent in 1999 and hospitals in China are increasingly dependent on paid patients for revenues

In the Yunnan province in China, where user fees now account for 50 percent of MCH costs, utilisation of SRH services has fallen. The out-of pocket burden of health care services for pregnancy, delivery or post-partum is now around 26 percent and 17.5 percent for gynaecological complications. Furthermore, due to

increasing operating costs and government cutbacks, cost recovery through user fees has not resulted in any improvement in the quality of service as had been envisaged under health sector reforms.[43](Studies indicate that at best, revenue from user fees has only contributed five to ten percent of recurrent costs, not enough to have any real impact on the quality of services). User fees may aid cost recovery, but they simultaneously reduce access for poor, vulnerable and marginal groups.

Evidence from Pakistan has shown that the private sector has taken over provision of family planning, drugs and preventive services. Basic health units and rural health centres are contracted out and tertiary hospitals charge user fees. Privatisation of parts of the health sector is also causing problems. In Indonesia, for example, multinational corporations have moved into the pharmaceutical industry in a big way and this has had a negative effect[44] on reproductive health services. Access to health services has become more difficult for less affluent social groups. Contraceptives used to be free in government hospitals and primary health centres but now injectables, for example, cost around $1.80 to $3.00.[45] In Makasar (Indonesia), the cost for injectable contraception before health sector reforms was Rp 5,000, and this was raised to Rp 12,000. The cost of contraceptive pills also rose from Rp 1,000 to Rp 2,500.

In one of the poorest states of India, Rajasthan, the out-of-pocket burden has had an adverse impact on the utilisation of reproductive health services. A study on households in 1999 reported that 45 percent of mothers in the bottom two income groups with children less than two years of age did not have antenatal care and 80 percent of them delivered at home without a skilled birth attendant. Furthermore, only 20 percent of women who reported RTI symptoms sought any care. Several of the insurance packages do not cover delivery costs and comprehensive SRH services. At the same time, there is evidence from Gujarat in western India that the inclusion of caesarean sections under insurance has lead to a high rate of caesareans.

Country-level public-private partnerships in the eight countries studied have not mobilised resources to provide additional services as mandated by the ICPD Programme of Action. Instead, in Asia they have only focussed on the promotion and marketing of contraceptives including condoms, and HIV/AIDS prevention, and not on the integration of sexual and reproductive health services as envisaged in the ICPD Programme of Action.

The mechanisms used for priority-setting developed by the World Bank, the DALY methodology (Disability Adjusted Life Year) does not see access to healthcare as a human right, but only prioritises those services that lead to maximum labour years saved per dollar spent. This has excluded a wide range of SRH morbidity and mortality services that are not amenable to calculations of the burden of diseases in terms of labour years lost, or where interventions are found to be expensive vis a vis costs. Such calculations have also led to less prioritisation of the SRH needs of the elderly, as such interventions lead to less DALYs saved.

The decentralisation of health/SRH services has not resulted in the anticipated benefits of enhanced accountability and responsiveness of health/SRH services to local needs for SRH services. The Philippines government acknowledges that decentralisation of health care services to local governments is a big problem. ‘Many local governments do not have adequate institutional preparation to take on the responsibility of health care. They suffer from shortages of technical manpower for health operations, lack of equipment, inadequate health facilities and inadequate referral systems among health facilities’ (Philippines Government

Country Report, ESCAP 2002). Local governments are also amenable to pressure from conservative forces, and some have restricted modern contraceptives due to pressure from conservative elements of the Catholic Church. Referral services – including maternal health services - have also been affected by devolution in Philippines.

Overall, governments are now less responsible for providing primary health care. Sector Wide Approaches (SWAPS), while focusing on coordinating poverty and development efforts, have led to delays in procurement in the area of maternal care supplies in Bangladesh and have generally meant less priority on sexual and reproductive health services at local levels.

No National System for Government Reporting and Accountability

We have yet to see any systematic move by governments or UNFPA to develop ICPD's reproductive rights and reproductive health agreements into comprehensive measurable indicators. The government reports for ICPD +5, and now ten years after ICPD, are still descriptive, without any comparison on what has changed since 1994. There has also not been a real assessment and accountability process to report on progress nationally. The 2003 UNFPA Country Field Enquiry asked governments to report on measures taken to implement ICPD. Whilst this is a good initiative, there was no process to review progress by government and all related NGOs at the country level as a country assessment exercise.

Few countries even have national plans on ICPD implementation that can be monitored or a national committee with all NGO stakeholders. Disappointingly, even the expert papers on reproductive health, gender equality and adolescents at the Asian and Pacific Population Conference in December 2002 did not give details on progress to meet ICPD objectives at the national level.

Negative Impact of Development Institutions and Donor Policies

Four countries concluded that the policies of the World Bank, IMF and USAID have had a negative impact on ICPD implementation. Not only did these agencies recommend health sector reforms and reduction of government expenditure in the health sector but they had no clear understanding of the rights-based framework in implementing SRH services. They were criticised for uncoordinated work, inefficiency in project implementation and lack of evaluation of country outcomes and impact.

Government ... Positive or Negative?

Political Commitment and Will

Commitment and will were understood in relation to a) implementation of the ICPD Programme of Action; b) achieving gender equality; c) implementing the human rights frameworks of the UN Conferences in the 1990s; d) budget allocation of sufficient funds for implementation of policies and plans; e) establishing genuine GO-NGO relationships.

Government commitment was assessed by NGOs as both a positive and negative factor in seven of the countries with only China reporting no negative aspects.

On the positive side was openness to dialogue with NGOs in Nepal and India in the early years and the Philippines up to 1998, as well as the priority governments have given to addressing poverty (Pakistan) and the attention they are beginning to pay to women's empowerment.

On the negative side: i) there are less resources for SRH vis a vis what is required to meet ICPD commitments; defence expenditure in most countries is higher than on health, ii) some gender unjust SRH laws persist revealing poor political will, iii) dealing with corruption and ensuring effective implementation still remain a problem. In addition, some of the countries have no clear-cut procedures for genuine civil society participation (Cambodia); others are minimal (India), and often there is no NGO consultation on new policies; these are exacerbated by token gender equality measures (Philippines) and slowness in repeal of discriminatory laws for women (Nepal and Pakistan). Other problems cited in the GO-NGO relationships were: the exclusion of advocacy oriented NGOs from government consultations and retaliation against NGOs when they were critical of government policies. GO-NGO relationships differed according to perspectives of the government in power in the Philippines and India showing that a more liberal government that genuinely supports human rights, enables greater participation of NGOs in policy development and evaluation.

Insufficient Government Recognition of the Critical Role of NGOs

The PoA's objective in Chapter XV is 'To promote effective partnership between all levels of government and the full range of NGOs and local community groups, in the discussion and decisions on the design, implementation, coordination, monitoring and evaluation of programmes relating to population development and environment' (PoA, 15.7).

There has been little evidence of sustained progress in this area. For example, the close engagement of government with women NGOs in the Philippines and India in the early post-Cairo years was discontinued by new government administrations. The Pakistan country monitoring study reports that 'selected NGOs', and not the 'full range of NGOs' are consulted by government. In fact, the more advocacy-oriented NGOs are deliberately excluded from the policy consultation process. Governments justify this by saying that NGOs are represented in their population boards and reproductive health committees, but frequently these are selected service oriented NGOs and as they receive government funding they dare not challenge existing policies and actions. They also generally do not represent all the diverse NGO views but represent only their organisations. Unless NGOs organise themselves into national sexual and reproductive rights networks in which the many different NGOs are represented, advocacy efforts will continue to be weak. The responsibility of reproductive health and family planning associations to initiate the broadening of NGO representation is critical. There needs to be clear agreement on what matters governments will decide and discuss with NGOs. This should cover at least all new population, reproductive health, health, women's empowerment policies and laws; annual monitoring and evaluation of policies and progress; and scaling up of successful NGO SRHR services.

There also needs to be agreement on mechanisms for broader civil society and community participation in policy planning and evaluation including draft laws and policies circulated in print and electronic media for comments, and public hearings and ombudsman centres.

Improvements and Lacunae in NGO Policy Advocacy Capacity

NGO capacity includes a) influencing planning, implementation and evaluation of policy; b) organising NGO alliances, coalitions and networks; c) accessing sufficient funding for advocacy and remaining autonomous, not donor driven, in advocacy agendas.

Women NGOs in India and the Philippines have successfully mobilised action and intervened in policy and reproductive health programme implementation and in some cases (e.g. Gujarat State Population Policy) have ensured that demographic targets and disincentives were not included in new state population policies. Several country ICPD monitoring reports stated that although NGO groups have attempted to resist conservative forces in reversing population policies or cutting back on reproductive health services, they have not been a sufficiently big and effective critical mass to make a real impact. The Philippines has seen a number of new NGO networks in the last decade including the Reproductive Health Network and the women's Reproductive Rights Advocacy network, which has intervened on and rallied grassroots women over the draft Reproductive Health Bill.

Although India has the Health Watch network, its members were not consulted on the new 2000 National Population Policy. The Indian report states Health Watch effectiveness and direction as a watchdog has waned in recent years. In other countries there have been new national NGO reproductive health networks (Pakistan) or reproductive health committees (Malaysia) but no policy advocacy intervention success has been reported yet due to their efforts. These mechanisms bring together Family Planning Associations, health NGOs, medical associations and women NGOs. This potentially powerful alliance of NGOs has sometimes been led by women's NGOs (as in Pakistan) or health NGOs (as in Malaysia).

Women's NGOs working in the area of health are only beginning to organise as an ongoing advocacy force at national and regional levels. ARROW and partners in the Women's Health and Rights Advocacy Partnership (WHRAP) aim to fulfil this function for the Asia-Pacific region. But more core funding is needed for women's groups to continue strengthening their monitoring and advocacy skills and to organise. Furthermore HIV/AIDS, reproductive health, and women's health activist NGOs have not yet worked strategically together, although they need to do so. Neither have these groups and the People's Health Movements formed close alliances in most countries. Both these groups also need to develop strategies to deal with religious institutions, dialogue with them, perhaps win them over, as these are a strong force in the countries in this study. Reproductive health and women activist NGOs committed to Cairo have only come together briefly for the ICPD +5 review and now for Countdown 2015. While this is encouraging, we need sustained equal partnerships and coalitions focusing on ongoing advocacy at country and regional levels on controversial and strategic issues. There have not been enough strategic alliances and advocacy to make a difference on issues of reproductive rights, access to affordable reproductive health services and reduction in maternal mortality, contraceptive unmet need and unsafe abortion.

US Global Gag Rule and US Interference

The US Global Gag Rule reintroduced in 2002 has resulted in funding cuts to both IPPF and UNFPA, which has been a serious constraint to the effectiveness of these organisations. The IPPF-affiliated Indian and Bangladesh FPAs consequently

had to close down some clinics due to insufficient funds. Budget cuts to UNFPA have meant less resources as have large cuts to innovative projects such as the IRRRAG (International Reproductive Rights Research Action Group) research and action project on men's responsibility. USAID's planned (at the time of writing) withdrawal from the Philippines family planning programme in 2004 is related to the US GAG Rule and cuts to USAID. This will greatly affect the availability of contraceptive supplies in the Philippines.

US interference at the 2002 ESCAP Asian and Pacific Population Conference involved threats, misinformation and intense lobbying by the US to government delegates to remove the words 'reproductive health' and 'reproductive rights' from the meeting report. Although the US did not succeed in its attempts to do this, as it was the only ESCAP member to vote for this action, much time and energy of both government and NGO delegates was spent on negotiating with the US to protect ICPD language and concepts. Such efforts at resisting threats due to US conservatism at this regional governmental meeting meant that less time was available for in-depth assessment of ICPD progress and reflection on steps for more effective implementation.

Implementing sexual and reproductive health services required an investment of US $17 billion in the year 2000. However less, not more, resources have been available for health financing through donor sources in recent years. Only Denmark, Netherlands and Norway have met their financing goals while overall donors between 1992 and 1997 saw their contribution reduced by 25 per cent.

General Recommendations on Critical Actions

Critical actions are defined as those that must be taken in order to move the ICPD agenda forward. Most of these recommendations are directed towards NGO advocacy and thus also imply recommendations for government and donors. They are based on a synthesis of the recommendations of the NGO country reports and the regional analyses. Some of the specific critical recommendations have been dealt with in the respective sections.

Health Sector Reforms (HSR)

- Health sector reforms initiated by neo-liberal institutions like the World Bank, ADB and USAID need to urgently undergo evaluation so that policymakers can assess the impact of reforms on the poor and also assess the quality and affordability of SRH services.
- Health sector reforms need to be based on principles of human rights, the right to health, women's rights and SRHR, not just on efficiency and other economic justifications. In this direction rights-based groups need to be part of the planning of reforms.
- Governments should remove user fees for priority SRH services such as antenatal care, delivery, emergency obstetric care, abortion and family planning services for all women, including young people and marginalised groups.
- In countries where social insurance has been introduced, coverage must include SRH services and be extended to the informal sector; i.e made universal.
- Gender-based vulnerabilities and differences should be included in calculations of the burden of diseases for priority setting as this methodolgy presently marginalises SRHR, and SRHR activist NGO groups should be involved in calculating burdens, costs and efficacy of interventions during priority setting processes.

- HSRs should be based on careful assessment of 1) existing infrastructure and resources; 2) targets committed to in ICPD and MDGs; 3) structured consultations/inputs from women service providers, local communities; 4) careful planning for optimal utilisation of resources available from federal and local budgets. This assessment should be done by the government, with NGOs and external bodies as advisors and/or observers.
- Budget allocations at federal, state or local levels should be monitored, audited and assessed for their impact on health status, and health service uptake and reports on these should be made available to the public. Resources to provide public SRH services at minimal cost for areas like treatment of Reproductive Tract Infections, Sexually Transmitted Diseases and HIV/AIDS, and treatment of infertility should be prioritised.
- Governments need to ensure mechanisms to promote accountability of public-private partnerships in the provision of integrated sexual and reproductive health services and their location in resource poor areas; rights based groups should compulsorily sit on boards of PPIs.
- Monitoring of decentralisation of health services needs to be done to ensure that national SRH policies are not compromised, that decentralisation better addresses local SRH priorities and needs, includes genuine participation of NGOs and civil society and has adequate capacities and resources. Ideally, national SRH programmes should be made mandatory for implementation by decentralised units.
- Advocate that integration within reforms moves beyond administrative aspects, to service integration, in particular of SRH services, where appropriate.

NGO-GO Roles and Relationships

- Advocate a greater role and respect for NGO contributions to decision-making in the design, implementation, monitoring and evaluation of policies, laws and programmes as agreed to in the ICPD PoA (Chapter XV) in order to ensure more effective and faster implementation of the PoA and the meeting of people's needs.
- Advocate for and support the 'full range of NGOs and local community groups' (PoA 15.7) to be included in 'discussion and decisions', especially advocacy oriented NGOs committed to ICPD implementation.
- Advocate for more formal/informal mechanisms for sustained NGO-GO relationships and dialogue through representation of diverse NGOs including women activist NGOs on Population Boards, and Reproductive Health Committees etc. and consultation on new policies and laws and their evaluation.

NGO Relationships and Partnerships

- Strengthen the capacity of local and national alliances and networks of health and reproductive health; ensure that women activist NGOs and human rights NGOs become better SRHR advocates and form such alliances and networks if they do not exist.
- Reproductive health NGOs such as the FPAs/IPPF and women activist NGOs and youth need to prioritise genuine and equal partnerships with each other to work strategically together on advocacy of priority issues

like maternal mortality, unsafe abortion, youth rights, reproductive rights, violence against women and the impact of health sector reforms.

- Influence religious institutions on SRHR, including issues on maternal mortality, contraception and abortion.
- NGOs need to prioritise participation and capacity building of young people and new people in their organisations to introduce more dynamism and fresh ideas to carry the ICPD agenda and NGO movements forward with greater enthusiasm.
- Women SRHR activist groups need to work more strategically with the broader women's movement, People's Health Movements, human rights NGOs nationally, regionally and internationally to mutually support critical and related SRHR advocacy issues.
- HIV/AIDS NGOs and networks and SRHR NGOs need to work more strategically together to support critical SRH rights advocacy issues and reduce the current separation of the reproductive health and HIV/AIDS issues.
- NGOs and women's health activists must work to strengthen and build coalitions that include professional associations, consumer associations and others.
- The critical role of activist NGOs in monitoring ICPD implementation, producing alternative country reports and acting as 'watchdogs' needs to continue and be funded on a regular and more effective basis locally and nationally.
- NGOs need to put forward more persuasive alternative perspectives, frameworks, models and tools for designing, implementing and evaluating rights based SRHR services and population and development policies.
- Strengthen NGO capacity in effectively using human rights instruments, mechanisms and structures at national and international levels to ensure the right to access quality SRH services.

Recommendations for UNFPA

- Strengthen the role of UNFPA in clarifying, promoting and defending the ICPD human rights and reproductive rights framework in national policies and programmes, donor funding, and health sector reform planning nationally, regionally and internationally.
- Advocate for the development of a national institutionalised monitoring system for ICPD reporting, accountability and evaluation involving government and diverse NGOs based on agreed up indicators.
- Prioritise working to ensure that up-to-date and accurate national SRHR data exist and are acceptable.

Recommendations for Donors and Financial Institutions

- Urgently fund the evaluation of the impact of HSRs on access of the poor and low-income people to comprehensive, affordable SRHR services within the public health system.
- Integrate the priority of access to SRHR services and the promotion of sexual and reproductive health and rights in all loans and funding grants as well as the need for active participation of all NGOs including activist NGOs, in planning and evaluation.
- Governments must commit to their health financing pledge of US$ 17 billion as affirmed in the ICPD PoA.

Annexures

Table 1: Human Poverty Index Value %

COUNTRY NAME	Value (%) 1997 [a]	Value (%) 2003 [b]
Cambodia	52.5	42.8
China	17.5	14.2
India	36.7	33.1
Indonesia	20.8	17.9
Malaysia	..	..
Nepal	..	41.9
Pakistan	46.8	40.2
Philippines	17.7	14.8

Source : [a] *Human Development Report*: 1997, p 126-27
[b] *Human Development Report*: 2003, p 245-46
[c] *Human Development Report*: 2003, p 198-99

Note : Human Poverty Index concentrates on deprivation in three essential elements of human life already reflected in HDI-Longevity, knowledge and a decent standard of living (population without access to safe water and health services and underweight children under age five).

Table 2: Population Living Below $1 A Day (1990-2001) %

COUNTRY NAME	Population living below $1 a Day (1990-2001)	Population living below $1 a Day (1990-2002) % b
Cambodia	..	34.1
China	16.1	16.6
India	34.7	34.7
Indonesia	7.2	7.5
Malaysia	<2	<2
Nepal	37.7	37.7
Pakistan	13.4	13.4
Philippines	14.6	14.6

Source: [a] Human Development Report: 2003, p 198-99
[b] Human Development Report: 2004, p 147-49

Table 3: New Reproductive Health Policy and Programme Changes Post-Cairo

Countries	Reproductive Health Policy	Reproductive Health Programme	Population Policy
Cambodia	-	National Reproductive Health Programme 1997	National Population Policy Feb. 2004
China	-	-	The Population and Family Planning Law, effective Sept 2003
India	National Population policy 2000 and National Health Policy 2002 include strategies for reproductive health of women and men in India	Reproductive and Child Health Programme (1997) [2]	National Population Policy 2000 and a number of state policies in Gujarat, Uttar-Pradesh, Bihar [1]
Indonesia	Proposed amendment of Health Law No 23/19923[3]	-	Proposed amendment of Population Law no. 10/1992 drafted and in parliament
Malaysia	-	-	-
Nepal	National Reproductive Health Policy- 1998 National Policy and strategy for Reproductive Health 2003 [2]	-	National Population Policy 2000
Pakistan	-	National Health Policy - 2001	National Population Policy- 2002
Philippines	-	Integrated Reproductive Health Programme (year 1995 to 1998)	

Source:
[1] Government ESCAP report [2] NGO country report [3] Indonesia country report

Table 4: Unmet Need for Contraception

Countries	Post ICPD [a] Year 2000 (current) Percent	Before ICPD [b]
Cambodia	33	NA
China	NA	NA
India	16	20 (31,005) 1992
Indonesia	9	14 (4,427) 1991
Malaysia	30 (M) 15 (C) 31 (I)	NA
Pakistan	33	19
Philippines	19	32 (5,738) 1990-91
Nepal	28	28 (970) 1991

Source:
[a] NGO Country Monitoring Reports and C. Westoff, 'Unmet Need at the end of the century' (2001).
[b] DHS tabulation, Westoff & Bankole 1995 (237), Westoff & Ochoa 1991 (238)

Note: M- Malay community in Malaysia
C-Chinese community in Malaysia
I-Indian community in Malaysia

Table 5: Contraceptive Prevalence Rates

Countries	Post ICPD 2003a		Before ICPD 1986-1993b
	Any Method	Modern Method	Any Method
Cambodia	24	19	NA
China	84	83	83
India	48	43	43
Indonesia	57	55	50
Malaysia	55	30	48
Pakistan	28	20	12
Philippines	47	28	40
Nepal	39	35	23

Source:
[a] UNFPA State of World Population, 2003
[b] Human Development Report,1995

Table 6: Initiatives to Address Reproductive Health Needs of Young People

Family Planning and Reproductive Health Policies and Services			
Countries	Policy on Adolescent Health	Services in PHC[46]	
		For all[47]	Limited[48]
Cambodia	-	√	
China	2000	√	
India	2002 (in population policy)	√	
Indonesia	1996		√
Malaysia	2001		√
Pakistan	2000 (in population policy)		√
Nepal	2000		√
Philippines	2000		√

Source: ICPD country reports, WOW country reports, WOW South Asia report

Table 7: New Laws and Policies on Violence Against Women Post-Cairo

Countries	Domestic Violence	Rape	Sexual Harassment	Trafficking of Women
Cambodia	Law drafted not yet passed 'Anti Abuse of Women in Intimate Relationship Act' National Declaration and law against Domestic Violence- 1996	-	-	Law against Sex Trafficking -1996
China	Regulations in Jiangsu and Shanxi Provinces to handle domestic violence Cases	-	-	-
India	Protection from domestic violence Draft Act,2002 [2]	2003 Draft Sexual Offences Bill. (Special courts)	Implementation of the Guidelines contained in Supreme Court of India Order in the case of Sexual Harassment of Women at Workplace and other institutions	-
Indonesia	Domestic Violence Law 2001 has been passed in parliament	Anti Rape law draft in Parliament	NA	Anti Trafficking Law(draft).
Malaysia	Domestic Violence Act 1994	-	Code of Practice, For Work Place 1999	-
Pakistan	Bill on Domestic Violence was tabled in Punjab Assembly in 2003 and awaiting discussion	-	-	-
Nepal	-	-	-	Law on Trafficking (no date)
Philippines	Anti Abuse of Women in Intimate Relationship Act	Anti Rape Law, 1997 (including marital rape)	Anti Harassment Act, 2003	Anti Trafficking of Person's Act, 2003)

Source:
[1] ICPD report

[2] CHETNA; SAHAYOG; Healthwatch.2002. 'Many Voices: One Agenda'. The National Consultation on Advocacy and Monitoring for Women's Health and Rights.26-28 June 2002.

[3] WOW report

Table 8: Maternal Mortality Rates and Annual Maternal Deaths

Countries	MMR/100,000lb		Annual Maternal deaths	
	Before CAIRO	Post CAIRO	1990[c]	2000[d]
Cambodia	590* (1995) 590(HDR 2003)**	500(HDR 1995)450(WHO/UNICEF/UNFPA 2000)*** 404(UNFPA 2003)**** 437(CDHS 2000)*****		2,100
China	89* 95(HDR 1995)	43.2 (MOH 2003)* 60(HDR 2003)** 56(WHO/UNICEF/UNFPA 2000)*** 56(UNFPA 2003)**** 69.6 *****	22,000	11,000
Indonesia	390*(90-94) 450(HDR 1995)	307(IDHS 2002-03)* 470(HDR 2003)** 230(WHO/UNICEF/UNFPA 2000)*** 226 (UNFPA 2003) **** 334*****	31,000	10,000
India	460* 460(HDR 1995)	570 (NFHS 1998)* 440(HDR 2003)** 540(WHO/UNICEF/UNFPA 2000)*** 540 (UNFPA 2003)**** 407 (1998)*****	147,000	136,000
Malaysia	20* (1990) 59(HDR 1995)	30(2000)* 39(HDR 2003)** 41(WHO/UNICEF/UNFPA 2000)*** 41 (UNFPA 2003)****	94	220
Nepal	850* 830(HDR 1995)	830 (HDR 2003)** 740(WHO/UNICEF/UNFPA 2000)*** 905(UNFPA 2003)**** 539 (1996)*****		6,000
Pakistan	500-700 500(HDR 1995)	300-700* 200 (HDR 2003)** 500(WHO/UNICEF/UNFPA 2000)*** 476 (UNFPA 2003)****		26,000
Philippines	209(93) 100(HDR 1995)	240(HDR 2003)** 200(WHO/UNICEF/UNFPA 2000)*** 213(UNFPA 2003)**** 172(NDHS 1998) *****		4,100

Source:

*NGO country monitoring report
** Human Development Report 2003
** Government report to 5th Asian And Pacific Population Conference ,2002
*** Maternal Mortality in 2000:Estimates developed by WHO, UNICEF and UNFPA
**** State of World Population 2003, UNFPA
***** Government Country Report

Note: The above table shows the differences in MMR from various sources implying inaccuracy in determining MMR estimates.

Source:

[c] . www.unescap.org/wid/04widresources/01statistic/table2.3.pdf
[d]. www.who.int/reproductive-health/publications/maternal_mortality_2000/analysis.html

Table 9: Skilled Attendance at Birth

Countries	Skilled attendance at birth (percent)	
	1983 – 1993[a]	1995 -2001[b]
Cambodia	47	32
China	94	76
Indonesia	32	64
India	33	43
Malaysia	87	97
Nepal	6	11
Pakistan	35	20
Philippines	53	58

Source: [a]. Human Development Report 1995 p 168
[b]. Human Development Report 2003 p 255-56

Table 10: Unsafe Abortion Estimates

Country	MMR [a]	Annual Maternal Deaths2000[b]	Percentage of maternal deaths due to unsafe abortion [c]	Estimated no.of unsafe abortions annually [c]	Estimated annual deaths due to unsafe abortions 2000[d]
India	570(NFHS II 1998)	136,000	13	South Central Asia 6,500,000	17,680
Nepal	539 (2001)	6,000	13		780
Pakistan	553(2001)	26,000	13		3,380
Cambodia	437(CDHS 2000) 2,100	2,100	15	South Eastern Asia 2,800,000	315
Indonesia	307 (2002-03)	10,000	15		1,500
Malaysia	30 (1998)	220	15		33
Philippines	172 (1998)	4,100	15	-	615
China	43.2(2002)	11,000	15	-	1,650
				TOTAL	**25,953**

Source:
[a] Country Monitoring Reports
[b] www.who.int/reproductive-health/publications/maternal_mortality_2000/analysis.html
[c] Cook, Dickens & Fathalla, Reproductive Health and Human Rights, 2003. Incidence of and mortality due to unsafe abortion, global and regional annual estimates, 1995-2000, 424p.
[d] This estimate is calculated by ARROW, Figures may be lower or higher Eg: Nepal annual unsafe abortion figure was 4,000 .

Table 11: Status and Change in Conditions of Abortion Law since Cairo

Countries	To save the life of the woman	To preserve Physical health	To preserve mental health. Can include rape and incest and foetal impairment	Economic and social reasons	Available on Request
Cambodia (New Law 1997)	Yes	Yes	Yes	Yes	Yes
China	Yes	Yes	Yes	Yes	Yes
India	Yes	Yes	Yes	Yes	Yes
Indonesia (1992)	Yes	No	No	No	No
Malaysia (1989)	Yes	Yes	Yes	No	No
Pakistan (1990)	Yes	Yes	No*	No	No
Nepal (New law 2002)	Yes	Yes	Yes	Yes	Yes
Philippines	No	No	No	No	No

Source:
Abortion policies: *Volume I* UN New York 2002 (Cambodia, China)

Abortion policies: Volume III UN New York 2002 (Pakistan and Philippines)
Abortion policies: Volume II UN New York 2001 (India, Indonesia, Malaysia and Nepal
* Abortion permitted only on grounds to preserve mental health in Pakistan but not for rape incest and foetal impairment.

Table 12: HIV Prevalence Among 15-49 Year Old Women

Countries	HIV Prevalence among 15-49 yrs old population (2000)	Estimated HIV prevalence among women
High Prevalence Countries (1% and above)		
Cambodia	169,000	50,700
Moderate Prevalence Countries(0.1% and 1 %)		
India	3,900,000	1,170,000
Malaysia	42,000	12,600
Nepal	34,000	10,200
Pakistan	73,000	21,900
Low Prevalence Countries (less than 0.1%)		
Indonesia	100,000	30,000
China	600,000	180,000
Philippines	10,000	3000

Source: UNAIDS/WHO.2000.Global Report (June 2000, estimated for the year 1999)

Table 13: Incidence of Violence Against Women

Incidence/Reports				
Countries	1990		2000	
	Domestic Violence	Rape	Domestic Violence	Rape
Cambodia	NA	NA	16%	NA
China	NA	NA	NA	NA
India	NA	12,351(1994)	45%*	16,075(2001)
Indonesia	NA	NA	11%	NA
Malaysia	39%/500	879	3,000	1,418(2002)
Pakistan	NA	NA	70-90 %	NA
Nepal	NA	NA	NA	NA
Philippines	NA	NA	NA	NA

NA – Data Not Available in ICPD and WOW Country Reports and Government ESCAP Reports.
Source: NGO Country Monitoring Reports (ICPD) & WOW Country Monitoring Reports
* UNICEF, 'Domestic Violence against Women and Girls', No.6, June 2000

Table 14: Gender Disparity in Education

Ratio of Female to Male Enrolments in Primary and Secondary School (percent)

Countries	1990	2000
Cambodia	NA	83
China	81	98
India	68	78
Indonesia	91	98
Malaysia	98	105
Pakistan	47	61
Nepal	53	82
Philippines	NA	103

NA – Data Not Available
Note : This ratio shows the number of female students enrolled in primary and secondary school to the number of male students.

Source: *World Development Report 2004*

Notes

1 HealthWatch.2004.'Healthwatch', June

2 A Herrin.2002. *Population Policy in the Philippines, 1969-2002,* Discussion Paper, series no. 2002-8. Philippines Institute for Population Studies.

3 HealthWatch.2004.'Healthwatch', June Murthy, R.K.2003. 'Sexual and Reproductive Rights in Integration of Reproductive Health Services in Asia. Initiative for Sexual and Reproductive Rights in Health Reforms.' Women's Health Project. Website: *www.arrow.org.my. http://www.worldbank.org/ssprojects*

4 Chetna,ANS-WERS,India. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights. Page 14 NGO Country Report.

5 Rashidah Abdullah'. 2000. 'Reproductive health and rights: the importance for Muslim women', in, Zainah Anwar; Rashidah Abdullah(eds).2000.*Islam,Reproductive Health and Women's Rights. Kuala Lumpur*; Sisters in Islam. Pp.19-31.

6 Zulkifli,SN;Low,W.T; Yusof,K.1995.'Sexual activities of Malaysian adolescents'. *Medical Journal Malaysia,* March, Vol.50.No.1.pp.4-10.

7 *Country Report: Government of Philippines.* Fifth Asian and Pacific Population Conference at the United Nations Conference Centre, Bangkok,11-17 December 2002.

8 Sison, M. 'Social Consensus Needed to Reduce Population Growth.' Philippine Centre for Investigative Journalism.12-13 March 2003.

9 *www.who.int/reproductive-health/publications/maternal_mortality_2000/analysis.html*

10 Cook, Rebecca; Dickens, Bernard M; Fathalla, Mahmood F. 2003. *Reproductive Health and Human Rights.424p.*

11 Institute of Population Research China 2004, ICPD Ten Years On: Country Monitoring and *Advocacy of Sexual* and Reproductive Health and Rights.

12 Federation of Family Planning Associations of Malaysia,Malaysia. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights. Page 14 NGO Country Report

13 Cook, Rebecca; Dickens, Bernard M; Fathalla, Mahmood F.2003.Reproductive *Health and Human Rights*.424p.

14 Likhaan. Philippines. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

15 ARROW.2003. Access to Quality Gender-Sensitive Health Services: Women-Centred Action Research.

16 Likhaan. Philippines. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

17 UNAIDS.2004.*Factsheet on AIDS epidemic in Asia*

18 UNAIDS.2004.*Factsheet on AIDS epidemic in Asia*.

19 *http://w3.whosea.org/hivaids/asia2-3.html*

20 Cambodian Midwives Association. Cambodia. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

21 Institute of Population Research China 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

22 ARROW. 1997. "Women at Greater Risk of HIV Infection". *ARROWs For Change, April, Volume 3, No. 1. Kuala Lumpur*: Asian-Pacific Resource and Research Centre For Women. p. 12

23 UNFPA.2003. *State of World Population*

24 ESCAP.UNFPA.2002.*Country Report: Indonesia*. Fifth Asian and Pacific Population Conference at the United Nations Conference Centre, Bangkok,11-17 December 2002.

25 ESCAP.UNFPA.2002.*Country Report: Nepal*. Fifth Asian and Pacific Population Conference at the United Nations Conference Centre, Bangkok,11-17 December 2002.

26 Cambodian Midwives Association, Cambodia. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights in Cambodia.

27 Human Rights Watch Report. 2004. *Philippines: Anti-Condom Policies Could Spark AIDS Explosion* .Manila: Philippines.

28 Likhaan. Philippines. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

29 Shirkat Gah, Pakistan. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

[30] http://www.youandaids.org

[31] http://w3.whosea.org/hivaids/fact1.htm

[32] Shirkat Gah. Pakistan. 2004. ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

[33] Cambodian Midwives Association, Cambodia. 2004. ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

[34] ARROW.1997."Reproductive Cancers: Women's access to screening services". *ARROWs For Change*, Dec 1997,Vol.3,No.3.12p

[35] Indonesia Reproductive and Sexual Health and Rights Monitoring and Policy Advocacy, Indonesia. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

[36] *http://www.hsph.harvard.edu/organizations/healtrhnet/Sasia/suchana/0416/pachuri.html*

[37] http://www.who.int/reproductive-health/publications/biennial_reports/2000-01/Chapter_3.PDF

[38] Chetna, ANS-WERS, India. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights. 14p.

[39] Chetna, ANS-WERS, India. 2004. ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights. 14p.

[40] Shirkat Gah, Pakistan. 2004. ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

[41] Yut Lin, Wong.2003. "Women's Access to gender-sensitive reproductive health services at the Kelantan Family Planning Assocation,Malaysia", in ARROW.2003. *Access to Quality Gender-Sensitive Health Services: Women-Centered Action Research*.pp.11-27.

[42] Initiative for Sexual and Reproductive Rights in Health Reforms. Women's Health Project.Website:www.arrow.org.my,http://www4.worldbank.org/ssprojects.

[43] Sundari Ravindran.2003. "Health Financing Reforms in Asia and the Impact on Reproductive and Sexual Health Services". Johannesburg. Initiative for Sexual and Reproductive Rights in Health Reforms. Women's Health Project.

[44] Indonesia Reproductive and Sexual Health and Rights Monitoring and Policy Advocacy, Indonesia. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

[45] Indonesia Reproductive and Sexual Health and Rights Monitoring and Policy Advocacy, Indonesia. 2004, ICPD Ten Years On: Country Monitoring and Advocacy of Sexual and Reproductive Health and Rights.

[46] PHC – primary health care centres

[47] Contraceptives and certain non-contraceptives services are available to both married and unmarried individuals.

[48] Contraceptives are available only to married individuals and non-contraceptives services such as awareness raising and counselling are available to unmarried individuals.