ASIAN-PACIFIC RESOURCE & RESEARCH CENTRE FOR WOMEN (ARROW)
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BRIEFING PAPER
The Women and Health Section of the Beijing Platform for Action[1]

Introduction

The Beijing Platform for Action (BPfA) asserts the human rights of women to have *control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health , free of coercion, discrimination and violence.*[2] *The BPfA calls upon the governments to support and implement the commitments made in the Programme of Action of the International Conference on Population and Development (ICPD PoA), and ensure that the necessary services are available at each level of the heath system and make reproductive health care accessible , through the primary health-care system, to all individuals of appropriate ages as soon as possible and no later than the year 2015.*

Sexual and Reproductive Health and Rights

Paragraphs 94, 95 and 97 of the BPfA fully reiterate the concepts and components of reproductive health, sexual health and reproductive rights which are enunciated in Paragraphs 7.2 and 7.3 of the ICPD Programme of Action. The BPfA underscores the importance of provision of sexual and reproductive health services to meet the health needs and rights of girls and women of all ages. This briefing paper will look at the following indicators of health outcomes and rights around contraception, pregnancy and childbirth related mortality and morbidity, adolescent fertility, safe and legal abortion and reproductive cancers as benchmarks of the realisation of the aspirations of the women and health chapter of the BPfA.

i. Contraception

The BPfA urges the governments to provide accessible and affordable primary health care services of high quality including sexual and reproductive health care, that includes family planning information and services.[3] Evidence in the Asia-Pacific region shows that the total fertility rates (TFR) have been declining steeply in all 12 countries (2008) but are still high in Pakistan (4) Cambodia (3.4), Laos (3.6). Total fertility rates compared to wanted fertility rates, are consistently higher for women living in rural areas, mountainous areas, lowest education quintile and lowest wealth quintiles. Women who have less forms of power at their disposal face greater inequities of fertility control, even when they desire it. The same pattern in seen in the contraceptive prevalence and unmet need. Contraceptive Prevalence Rates (CPR) are moderate, except in China (90.2), but low usage of modern methods are seen in Cambodia (27.2), Laos (35), Malaysia (29.8), and Philippines (33.4). The availability of range of contraceptive methods to women and informed choice still seems distant to many women (e.g. high CPR countries like China – main contraceptive methods include IUD and sterilisation; Vietnam - IUD & traditional methods). Provider bias towards one method is seen in many countries (e.g. sterilisation in India; injectables in Indonesia; oral contraceptive pills & sterilisation in Thailand). Informed choice on contraception methods and side-effects have not been emphasised in service provision. Key factors in addressing the causes of unmet need in Asia Pacific region include, concerns about side-effects, health consequences and inconvenience of methods of contraception as well as non-use of contraception due to opposition.
Male contraception is nowhere near the desired ideal of having both men and women sharing equal responsibility over SRH decisions as couples.

Male contraception still remains at very low levels, although condoms offer dual protection against pregnancy and disease, despite the context of AIDS/ HIV. Condom usage is highest in Pakistan (22.97% of all contraceptive methods); it stands at 9-10% in Nepal, Malaysia and India; and stands lowest 1-2% in Indonesia, Laos and Thailand.

ii. Pregnancy and Childbirth Related Mortality and Morbidity

The BPfA urges the governments to reduce maternal mortality by at least 50 per cent of 1990 levels by year 2000, and a further one half by the year 2000 and further one half by the year 2015. None of the 12 Asian countries are anywhere close to achieving the Beijing 2015 target for maternal mortality reduction – even China and Malaysia who are regarded as having achieved the MMR targets for the MDGs. Highest maternal mortality rates have been observed in Nepal (830), Lao PDR (660), Bangladesh (570), Cambodia (540), India (450), Indonesia (420), and Pakistan (320) in 2005.

For the purposes of cross-country comparison we use the estimates of WHO/UNFPA/UNICEF for maternal mortality rates, and we base interpretation of reduction on this particular data source.[4]

Table 1. Maternal Deaths per 100,000 live births in 12 Asian Countries

Country	1990	2000 levels		2005 (2015)	
		Actual MMR	Beijing Target (2000)	2005 MMR	Beijing Target (2015)
Bangladesh	850	380	425	570	212
Cambodia	900	450	450	540	225
China	95	56	47	45	23
India	570	540	285	450	142
Indonesia	650	230	325	420	162
Lao PDR	650	650	325	660	162
Malaysia	80	41	40	62	20
Nepal	1,500	740	750	830	375
Pakistan	340	500	170	320	85
Philippines	280	200	140	230	70
Thailand	200	44	100	110	50
Vietnam	160	130	80	150	40

Source: Maternal mortality estimates, 1990, 2000 and 2005, WHO/UNICEF/UNFPA

Interventions that prevent maternal deaths include access to emergency obstetric care (EmOC), skilled attendants at birth and post-partum care. Skilled attendance at birth is above 80% in China (97.8%), Malaysia (100%), Thailand (97.2%) and Vietnam (87.7%) and not in the other 8 countries. South Asia shows a poorer compliance in both provisions of EmOC and skilled attendants at birth. Professionalisation of midwifery, and increased number of births with a skilled attendant, backed by facilities providing EmOC was associated with a declining MMR. Post-partum care is also critical as 25-33% of all maternal deaths are caused by obstetric haemorrhage generally occurring postpartum i.e 24 hours - 2 days after delivery.

iii. Safe and legal abortion

The BPfA adopted the ICPD paragraph 8.25, which talks about the need to reduce the recourse to abortion through contraception, of pre- and- post abortion counseling , of access to safe abortion services where abortion is not against the law; and that at the very least all countries should have access to services for the management of complications arising from abortion. In addition the BPfA further added that countries should "consider reviewing laws containing punitive measures against women who have undergone illegal abortions, which shifted the framing of abortion from a public health perspective to a more progressive human rights perspective. Four countries in the region (Cambodia, China, Nepal and Vietnam) have abortion available on request; 1 country (India) provides abortion on all grounds except request; only in Bangladesh, Indonesia and the Philippines is it available on limited grounds. Changes in law/ policy since ICPD and/or Beijing include, Vietnam legalising abortion and menstrual regulation in 1989; Cambodia legalising abortion in 1997 concerned with the high MMR due to unsafe abortions; Nepal legalising abortion in 2002; Thailand broadening the grounds for abortion to reasons of mental health in 2005; and Indonesia amending grounds for abortion to those who had been raped in 2009.

Lack of knowledge about abortion laws among women and service providers continues to be an issue. Unsafe abortion is negligible in China and Vietnam but continues to be a major factor in maternal deaths in the region contributing 14% and 13% of all maternal deaths in Southeast Asia and South Asia. Although access to safe abortion services has been proved to be linked to a lower level incidence of unsafe abortions and lower percentages of maternal deaths due to unsafe abortion progress on amending laws seems slow. Where abortion laws are restrictive, it is important to look at how women's NGOs are working to amend these laws as recommended by the Beijing Platform for Action. It is useful to note that abortion services are provided safely through the private sector in Malaysia and Thailand, through family planning methods such as menstrual regulation in Bangladesh and through private provision of medication abortion in Southeast Asia. In Lao PDR, the Philippines, Indonesia, Bangladesh and Pakistan legal barriers curb access; in Malaysia - non-legal barriers such as hospital administration policies; in countries with liberal policies such as Nepal, India and Cambodia service barriers for safe abortion still exist and governments must follow through policies with services.

iv. Reproductive Cancers

The BPfA reiterates that *cancers of the breast and the*

cervix and other cancers of the reproductive system, as well as infertility affect growing numbers of women and may be preventable, or curable, if detected early.[5] Reproductive cancers include breast, ovarian, endometrial and cervical cancers but this review only focuses on cervical cancer and breast cancer both of which are at epidemic proportions. Cervical cancer accounts for approximately 12% of all cancers in women. Cervical cancer is the most frequent cancer among women in Bangladesh, Cambodia, India, Lao PDR, Nepal, Thailand and Vietnam. It ranks as the second most frequent cancer among women in Malaysia, Indonesia and the Philippines. In addition to pap smears, VIA (visual inspection approach with acetic acid) with cryotherapy is being researched as an alternative method. In the 12 countries, Malaysia has made a commitment to universal vaccination against cervical cancer. Breast cancer is common and early detection through screening and improvements in therapy have reduced mortality - however early detection and screening are inaccessible to large segments of the population in the region.

v. Adolescent Sexual Rights & Adolescent Fertility

Adolescent fertility characterised by births to women under age 20, account for 11% of all births worldwide and account for 23% of the overall disease burden. Adolescent fertility rate per 1000 girls aged 15-19 years is higher in Bangladesh (127) and Nepal (106) than the Southeast Asian countries: Malaysia (13), Vietnam (35), Cambodia (52), the Philippines (55). Adolescent fertility continues to be a major concern for governments in Bangladesh, India, Indonesia, Lao PDR, Malaysia, Nepal, Pakistan, the Philippines, Thailand and Vietnam and these countries have reported policies and programmes to address adolescent fertility.

Governments are urged in Paragraph 107 (e) in the BPfA to *'prepare and disseminate accessible information, through public health campaigns, the media, reliable counseling and the education system, designed to ensure that women and men, particularly young people, can acquire knowledge about their health, especially information on sexuality and reproduction* …'and in Paragraph 107 (g) *'to recognise the specific needs of adolescents and implement specific appropriate programmes, such as education and information on sexual and reproductive health issues and on sexually transmitted diseases, including HIV/AIDS.'* There are 2 clear strains of thinking about adolescents. In South Asia, where the age of marriage is low, adolescents are very often married and their rights are recognised within this framework. In Southeast Asia, age of marriage is higher, adolescent sexual activity is often perceived as taking place outside the framework of marriage. SRH services have been so often subsumed within the framework of reproduction, access to services and information becomes problematic. Progress on imparting sex and sexuality education to adolescents is uneven and sketchy across all 12 countries. Only in 3 countries (Vietnam, India and Nepal) are there attempts to introduce sex education as part of the curriculum. Only Thailand has started to address and attempt to provide sexuality education.

vi. Sexual rights

Sexual rights is a highly contested term in international arenas; and seen as terminology which has not been 'agreed upon.' Many governments limit and equate sexual rights with legalisation of homosexuality and same sex marriage however the majority of women who live in patriarchal societies continue to struggle with sexual rights. Legal age of marriage and existence of arranged and forced marriages indicate rights around choice of partner, decision to be sexually active or not, consensual sexual relations and consensual marriage. The BPfA urges the governments to *enact and strictly enforce laws to ensure that marriage is only entered into with the free and full consent of the intending spouses; in addition, enact and strictly enforce laws concerning the minimum legal age of consent and the minimum age for marriage and raise the minimum age for marriage where necessary.*[6] Differences between legal age of marriage and median age of marriage show that in Bangladesh, India and Nepal laws on legal age of marriage are not enforced. There are many loopholes within the law which makes it is possible to marry off young girls. In Southeast Asia, arranged marriages are practised in Cambodia and Indonesia. In South Asia both arranged marriages and forced marriages have been documented. Child marriages have been documented in South Asia especially in Pakistan and Bangladesh and in Indonesia.

Traditional practices which are harmful to women, sexual violence and trafficking denote rights on bodily integrity. Among traditional practices, female circumcision is widespread in Indonesia, reduced in Malaysia, low in Pakistan and completely non-existent in all the other 9 countries. Symbolic prick is recorded in the Philippines. In 2007 the CEDAW committee recommended to the government of Indonesia to speedily enact legislation prohibiting female genital mutilation and to ensure that offenders are prosecuted and adequately punished.

The BPfA urges the governments to take integrated measures to prevent and eliminate violence against women and eliminate trafficking in women.[7] This review examines four aspects of sexual violence: rape; marital rape; sexual harassment and new and emerging forms of sexual violence.

All 12 countries have anti-rape laws; most laws crafted around 'consent' and 'forced vaginal penetration.' Consent

is difficult to establish, especially problematic with women who are perceived as transgressing society's acceptable expressions of sexuality e.g. young women who have had consensual sexual relations and sex workers. 'Forced vaginal penetration' fails to recognise rape can be a crime against children, men and transgender people. Marital rape is highly contested. In 5 countries (Cambodia, India, Thailand, Indonesia and Vietnam) the marital rape provision is found within the Domestic Violence Act. In the Philippines, it is part of the anti-rape law. In Malaysia, marital rape is part of the penal code (amended 2007). In Nepal, it is part of the gender equality bill. China, Lao PDR, Bangladesh and Pakistan do not have legal provisions for marital rape.

With respect to sexual harassment, anti-sexual harassment provisions exist in Bangladesh, Cambodia and Nepal; sexual harassment is part of the labour law in Malaysia and Thailand; only the Philippines has an anti-sexual harassment act; no such laws exist in China, India, Indonesia, Lao PDR, Vietnam and Pakistan. New and emerging forms of sexual violence include harassment via email and mobile phones. Currently there exists no legal curbs and little retribution for perpetrators. The data collected for violence currently does not disaggregate women, men and transgender. In analysing violence as a manifestation of unequal power relations, women are not the only group that suffers; violence also occurs against gays, lesbians, bisexual and transgender people.

RECOMMENDATIONS

Recommendation 1

Policy change underpinned by commitment to human rights and the recognition of rights to highest attainable standard of sexual and reproductive health(SRH) and to the sexual autonomy of all human beings. Policies should be aligned to providing the range of services; policies should be implemented and backed by functional health systems and adequate budgets; policy review should be backed by robust data and should measure indicators of rights; SRHR policy review processes need to be integrated with CEDAW and ICESR reporting mechanisms at the international level to hold governments accountable.

Recommendation 2

Ensure universal access to affordable, quality, gender-sensitive and comprehensive sexual and reproductive health services through functional and integrated health systems. These services should start form the primary health care level, and be available during times of conflicts and disasters. Governments need to commit to the provision of a full range of contraceptive methods (including condoms and emergency contraception), the full range of abortion services (including manual vacuum aspiration and medical abortion) and post abortion care, skilled attendance at birth, emergency obstetric services , services to address gender-based violence , services to treat STIs and HIV/AIDS, as well as counselling and information services. At all times, providers should give non-judgmental and gender-sensitive services, which include receptive to differences in sexual orientation and gender identities.

Recommendation 3

Governments (both national and local), donors and international and regional institutions need to ensure adequate and sustained investments in women's sexual and reproductive health and rights. An additional $ 24.4 billion is projected as requirement by 2015, to provide universal access to sexual and reproductive health information and services as agreed in the ICPD, excluding HIV/AIDS and other components; actual spending on SRH services at the national and local levels needs to eb tracked through the creation of SRH sub- accounts; funding mechanisms for SRH services, including HIV/AIDS, needs to be integrated.

REFERENCE

Thanenthiran, S. & Racherla, S. (2009). *Reclaiming and Redefining Rights- ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia.* Kuala Lumpur, Malaysia: The Asian-Pacific Resource and Research Centre for Women (ARROW).

ENDNOTES

1 *The Asian–Pacific Resource and Research Centre for Women (ARROW) is committed to the ICPD Programme of Action and the Beijing Platform for Action. Since its inception in 1993, ARROW has been consistently monitoring the implementation of the Cairo and the Beijing in the Asian Region. In 2009, ARROW carried out a research, monitoring and advocacy initiative to monitor the 15 years of ICPD implementation in 12 Asian countries. A summary on the progress, trends and lack of progress in the areas of sexual and reproductive health and rights, fifteen years after the Cairo and Beijing landmark conferences, and the recommendations to improve the sexual and reproductive health and rights of individuals is presented in this briefing paper.*

2 *Beijing Platform for Action Paragraph 94, 95 and 96*

3 *Beijing Platform for Action Paragraph 106*

4 *MMR varies between sources (Demographic Health Surveys, UNDP and WHO/UNICEF/UNFPA) and this clearly has become the source of conflict between different agencies, NGOs and governments. This is an important problem to resolve not only for monitoring purposes but also because intervention strategies for maternal mortality reduction may be different.*

5 *Beijing Platform for Action Paragraph 100*

6 *Beijing Platform for Action Paragraph 274*

7 *Beijing Platform for Action Strategic Objective D1-D3*