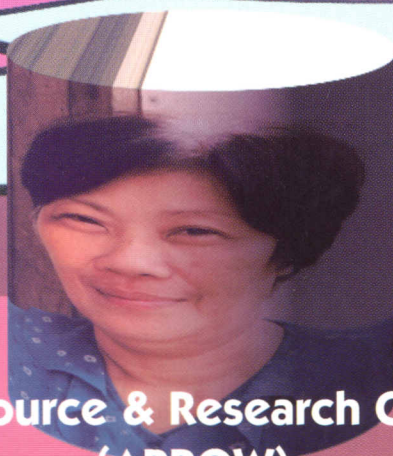
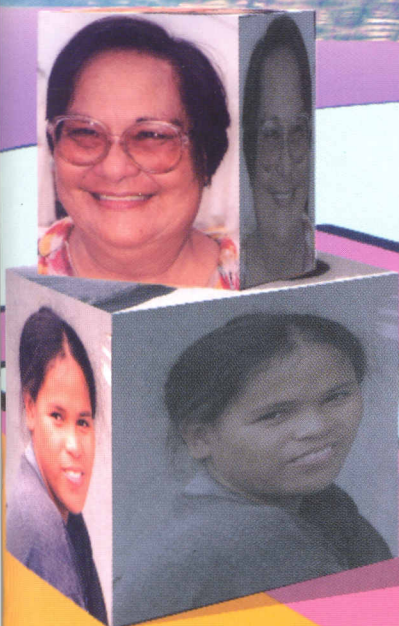


# **Women's Health Needs and Rights in Southeast Asia**

## **A Beijing Monitoring Report**



**Asian-Pacific Resource & Research Centre for Women  
(ARROW)**

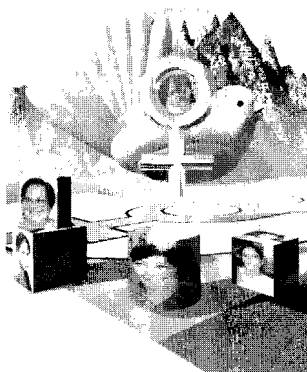
with funding support from the

**Southeast Asia Gender Equity Program (SEAGEP),  
a project of the Canadian International Development Agency (CIDA)**

**Women's Health Needs and Rights  
in Southeast Asia  
A Beijing Monitoring Report**

The Asian-Pacific Resource & Research Centre for Women (ARROW) was established in January 1993 as a regional non-governmental non-profit women's organisation based in Kuala Lumpur, Malaysia. ARROW's goal is for women in Asia and the Pacific to be better able to define and control their lives, particularly in the area of women's health and women's rights. Since 1993, ARROW has been able to make significant progress towards this goal through the provision of practical information, resources and research findings on women and development in the Asian-Pacific region. ARROW remains committed to its Women and Health Programme focus of strengthening initiatives to reorient health, population and reproductive health policies and programmes with women's and gender perspectives and, at the same time, strengthening women NGOs' capacity to influence relevant organisations, both governmental and non-governmental. This programme focus has been further tailored to strategically cover four key areas of the recommendations from both the Cairo and Beijing Conferences. The four key areas are:

- ❑ Women's right to comprehensive, accessible, affordable and quality health services throughout their lives recognised and implemented in the health care system;
- ❑ Sexual and reproductive health and rights approach included in health policies and programmes rather than a narrow maternal health and family planning focus with demographic objectives;
- ❑ Women-centred and gender-sensitive approach addressing the effects of gender inequality on women's health status and the need for women's perspectives and experiences to be included in health policies and programmes; and
- ❑ Violence against women recognised as an important women's health concern.



## CONCEPT OF COVER DESIGN

The design on the cover shows women of the Southeast Asia region as the strength (foundation blocks) of nations—contributing to society and the economy. This is shown against a very significant woman sign and the bird of Beijing (similar to the

Beijing logo). The bird in white is a sign of hope and peace. The woman sign stands out strongly depicting women activists' determination to continue to fight for women's rights. On the ground is a reflection of the Beijing logo which represents all the recommendations of the Beijing Platform For Action (PFA) of the 12 critical areas. The mountain in the background symbolises national sovereignty and the nature of governments—large bureaucracies that seem slow in taking action to effectively implement the recommendations of the Beijing PFA. Grass patches on the mountain slopes show how when governments are open to ideas and working in true partnership with the NGOs and are more consultative and participatory in the design and review of policies, programmes and services, they become catalysts of action for the improvement of women's lives and the fulfilment of women's needs and rights.

Cover and layout design by Angela M. Kuga Thas.

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1. Siriwan, Grisurapong; Ma-un, Wanpen; Boonmongkon, Pimpawun. 1998. "Indicators of action on Thai women's health after Beijing Platform for Action", in Asian-Pacific Development Centre. *Asia-Pacific Post-Beijing Implementation Monitor, 1999—Health*. Kuala Lumpur: Asian-Pacific Development Centre, Gender and Development (GAD) Programme. pp.85–103.
2. Cambodia Midwives Association. 1998. "Indicators of action on women's health and rights after Beijing". [Cambodia country paper, unpublished]
3. Le Thi Nham Tuyet; Hoang Ba Thinh. 1999. "Indicators of action on women's health and rights after Beijing", in *Some Studies on Reproductive Health in Vietnam Post-Cairo*. Hanoi: National Political Publishing House. pp.40–154.
4. Marcelino, Aleli B.; Verzosa, Emmeline L; Villar, Ma Georgianna A. 1998. "Indicators of women's health needs and rights: Philippine country paper". [Unpublished].
5. "Indicators of action on women's health needs and rights after Beijing Platform for Action: Indonesia country paper". [Unpublished].
6. "Indicators of action on women's health needs and rights after Beijing Platform for Action: Country paper of Lao PDR". [Unpublished].
7. "Indicators of action on women's health needs and rights after Beijing Platform for Action (PFA):Malaysia". [Unpublished].

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Rashidah Abdullah  
Executive Director, ARROW

10<sup>th</sup> September 2001

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# CONTENTS

	<b>Page</b>
<b>INTRODUCTION</b>	1
<b>CHAPTER 1: Women's Health and Rights</b>	7
<b>CHAPTER 2: Sexual and Reproductive Health and Rights</b>	13
<b>CHAPTER 3: Violence Against Women</b>	23
<b>CHAPTER 4: Gender-Sensitive Health Policies and Programmes</b>	29
<b>CHAPTER 5: Women's Health Data—Problems of Availability, Reliability and Accessibility</b>	33
 <b>ANNEXURES</b>	
<b>ANNEX 1: List of Contributors</b>	35
<b>ANNEX 2: Abortion and Sexuality Rights:</b> An extract from Rashidah Abdullah. 2000. <i>A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing</i> . Kuala Lumpur: ARROW. pp.13 & 14.	37

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# INTRODUCTION

In the Fourth World Conference on Women that took place in Beijing in 1995 governments agreed on the Platform For Action (PFA). It highlighted twelve areas of critical concern, one of which is women and health. This report is an outcome of the first regional effort in Asia-Pacific by women NGOs to systematically monitor the implementation of the recommended actions of the PFA's women and health section and give an account of the findings. With a focus on Southeast Asia, it clearly outlines the broad conceptual, policy, service delivery and financial resource changes needed for governments to better address women's health needs and rights.

Originally conceptualised in 1996 and implemented in 1997 and 1998 as a Beijing monitoring project, the regional findings are now being published after the UN-initiated Beijing+5 review in 1999. The report hopes to monitor the implementation of the Beijing recommendations through factual assessment of what has been accomplished in the region in terms of changes in health services, policy and legislation, using practical indicators of action. Southeast Asian women's health status and their still unfulfilled needs are also highlighted since they must be addressed before women can experience the well-being to which they are entitled.

## THE BACKGROUND

The health needs of women in Southeast Asia, a small but diverse geographical sub-region of Asia, are still largely unmet. This comes as a surprise to many who incorrectly assume that lower levels of poverty and higher availability of resources automatically translate into adequate health services and better health conditions. However, women still face problems of moderate to high rates of maternal mortality, high incidence of violence against women coupled with a lack of health care and support services, little availability of reproductive cancer screening and an increase in HIV/AIDS and sexually transmitted infections in the absence of comprehensive women-centred and gender-sensitive services.

The rates for life expectancy, death in pregnancy and childbirth and contraceptive use continue to be inappropriately used globally as the main indicators to assess women's health status. The Beijing PFA, however, advocated a broader concept of women's health and well-being, women's rights to high quality health care and the right to decide in matters of sexuality and reproduction, free from coercion and violence. These concepts require expanded indicators to also measure for example, the exercise of women's choice, happiness, freedom from violence and sexual satisfaction. This monitoring project uses comprehensive indicators to more accurately assess women's health needs and rights. However, despite Beijing's promotion of a very broad concept of women's health and well-being based on gender equality and women's rights to high health standards and health care, women's health rights and equality with men have hardly been recognised by governments or acted on even five years after the Beijing conference.

## THE CO-ORDINATING ORGANISATION

The Asian-Pacific Resource & Research Centre for Women (ARROW) was established in January 1993 as a regional non-governmental non-profit women's organisation based in Kuala Lumpur, Malaysia with the vision of enabling women in Asia and the Pacific to better define and control their lives, particularly in matters of their health and rights. ARROW's main goal is to reorient health, population and reproductive health policies and programmes with women's and gender perspectives. One of ARROW's programme strategies is action-oriented research and monitoring, especially in relation to the implementation of the recommendations proposed in the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Beijing conference. In 1996, ARROW collaborated with eight committed NGO national partners in its first regional monitoring of ICPD implementation in eight Asia-Pacific countries. The findings have been used at country, regional and international levels as part of the ICPD+5 review process and beyond,

to assist in identifying critical actions that need to be taken. These findings have been published in ARROW's 1999 publication, *Taking Up the Cairo Challenge: Country Studies in Asia-Pacific*. One of the recommendations emerging from this first monitoring study was that women NGOs need to produce more convincing research-based country-level information on women's health needs in order to advocate for change more effectively.

## THE PROJECT

With this in mind, in 1996 ARROW conceptualised a second monitoring project with the goal of initiating the establishment of Southeast Asian regional and national processes and mechanisms to monitor and support the swift and effective implementation of the health section of the Beijing PFA. The objectives of the project were:

- ❑ To develop comprehensive and gender-sensitive databases of indicators and analyses at country and regional levels of women's health needs and situations in Southeast Asia within the Beijing PFA framework of priorities, as a foundation for monitoring progress in implementing the Beijing PFA in the short and long terms;
- ❑ To monitor the development and implementation of National Action Plans on women's health post-Beijing and sharing analyses, strategies and actions from these plans; and
- ❑ To strengthen the capacity and commitment of government organisations to implement key areas of the Beijing PFA health section and the capacity of women NGOs to monitor implementation and to co-operate and mainstream their concerns with the government through regular mechanisms.

The project had three main activities:

- ❑ Compilation of seven country monitoring studies on women's health and rights and a Southeast Asian regional overview of findings;
- ❑ Organising of a "Southeast Asian Regional GO-NGO Policy Dialogue on Monitoring and Implementation of the Beijing PFA"; and
- ❑ Production of publications of the country studies findings and key insights and outcomes of the dialogue.

## THE FUNDERS

The project was funded by the Southeast Asian Gender Equity Program (SEAGEP) of the Canadian International Development Agency (CIDA) and the International Development Research Centre (IDRC) of Canada, both based in Singapore. Core programme support was provided by the Swedish International Development Cooperation Agency (SIDA).

## THE PARTNERS

In preparation for the project, country visits to Cambodia, Lao PDR and Vietnam were conducted to develop key contacts and acquire materials and documents. In other countries, ARROW used its existing contacts and relationships to identify partners. Women NGOs committed to Beijing and Cairo implementation and advocacy, experienced in research and monitoring, and keen on the project activities and outcomes were identified. Some organisations carried out the monitoring themselves while some commissioned women researchers to assist. The NGO partners involved were the Cambodian Midwives Association (CMA) of Cambodia; the Women's Health Advocacy Network (WHAN) of Thailand; *Serika Perempuan Anti Kekerasan* (SPEAK) and Kalyanamitra of Indonesia; the Research Centre for Gender, Family and Environment in Development (CGFED) in Vietnam, WomanHealth Philippines, Inc. of the Philippines and the CHAMPA Project of Lao PDR (see Annex 1 for "List of Contributors"). Two of the NGOs, CGFED and WHAN had been involved in the ARROW Post-Cairo monitoring project.

## THE ACTIVITIES

The country reports were to be used as a national database on women's health needs, rights and actions after Beijing. They would provide baseline data to: 1) monitor progress in implementing the Beijing PFA; 2) compile a Southeast Asian comparative database for regional monitoring of progress on women's health needs and rights; and 3) discuss

problems and barriers in implementing the Beijing PFA.

Subsequently, a five-day regional policy dialogue for both governmental and non-governmental organisations was organised by ARROW in collaboration with the Gender and Development (GAD) Programme of the Asian and Pacific Development Centre (APDC) on June 1–4, 1998 in Kuala Lumpur, Malaysia. The objectives of the dialogue were threefold:

- To strengthen government capacity to monitor and implement the Beijing PFA;
- To provide a forum for exchange of experiences and practical lessons; and
- To enable the prioritisation of women's health needs at country level and identification of the actions required in implementing strategies to improve women's health status.

The dialogue aimed to look at monitoring and implementation efforts in the three broad themes of sexual and reproductive health and rights, violence against women and gender-sensitive health programmes. Participants of the dialogue were from all the countries involved in the project. They included top government policy makers from ministries of health, women's development and population or family planning organisations, extending from senior department heads to ministers of two countries and the NGOs and/or researchers involved in producing the country reports. The dialogue participants comprised both women and men. The report has been published as *In Dialogue for Women's Health Rights: Report of the Southeast Asian Regional GO-NGO Policy Dialogue on Monitoring and Implementation of the Beijing Platform for Action, 1–4 June 1998, Kuala Lumpur, Malaysia*. The policy dialogue has been recognised as an innovative best practice model and presented as one of the ten case studies at the international conference, "Confounding the Critics: Cairo Five Years On" organised by the women's NGO network, Health, Empowerment, Rights & Accountability (HERA) on 15–18 November 1998 as part of the ICPD+5 review.

As the final part of the project, this publication presents the recommendations that emerged from the findings and the critical actions put forward by ARROW and the other organisations involved in this project. These require serious consideration by governments with support from NGOs in order to better implement the Beijing PFA and improve women's health and rights.

## **THE MONITORING FRAMEWORK AND METHODOLOGY**

ARROW developed the overall framework for the country monitoring reports after studying what little was available globally in terms of frameworks and indicators. This comprehensive framework focused on the key Beijing PFA recommendations within the following four priority areas:

- Women's rights to comprehensive, accessible, affordable and quality health services throughout their lives;
- Sexual and reproductive health and rights;
- Violence against women; and
- Gender-sensitive health policies and programmes.

These areas were chosen as they were the newer and the more difficult areas to implement of the Beijing PFA. For each area, the key recommendations were operationalised into a total of 190 indicators that would enable the measuring of action taken as well as the assessing of women's health needs. The categories of indicators were:

- Health service provision, use and quality (which include availability, accessibility and affordability);
- National laws, policies, plans and regulations; and
- Women's health status.

Indicators were both quantitative and qualitative, and covered both process as well as health outcome or impact. An extract from the framework on abortion and sexuality rights has been provided for reference in Annex 2. Country researchers used the indicators as a guide and focused on the priority indicators for their own country context, adding on new indicators when necessary.

The monitoring methodology of the researchers was primarily an analysis of existing reports and statistical and research data of both governments and NGOs in the areas of health, violence and women's development. National policies and plans on women developed after Beijing, and health and population policies and plans were also studied. When necessary, interviews were also conducted with government officials and NGOs to obtain the latest information.

The framework has now been published by ARROW as a useful tool for future monitoring and implementation of the Beijing PFA in *A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing* (2000, 30 p.). It has generated much interest and has been presented in a number of regional and international events between 1998 and 2000 on monitoring health, including sexual and reproductive health and rights, such as the "Expert Meeting on Indicators for Sexual and Reproductive Health" organised by the Ford Foundation in New York in October 2000.

## COUNTRY MONITORING REPORTS

The country monitoring reports were completed in 1998, some early in the year and some towards the end. They were used as background papers in the 1998 ARROW-APDC GO-NGO regional policy dialogue specifically for work on developing national GO-NGO monitoring plans. The reports were also read by relevant government personnel of the same countries to ensure factual accuracy.

ARROW encouraged ministries and departments of women's affairs to use the reports in preparing their country reports for the Beijing+5 review from 1999 to 2000. However, funds were insufficient for publishing the reports at the country level. Nevertheless, the Thailand country report has been published by APDC<sup>1</sup> while the Vietnam country report has been featured separately in another publication.<sup>2</sup> The project has been recognised regionally as an important Beijing monitoring effort by both governments and NGOs in publications and papers on implementation of the Beijing PFA such as two of APDC's publications<sup>3</sup> and the paper, "Monitoring and Evaluation Strategies for the Empowerment of Women"<sup>4</sup> which was presented at the ESCAP "High-level Intergovernmental Meeting to Review the Regional Implementation of the Beijing Declaration and the Programme For Action" in September 1999 in Bangkok.

## COMPARATIVE COUNTRY ANALYSIS OF THE FINDINGS

For the purposes of this report, completed in the year 2000, additional data had been included in the analysis based on information presented by governments in their verbal and written reports at the 1999 ESCAP High-level Intergovernmental Meeting in Bangkok. In addition, when reliable prevalence data on women's health status was unavailable at country level, other data sources were included for the comparative country analysis. Data and information from presentations in the ARROW-APDC Policy Dialogue were also included. The information presented in the reports is thus dated to 1998 and 1999 sources. The draft publication was circulated to both government departments and NGOs for verification of data before printing.

Comparable data on all key indicators at country level was not always available due to difficulties in the availability and accessibility of data, the extent of government agencies' co-operation in supplying information, and the capacity of the researchers and their organisations in obtaining the required data. The comprehensiveness of the monitoring framework, individual country priorities, and time and funding constraints also influenced the country reports produced. Despite these constraints, significant findings have been produced both at country level and in this regional analysis. The preliminary findings of this monitoring study were used to input into the ARROW Beijing+5 lobby document and the Beijing+5 review process at the meeting of the Commission on the Status of Women in March 1999 in New York. Several sections of this draft report were also used as input into the NGO Alternative Global Report on Beijing Plus Five that was produced by the Conference of Non-Governmental Organisations in Consultative Relationship with the United Nations (CONGO).<sup>5</sup> Finally, the national and regional findings were also used by international women NGOs such as the Women's Environment and Development Organisation (WEDO)<sup>6</sup> and Development Alternatives with Women for a New Era (DAWN)<sup>7</sup> in their global monitoring of Beijing implementation.

### REFERENCES:

<sup>1</sup> **Siriwan, Grisurapong; Mau-un, Wanpen; Boonmongkon, Pimpawun.** 1999. "Indicators of action on Thai women's health after the Beijing Platform for Action". *Asia-Pacific Post-Beijing Implementation Monitor, 1999-Health*. Kuala Lumpur: APDC-GAD. pp.85-103.

<sup>2</sup> **Le Thi Nham Tuyet; Hoang Ba Thinh.** 1999. "Indicators of action on women's health

and rights after Beijing". *Some Studies on Reproductive Health in Vietnam Post-Cairo*. Hanoi: National Political Publishing House. pp. 40–154.

<sup>3</sup> **Asian and Pacific Development Centre (APDC), Gender and Development (GAD) Programme.** 1999. *Asia-Pacific Post-Beijing Implementation Monitor, 1999-Health*. Kuala Lumpur: APDC. 389p.; **Gender and Development (GAD) Programme, Asian and Pacific Development Centre (APDC).** 2000. *Steps Forward: Initiatives in Beijing Implementation*. Kuala Lumpur: APDC-GAD. 112p.

<sup>4</sup> **Licuanan, Patricia B.** 1999. "Monitoring and evaluation strategies for the empowerment of women". [Paper presented at the] *High-level Intergovernmental Meeting to Review Regional Implementation of the Beijing Platform for Action, Bangkok, 26-29 October 1999*. 66p.

<sup>5</sup> **.** 2000. *NGO Alternative Global Report to the United Nations General Assembly Special Session 5 Years After Beijing June 5-9, 2000*. [s.l.]: [s.n.]. 84p.

<sup>6</sup> **WEDO.** 1999. *Risks, Rights and Reforms: A 50 Country Survey Assessing Government Actions Five Years after the International Conference on Population and Development*. New York: WEDO.

<sup>7</sup> **Corréa, Sonia.** 2001. *Weighing Up Cairo: Evidence from Women in the South*. Fiji: DAWN.

# CHAPTER 1

## WOMEN'S HEALTH AND RIGHTS

*"Women have the right to the enjoyment of the highest attainable standard of physical and mental health" – Beijing Platform For Action [C.89]*

### WOMEN'S RIGHTS TO HEALTH

The Beijing PFA strongly articulates the right of all women to enjoy the highest standard of physical and mental health and the necessity of attaining this right to ensure women's well-being and full participation in life (see Text Box 1.1). The PFA links the belief in this right and the understanding of its effect on women's advancement and happiness, to the level of government commitment to seriously work towards achieving a high status of health for women. The government's commitment to this goal must be clearly expressed in relevant national policies, plans and legislation on women and health and agreements to conventions and treaties such as the Convention on the Elimination of All Forms of Discrimination Against Women (1979) and the Convention on the Rights of the Child (1989).

A key finding of this study was that a belief in and commitment to women's right to a high level of health has not been expressed by Southeast Asian governments (with the exception of the Philippines) in their national health policies, women's health policies, population policies or relevant National Action Plans on women's development after the Beijing Conference. Indonesia, however, reported that the right to a high standard of health for both women and men had been stated prior to Beijing in national laws and policies such as the 1992 Indonesian law on health.

The Philippines is the only country in which the government has clearly expressed a policy commitment to women's rights to health based on an overarching framework of women's human rights in the Philippine Plan for Gender Responsive Development (1995–2025) developed after the Beijing Conference. Before the Beijing Conference, governments of all the countries ratified the Convention on the Elimination of All Forms of Discrimination Against Women (better known as the Women's Convention). However, at the end of the year 2000, countries such as Indonesia, Malaysia, Thailand and Vietnam still had reservations on some articles.<sup>1</sup>

#### **Text Box 1.1: Main Recommendations from the Beijing Platform For Action:**

*Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation, ...as well as policies, where necessary, to reflect a commitment to women's health... [C.106 (b)]*

*Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life... [C.89]*

*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology... [C.89]*

### CONCEPT OF HEALTH AS TOTAL WELL-BEING

The broad concept of health advocated by the Beijing PFA as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [C.89] was reportedly not included in national policies on health or National Action Plans on women after Beijing, with the exception of the Philippines. The concept of health, ironically, remains a narrow one focusing on mortality or death rather than well-being. This is

reflected in the indicators that continue to be used by governments in the Beijing+5 review to assess women's health status such as life expectancy and maternal mortality. It shows that a broad concept of health has not yet been adopted or operationalised as advocated by the Beijing PFA. New indicators have not yet been developed by governments to measure well-being. Similarly, data on the level of women's well-being measured by the extent of their overall satisfaction and happiness with their lives is unavailable in Southeast Asian countries. Such information could have been derived directly from quantitative and qualitative researches in which such questions are posed to women. However, no innovative women-centred research based on women's own experiences of well-being was reported in any of the countries studied.

Indirectly, data on the extent of mental illness and suicide for women and men would have indicated the level of women's psychological problems and unhappiness. But even in this more traditional area, it was found that there were no up-to-date prevalence data and trends on mental illness. Moreover, even if the national data on suicide and mental illness of most of the countries were available, they were often not sex-disaggregated. Small-scale studies in Thailand after 1995 however, have shown that women have a higher rate of attempted suicide although men tend to be more successful in their attempts.

Government health services in all countries were reported to have not yet provided psychological and mental health services for women (and men) at all levels including the state, province and village. Without the availability of such health care, it would be very difficult to assess the extent of mental health problems and to meet women's need for such services. The extent of domestic violence is another indirect indicator of women's mental and social well-being as spousal abuse, which tends to be a regular occurrence, causes a woman to be generally unhappy with a number of aspects of her life and experience a higher rate of psychological problems and mental illness. It was reported that rates of domestic violence continue to be high in Southeast Asia, between 16 and 59 per cent. In Cambodia and Lao PDR, which are still recovering from the aftermath of long periods of war in the 1970s and 1980s, women's physical and mental health status is particularly low and the incidence of war-related mental health problems and the stress of the many women-headed households are reported to be high, particularly in the absence of the provision of any mental health services.

## **PROVISION OF AVAILABLE, ACCESSIBLE, AFFORDABLE AND HIGH QUALITY SERVICES**

A strategic objective of the Beijing PFA is to "provide more available, accessible, and affordable high quality primary health services". Structural adjustment, decreased public health spending, deteriorating public health systems and privatisation of health care systems are mentioned in the PFA as related problems [C.91]. No specific recommendations for action to address these problems, however, were included in the PFA.

Malaysia and Thailand reported that the objectives of accessibility and affordability of health services had been included in National Action Plans on Women after Beijing. This shows recognition of the problems and the intent to address them at policy level.

### **AVAILABILITY**

Overall, the seven countries did not report an increase in the availability, accessibility and affordability of primary health services after the Beijing Conference. The main reasons given were continued inadequate government resource allocation, compounded by the financial crisis in 1997 that adversely affected government health budgets and consumers' ability to pay for services and medication, particularly in Indonesia and Thailand. This was a serious constraint to further expansion and improvement of services in terms of making new facilities and services available and extending their coverage and quality to reach more people more effectively.

Only in Malaysia and Thailand was it reported that government primary health care services were available to almost all of the population throughout the country. Availability of health facilities and services was reported to be low in Lao PDR, where only two-thirds of the population were covered by existing health services. For 49 per cent of the rural population, it takes up to two or three days to walk to the nearest district primary health care centre. In Indonesia, emergency obstetric care as part of primary health services was

only available at the province level but did not extend to the district and village levels. For Vietnam, the availability of health services in communes or villages was not as wide-reaching as it had been before the economic reforms of the 1980s. Seven per cent of the communes were reported to have no health services at all. Cambodia was reported to have an insufficient number of health care providers due to genocide during the 1970s. Lao PDR had similar problems, with few qualified nurses and midwives.

## **ACCESSIBILITY**

Researchers found it difficult to monitor the accessibility of health services to women as indicated by the extent of actual utilisation of services. This was because health statistics were not disaggregated according to the necessary dimensions outlined in the Beijing PFA. The PFA recommended increased health service accessibility to women of various ages throughout the life cycle, to women of different ethnic groups and income levels, and to disabled, migrant and other disadvantaged women. A common finding however among the countries, was that health services for women continue to be utilised mainly by married women of reproductive age. Reproductive cancer screening for younger, unmarried or older women is still inaccessible although the service is widely available in countries such as Malaysia, Indonesia, the Philippines and Thailand. Similarly, contraceptive information and services are accessible through government services only to married women because of restrictive programme policies, despite research-backed reports of increasing trends of sexual activity among unmarried young people. Thailand reported women's preference to not use government health services located near their homes, but to go to more distant ones, which suggested possible problems of access due to quality of care, including the lack of cultural sensitivity towards women's needs and privacy.

Data on trends in differentials in the use of public and private health services, were not obtainable in all of the countries. In Malaysia, childbirth records indicate that in 1997, about three-quarters of women used government services. The Indonesian report on the other hand, states that since privatisation of health services, only 14 per cent of the poor use primary health centres and two per cent go to government hospitals compared to private hospitals. There are no reports of studies on women's perception of the qualitative differences between public and private health care and women's experiences and needs in relation to accessibility and affordability of services.

## **ACCESS TO SAFE WATER AND SANITATION**

Access to safe water and sanitation is very important for women's overall health status. Many problems were reported in the provision of safe water facilities. In Lao PDR, only 51 per cent of the population had access to safe water; in Indonesia, the figure was 69 per cent; and in the Philippines, it was 65 per cent overall, but only 46 per cent had access in rural areas, similar to Vietnam (1996). Malaysia, with 89 per cent of the population covered by national water supply services, reportedly had the highest coverage. The quality and safety of water, however, was difficult to assess. In Indonesia, Malaysia and the Philippines, urban water supply is often of poor quality and implementation and monitoring of water standards and environment legislation needs improvement. No national data exist on accessibility of safe water specifically for women and it is assumed incorrectly that this is a gender-neutral area. The impact on women's health however, does require analysis.

## **AFFORDABILITY**

Client user fees introduced in government health services as part of the continuing trend of privatisation of health services due to health sector reform, were reported to have increased the cost of health services in Vietnam, Indonesia and Malaysia, thus reducing the affordability of health services in the post-Beijing period. This included the cost of childbirth services and medication in Indonesia. Also linked to the financial crisis, the costs of contraceptives spiralled in Indonesia in 1997, compromising women's ability to afford them. Overall trends to privatise and reform health services in Southeast Asia were not influenced by the Beijing PFA's objective of increasing affordability of services. Health services thus generally became less affordable for women.

## HEALTH EXPENDITURE

The Beijing PFA recommended that governments increase their resources for women's health, particularly the budgetary allocation for primary health care. Country reports provided whatever information they could in this area, but what was usually available was outdated, thus making an analysis of trends impossible. For 1995 and 1996, Lao PDR, Malaysia, Indonesia, the Philippines and Vietnam reported that allocation to the health sector was between one to five per cent, with Malaysia having the highest allocation and small increases, and Vietnam the lowest. Data on trends of increase or decrease in government health expenditure and the specific expenditure on family planning and health services for women were generally not obtained or reported on. Governments were allocating less than the minimum requirement of five per cent of their gross national product recommended by the World Health Organisation long before the Beijing Conference.

## THE FINANCIAL CRISIS

All governments had reported in the ARROW-APDC Southeast-Asian Regional GO-NGO Policy Dialogue in 1998 that the financial crisis in the region that had begun in 1997 adversely affected health spending, including spending on women's health services. In Indonesia, the innovative 1996 programme aimed at reducing maternal mortality, the Mother-Friendly Movement (also called *Gerakan Sayang Ibu*) could not be implemented due to lack of funds. In Malaysia, the health budget was reduced in 1997 by 12 per cent together with across the board cuts for all government ministries. In 1998 fortunately, funding to the Family Health budget, which includes women's health, was restored due to the successful lobbying of senior women's health government officials.

## MAIN OBSTACLES

The main obstacles identified in the country reports and the ARROW-APDC Policy Dialogue in relation to women's health and rights were:

- Lack of conceptual and operational clarity on the women's health rights approach and the broad Beijing concept of women's health and well-being, which includes a gender perspective;
- Insufficient government political will and commitment to fulfil women's right to a high standard of health and ensure that health services are available, accessible and affordable;
- Inadequate data and information available on health services, privatisation and health expenditure trends and the impact of health sector reform on women's health and lives; and
- Lack of time allocated to planning new approaches to women and health, improving women's health services and planning the financial resources required.

## RECOMMENDATIONS

### RIGHTS

- Governments need to develop and promote a rights-based approach to women's health with a broad understanding of women's health goals and health determinants including gender, in collaboration and consultation with women NGOs and women themselves.
- UN agencies and funders need to increase technical and funding support for planning and information materials for training on promotion of the rights-based approach in health services and curriculum.
- a Governments need to develop, agree on and use national indicators to measure and monitor women's physical, mental and social well-being, which go beyond the usual life expectancy and maternal mortality indicators.
- UN agencies and NGOs need to utilise the Convention on the Elimination of All Forms of Discrimination Against Women for monitoring and advocacy, in particular, general resolution number 24 which clearly articulates the agreement and requirement of States

to promote and protect women's rights to health care.

- ❑ Governments need to collaborate with women NGOs to develop and use agreed upon indicators to measure progress in the implementation of the rights-based approach to women's health.

### **FINANCE/RESOURCES/AFFORDABILITY**

- ❑ Governments need to increase annual national health budgets in order to enable better availability and quality of primary health services, particularly childbirth services, reproductive cancer screening and treatment, HIV/AIDS screening and treatment, mental health services and VAW services.
- ❑ Governments need to annually publicise any reports on women's health status and monitor trends in government health expenditure in terms of key indicators such as the overall budget and expenditure, spending on different aspects of women's health, and the percentage of the gross national product spent on health.
- ❑ NGOs need to closely monitor, evaluate and report on trends in health sector reform and the impact on the use, affordability, accessibility, quality and satisfaction with health care services, particularly for women who are the most frequent users.
- 3 Governments need to monitor and report on changes in the existence or availability of basic primary health care facilities and services for women of all ages and with diverse needs, including in the areas of maternal health, mental health, violence against women, nutrition, reproductive cancers, gynaecological problems and HIV/AIDS.
- ❑ Governments need to reduce the trend of privatisation of health care services and instead, increase the funding of public health care as a critical step towards ensuring the fulfilment of women's rights to high quality health care and status.

### **AVAILABLE AND ACCESSIBLE HEALTH SERVICES**

- ❑ Governments need to include in their National Action Plans on Women and in National Health Policies and Plans, objectives and targets for increasing the availability and accessibility of specific health services needed by women.
- ❑ Governments and NGOs need to monitor and report on the progress in increasing availability and accessibility of health services for women, especially for those who have problems of access, such as younger women, older women, unmarried women, migrant women workers, disabled women and indigenous women.

#### **REFERENCE:**

<sup>1</sup> **Division for the Advancement of Women.** "States Parties to CEDAW". New York: United Nations Division for the Advancement of Women. <<http://www.un.org/womenwatch/daw/cedaw/states.htm>>.

## CHAPTER 2

# SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

*"The human rights of women include their right 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"- Beijing Platform for Action [C.96]*

Sexual and reproductive health and reproductive rights as affirmed both by the International Conference on Population and Development (ICPD) in 1994 and the Beijing Conference, were grounded in and defined by the belief in the equality of men and women; the right to universal access to affordable, high quality health care services; and women's ability to control their own fertility, which is central to their empowerment and their attainment of other rights. The Beijing Conference took the rights-based approach further than the ICPD by advocating for the concept of sexual rights as an integral part of human rights and therefore, women's rights.

The Beijing Conference also reaffirmed women's sexual and reproductive health rights throughout the life cycle, and not just to be considered in the context of their reproductive roles and functions alone. The Beijing Platform for Action (PFA) stressed that women should have access to health care information and services that are appropriate, accessible, affordable and of high quality. The Beijing Conference also recognised that economic and social factors are a hindrance to women's access to health care services and overall health and well-being.

The Southeast Asian country reports showed that although there were some improvements in addressing women's reproductive health concerns, there were still many aspects of women's reproductive health needs that had not been sufficiently addressed. These included the understanding and operationalising of the concept of reproductive and sexual rights, reproductive cancer screening and treatment, treatment of STDs and RTIs, the unmet need for family planning and availability of safe methods of modern contraceptives and the problems, unsafe abortions and mortality associated with pregnancy and childbirth.

## NATIONAL POLICIES AND PROGRAMMES ON REPRODUCTIVE HEALTH

Since the Beijing Conference, countries like Thailand and the Philippines have designed policies and programmes that incorporated much of the broader areas of reproductive health. Cambodia and Lao PDR reported having integrated some reproductive health concerns into policies and programmes, although the concentration remained in maternal and child health. For example, in Cambodia, although the government was reported to now have a policy statement on reproductive health, these policy directives referred to the right to enjoyment of the highest attainable standard of physical and mental health; accessibility to health care services which include birth spacing and sexuality; provision of the widest

### **Text Box 2.1: Main Recommendations from the Beijing Platform For Action:**

*Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes... [C.94]*

*...reproductive rights...rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health... [C.95]*

*Strengthen and re-orient health services, particularly primary health care, in order to ensure universal access to quality health services for women and girls; reduce ill-health and maternal morbidity... [C.106 (i)]*

range of services without coercion; high priority to safe motherhood and reduction of maternal and prenatal morbidity and mortality; and improvement of maternity care services including birth spacing and nutrition at all levels of health care delivery. Similarly in Lao PDR, although there was no comprehensive reproductive health policy, the government initiated a reproductive health sub-programme in 1997 with the aim of strengthening reproductive health services as well as promoting reproductive health among adolescents and young adults by including sexuality education in the formal and non-formal education system. Lao PDR does however, have policies on maternal and child health, particularly on safe motherhood (1997) and birth spacing (1995). Indonesia too reported to have focused on safe motherhood. As a follow-up to the Beijing Conference, it launched the "Mother-Friendly Movement" (*Gerakan Sayang Ibu*) in 1996 to reduce maternal mortality rates and enhance the quality of women's lives through community involvement in women's health programmes. As a result of the 1997 financial crisis, the Indonesian Government had insufficient funds to continue implementing this innovative programme.

For countries such as Thailand and the Philippines, operationalising the concept of reproductive health was reported to be a challenge. Nevertheless, these countries made gains in ensuring that reproductive health received priority attention at policy level. For example, Thailand's national reproductive health policy of 1996 included ten areas of reproductive health concerns, such as family planning, maternal and child health, HIV/AIDS, reproductive tract infections, sex education, adolescent reproductive health, abortion and its related complications, infertility, reproductive cancers and post-reproductive care.<sup>1</sup> These reproductive health concerns did not only involve women but also men. Similarly in the Philippines, in response to the recommendations of the Cairo and Beijing Conferences, the Philippine Plan for Gender-Responsive Development (1995–2025) which was formulated and implemented by the National Commission on the Role of Filipino Women (NCRFW), also gave priority attention to women's reproductive health as well as the recognition that reproductive rights was fundamental to achieving reproductive health.<sup>2</sup> In Vietnam, activities to promote reproductive health were introduced together with its population and family planning policies after ICPD. Vietnam considered maternal and child health and family planning as important components of reproductive health. At the same time, the government also focused on other aspects of reproductive health, especially adolescent reproductive health concerns, older people's health, abortion, reproductive tract infections (RTIs)/sexually transmitted diseases (STDs) and HIV/AIDS.<sup>3</sup> Malaysia, on the other hand, reported that it had moved towards a broader concept of reproductive health long before the ICPD Programme of Action."

## **OPERATIONALISING SEXUAL AND REPRODUCTIVE RIGHTS**

The reproductive health concept includes the right of women to make their own choices on reproduction and sexuality and the right to the provision of high quality services based on women's experiences and needs. Such rights recognise women as the primary decision-makers over issues concerning their bodies. Both the Cairo and Beijing documents place great importance on enabling women to exercise these rights. However, operationalising strategies to achieve these rights were reportedly very weak and problematic for most of the Southeast Asian countries. In Malaysia and Indonesia for example, the debate surrounding reproductive rights has been contentious, especially pertaining to contraceptive services for unmarried women and adolescents, and the definition of "family" and gender equality within the family. Cultural, religious and patriarchal values were reported to be underlying the difficult issues in the rights debate. For other countries, there had been no reference to reproductive rights made in health policies and programmes of Cambodia, Lao PDR and Thailand. The Vietnamese Law on Protection of People's Health (1989) included two articles on reproductive rights. Only the Philippines was reported to have included the concept of reproductive rights in its health, population and family planning policies and programmes after the Cairo and Beijing Conferences. Even then, the Philippines Department of Health was mentioned to have problems in operationalising this concept into concrete programme activities.

## SEXUALITY

The Beijing PFA recognises sexual rights as part of human rights, which includes the right to decide freely and responsibly on all matters relating to sexuality (including sexual and reproductive health) free of coercion, discrimination and violence. The concept also includes the equal relationship between women and men in matters of sexuality and reproduction, including full respect for the integrity of the person, and mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

In terms of data, there were none available for all countries on indicators of sexuality such as women experiencing sexual pleasure with a partner or through masturbation; and on the extent of women experiencing sexual coercion or abuse from male family members, husbands or boyfriends. The Philippines, however, carried out a "Young Adult Fertility and Sexuality II Study" on young people's sexual practices, and had found that a significant number of young Filipinos engage in pre-marital sex at the average age of 18 years. Furthermore, a Care International study in Vietnam in 1997 found that 71 per cent of men and 32 per cent of women surveyed thought that Vietnamese men and women were having sexual relations before marriage. In 1999, the Malaysian Ministry of Health reported that a programme called Health Promoting School, which included concepts of sexuality (although sexuality would not be openly discussed) and reproductive health for school children, was being piloted in some schools. As far as homosexuality was concerned, none of the countries reported that there was any law legalising homosexuality.

Most countries reported that the concept of sexuality remained a taboo subject, more so when it concerned adolescents' or young women's sexual rights, especially with information and services in relation to sexuality. Once again cultural and religious objections remained significant barriers.

## INDICATORS OF WOMEN'S REPRODUCTIVE HEALTH

### MATERNAL MORTALITY

The goal of the Beijing Conference was to reduce maternal mortality by 50 per cent from the 1990 levels by the year 2000. From Table 2.1, which gives revised estimates of maternal mortality, it could be inferred that little progress has been made to achieve this goal. The maternal mortality ratio (MMR) recorded showed relatively high figures for all countries, except for Malaysia. However, it was difficult to ascertain whether there has been a reduction in the MMR for these countries as some like Cambodia and Thailand showed no change in the MMR between the 1990 and the 1990-97 figures, although official national figures stated a much lower MMR than those reported in the table. For example, Cambodia's National Maternal and Child Health Statistics Report of 1994 gave Cambodia's maternal mortality rate as 500 per 100,000 live births, while Thailand's Ministry of Public Health

reported the MMR to be 23 per 100,000 live births in 1995. Although, such inconsistencies in the maternal mortality estimates highlighted the serious question of reliability and validity of the MMR data; the MMR is still an important indicator as it shows that high birth rates and poor access to and availability of health services, including family planning, was contributing to the high levels of maternal mortality. For example, in Cambodia, it was reported that an average of 2,000 mothers died annually from pregnancy complications while in Lao PDR, approximately one-third of all deaths of women were related to pregnancy (including induced abortion) or childbirth.

There was still a problem in identifying causes of maternal mortality for countries such as Cambodia, Lao PDR and Indonesia due to the high number of unsafe home deliveries that took place without trained midwives and the absence of

**Table 2.1: Maternal Mortality Ratio (per 100,000 live births)**

	1990 <sup>a</sup>	1990-97 <sup>b</sup>
Cambodia	900	900
Indonesia	650	390
Lao PDR	650	660
Malaysia	80	34
Philippines	280	210
Thailand	200	200
Vietnam	160	105

Data Sources

<sup>a</sup> WHO and UNICEF. 1996. *Revised 1990 Estimates of Maternal Mortality A New Approach* Geneva WHO.

<sup>b</sup> World Bank. 1999. *World Development Indicators 1999*. Washington, D.C. World Bank pp.98-101.

policies on carrying out systematic maternal and prenatal audits. In Cambodia, for example, 85 per cent of deliveries took place at home. Around 50 per cent of these were assisted by traditional birth attendants. Similarly, in Lao PDR, 91 per cent of all deliveries took place at home while 80 per cent of pregnancy-related maternal deaths also occurred at home, most of them without access to equipped hospitals. In Indonesia, it was reported that the number of women giving birth at home, attended by traditional birth attendants, increased after the Beijing Conference. The Philippines also reported that two-thirds of deliveries occurred at home with traditional birth attendants assisting approximately 41 per cent of the births.

On the other hand, Malaysia in 1997 reported that 96.1 per cent of births were attended by trained health personnel, which was a critical factor in lowering the MMR. Furthermore, the Malaysian Ministry of Health has continued to strengthen its system of confidential enquiry into maternal deaths and to further improve the quality of maternal and child health. The Ministry reported implementing quality assurance programmes, risk approach strategies and safe motherhood initiatives. Improving access to adequate health care services, including safe and effective family planning methods and emergency obstetrics, continue to be a major problem for those countries with a high MMR. Thailand also reported that in 1996, 95 per cent of the women who gave birth, delivered with the help of trained birth attendants, while only two per cent used traditional birth attendants. Furthermore, in countries like Cambodia and Lao PDR, the rural areas had health care services that were not only limited but also provided poor quality facilities and medical supplies.

**Measuring MMR:** Although the Beijing PFA identified broad determinants that affected women's overall health and well-being, some countries continued to rely on maternal mortality and life expectancy data as the main indicators to gauge women's health status. In most instances, maternal mortality indicators do not reflect the true status of women's health as there is still the question of the reliability and validity of the maternal mortality data available. In some countries, there was no complete and reliable system to monitor maternal deaths and often, poor people, especially those in rural and remote areas, had no way of reporting such deaths.

## ANAEMIA

Although the Beijing PFA had the objective of reducing iron-deficiency anaemia in girls and women by one-third of the 1990 levels by the year 2000; it was not possible to assess the achievement of this due to the unavailability of up-to-date data. Most countries indicated that there was little reduction in the prevalence of anaemia among pregnant women. Pre-Beijing anaemia levels were very high. For example, in Indonesia in 1992, 50 per cent of pregnant women suffered from anaemia while in the Philippines in 1993, 24 per cent of non-pregnant or lactating women between the ages of 20 and 59 years were anaemic. Similarly, in Lao PDR, 27.6 per cent of pregnant women between the ages of 15 to 49 were anaemic in 1997. In Thailand, WHO reported that the rate of anaemia among both pregnant and non-pregnant women halved over the last decade. The country report however states that the anaemia level of young girls is not known although a prevention strategy needs to be developed. Some actions were reported to have been taken to address this problem. For example, the Lao PDR Government developed a National Plan of Action for Nutrition (1998–2000), while the National Nutrition Council, formulated the Philippine Plan of Action for Nutrition in 1995, and launched a comprehensive nationwide nutrition programme and multi-sectoral nutrition status monitoring and intervention programme consisting of a standard nutrition supplement for women.

## BREASTFEEDING

The benefits of breastfeeding had long been known especially in relation to infant and child well-being and survival, and women's health. The Beijing PFA recognises the importance of breastfeeding and recommended the implementation of the WHO/UNICEF International Code of Marketing of Breastmilk Substitutes and called for legal, economic, practical and emotional support to enable women to breastfeed their infants. Some country reports did not indicate the number of women known to practise breastfeeding, except for Lao PDR,

Indonesia, Philippines and Vietnam, while some countries were reported to have implemented the WHO/UNICEF Code. In Lao PDR, for example, approximately 96 per cent of babies under two years of age were breastfed, while the Indonesian Demographic Health Survey of 1992 reported that 97 per cent of all children were breastfed. Similarly in Vietnam, according to the Human Development Report of 1997, 88 per cent of mothers breastfed their babies, and in the Philippines, the figure was 88 per cent as well. In Malaysia, however, only 29 per cent of babies were exclusively breastfed over a period of four months.<sup>5</sup>

Data on the number of breastfeeding working mothers was not reported but it is essential for monitoring the implementation of the International Code. The Philippines was reported to be one of the first countries to enact the International Code of Marketing of Breastmilk Substitutes. Prior to the Beijing Conference, the Philippines had passed the "Roaming-in and Breastfeeding Act" in 1992. This Code mandates all government hospitals to convert their obstetrical units into mother-friendly and baby-friendly areas. Malaysia too reported having 115 of its government hospitals accredited by WHO as baby-friendly in 1998.<sup>6</sup> The Lao PDR Government adopted the Code in 1995, while the Indonesian Government was reported to have prohibited the marketing of infant formula. However, despite this regulation, it was reported that infant formula continued to be promoted widely all over the country.

## CONTRACEPTION

**Table 2.2: Contraceptive Prevalence Rates**

<b>Country</b>	<b>(%)</b>
<i>Cambodia</i>	..
<i>Indonesia</i>	55 (1994)
<i>Lao PDR</i>	19 (1993)
<i>Malaysia</i>	48 (1988)
<i>Philippines</i>	40 (1990)
<i>Thailand</i>	74 (1993)
<i>Vietnam</i>	65 (1994)

*Data Source:*

**United Nations.** 1998. *World Contraceptive Use 1998 Chart*. New York: UN.

Beijing recognised the right of women and men to information and to safe, effective, affordable and acceptable methods of family planning and services of their choice. Although contraceptive prevalence rates (CPR) were an important indicator of women's accessibility to family planning methods and services, nearly all country reports were unable to give the most up-to-date information on contraceptive use. Moreover, the figures provided by UN agencies were also outdated (see Table 2.2). A large unmet need for contraceptives was reported especially for countries like Cambodia and Lao PDR. For example, in Cambodia, it was reported that less than one per cent of women used contraceptives or birth spacing methods. In Malaysia, the prevalence of contraceptive use was moderate; the

last estimated rate was in 1994 where the CPR was 54.5 per cent, of which 24.6 per cent used traditional methods. A Family Planning Survey (1997) carried out in the Philippines revealed that only 47 per cent of currently married women aged 15 to 49 years reported using some form of contraception. In Thailand, however, an evaluation of the Family Health Project in 1995 found that the CPR was 75.1 per cent although condom use was the lowest recorded, at only 1.8 per cent.

Regarding the availability of contraceptive services, most countries except Cambodia and Lao PDR reported that contraceptive services were available through government and family planning associations, although not necessarily widely accessible due to cultural, religious and political factors. In most instances, such services were only available for married women and excluded adolescents and single women. In some cases, they were also unavailable for rural women. Most countries, however, did report progressive policies in line with contraceptive use and availability, including Cambodia and Lao PDR. For example, it was reported that Cambodia had a Birth Spacing Policy, introduced in 1995 and partly attributed to the influence of ICPD, which stated that wide access of contraceptive methods were to be made available for women regardless of age, marital, ethnic or religious background. However, it was reported that Cambodian women were not accessing contraceptive services either due to ignorance of the methods or the price of contraceptives, which were too expensive for most women.

Lao PDR had progressive policies on contraceptives whereby they were to be provided for free. However, the policies also targeted only married women. In Indonesia, it was

reported that the 1997 financial crisis impacted heavily on the implementation of the family planning programmes and services. Budget cuts had affected the range of contraceptive methods available, staff training and efforts to improve the quality of family planning programmes.' Meanwhile in Thailand, although the Thai National Health Plan aimed to encourage men to practise more contraception, it was reported that only women appeared to take responsibility in practising contraception as indicated by the low use of condoms despite the campaigns.

## INFORMED CHOICE

A number of countries had reproductive health policy statements with the goal of access to safe, effective and affordable contraceptive methods. It was not reported however, if such access was expressed as a right together with the right of informed choice in these policy statements. Indonesia and Thailand reported that the concept of informed choice had not been operationalised. An indicator related to this is the use of different contraceptive methods, which varied widely in all the countries. For example, the injection Norplant was the second highest contraceptive method used in Thailand and the highest in Lao PDR, whereas in Vietnam, the intra-uterine device (IUD) was the predominant method used by almost half the women. The availability of emergency contraceptive methods was not reported in all the countries. It would appear that factors of cost, donor supplies and provider convenience and preference influenced this diverse contraceptive use rather than women's own informed decisions. Women NGOs' research on women's reproductive rights in Indonesia, Malaysia and the Philippines, after the Beijing Conference, showed that women's decision-making on contraceptive use was an important area which needed to be addressed by programme interventions (IRRRAG, 1998).

Usage of male contraceptive methods was low in all the countries. Even condom use in Thailand was low despite the high prevalence of HIV/AIDS there. Male sterilisation was reportedly unavailable as a method in Lao PDR. No country reported effective interventions to reach more men despite related policy statements in some countries such as Cambodia and Thailand which expressed this as a goal.

## ABORTION

The Beijing Conference reaffirmed the commitment made at the ICPD which recognised unsafe abortion as a major public health issue and recommended the recourse to abortion be reduced through expanded and improved family planning services; as well as stressing that where abortion was not against the law, such abortion should be safe. Importantly, the Beijing Conference called for the review of laws that contained punitive measures against women who had undergone illegal abortion.

National up-to-date data on the prevalence of safe and unsafe abortion was found to be unavailable for all the countries. Those country reports that did provide data gave those that were prior to the Beijing Conference. For example, in Indonesia it was reported that an estimate of 750,000 to a million abortions took place in 1991, while Thailand estimated 200,000 to 300,000 cases of abortion per year. Similarly in Vietnam, the annual average number of abortions according to UNICEF was reported to be between one to 1.2 million abortions a year. In 1997, a small-scale survey of 457 married women in selected areas of Lao PDR showed that one-tenth of pregnancies were aborted and one-fourth of women had experienced abortions at some time. It has been reported that abortion had become more or less a form of birth spacing in Lao PDR due to the lack of contraceptive services outreach. With the unavailability of up-to date abortion data, it was difficult to state if unsafe abortions had decreased since the Beijing Conference as an outcome of more access to safe and effective family planning methods or through the availability of extended health care services.

In relation to national abortion laws, only Cambodia had reviewed its abortion law, which was broadened in 1997 to legalise abortion without any restriction. Access to legal abortion in Cambodia however was reported to be low due to the high cost of abortion services. Deaths due to unsafe abortion thus were continuing. In Vietnam, where the law also allows for abortion without any restrictions, it was reported by the National Committee for the Advancement of Women in Vietnam (NCFAW) that there is a declining trend in the number of women suffering from infection and haemorrhage, with only 0.4 per cent known

to have such problems in 1999. No changes had been made after the Beijing Conference to review abortion laws. In countries where abortion was legal only under certain conditions (e.g. when a pregnancy is life-threatening), there are no allowances made for abortion in cases of rape or incest, as in the case of Lao PDR and Indonesia. Malaysia, instead, was more liberal, permitting abortion to save a woman's life and for physical or mental health reasons.<sup>8</sup> Philippines was the only country that prohibited abortion altogether. Thailand, which allows abortion to save a woman's life or for physical health reasons, was the only country that explicitly mentioned the legality of abortion for pregnancies caused by rape.

## **REPRODUCTIVE CANCERS**

The Beijing PFA highly recommended the establishment and strengthening of programmes and services to address the early detection, prevention and treatment of reproductive cancers. In order to assess this Beijing goal, it is imperative in the short term to determine what actions have been taken, and in the long term, monitor trends in the mortality and morbidity of reproductive cancers.

Many country reports mentioned the unavailability of data on mortality and morbidity of reproductive cancers such as breast, uterus, ovarian and cervical cancers; except for countries like Malaysia, the Philippines and Thailand, where the prevalence rates of reproductive cancers were available through sources such as medically certified data. For instance, in Malaysia, 297 women died from breast cancer alone in 1997<sup>9</sup>, while Thailand reported 446 deaths in 1994.<sup>10</sup> Furthermore, Thailand's incidence of cervical cancer was 23.4 per 100,000 women which is reported to be the tenth highest in the world. It was believed that the incidence and mortality rates for reproductive cancers were likely to be much higher than those reported in medically certified deaths.

The absence of a formal reproductive cancer screening policy and programme in a number of countries (e.g. Cambodia, Lao PDR and Indonesia) as well as a national cancer screening registry added to the problems of acquiring valid and accurate mortality and morbidity data. Nevertheless, cancer-screening services such as pap smear screening services for cervical cancers was carried out in countries like Malaysia, the Philippines and Thailand but nearly all countries reported having encountered similar problems in that women were not having regular pap smear tests done despite the availability of information and services. Thailand was the only country that reported an estimate of 30.8 per cent of women having had a pap smear in 1995. In Malaysia, where extensive health care facilities exist and reproductive cancer screening campaigns had been stepped up since (but not because of) the Beijing Conference, the majority of women were reported to only seek medical help at advanced stages of both breast and cervical cancers. Research studies show that cultural insensitivity, inadequate information and education, unsuitability of the gender of service providers and lack of understanding on preventive health care were some of the barriers to Asian women reporting or accessing health care services for screening and treatment of reproductive cancers." Moreover, the lack of affordability of such services also hinder women from seeking help for reproductive cancers as in the case of Indonesia. Researchers were unable to provide up-to-date information on reproductive cancer treatment facilities and services nationally. Lao PDR reported that radiotherapy for any kind of cancer is not available. In Vietnam, services exist only at central and provincial levels. It appears as though decentralised treatment services at state or provincial level do not exist in Southeast Asian countries with the exception of Malaysia.

## **REPRODUCTIVE TRACT INFECTIONS**

Although estimated to be an important health problem for women in some countries such as Cambodia, Lao PDR, Thailand and Vietnam, no national statistics were reported to be available on the incidence and prevalence of RTIs. Only micro studies data were available. In Indonesia, it was reported that health providers discover RTI cases only when women come for antenatal care or when they come to get an IUD. In Northern Thailand, an innovative women-centred research carried out in the Khon Kaen province, found that five types of RTIs were prevalent among rural women, the rate being as high as 24.3 per cent. It also found that cultural insensitivity of health providers was a barrier to women's use of available services. In Malaysia, the Ministry of Health reported that in 1997, the incidence

of RTIs was the highest among those aged 20 to 29 years. In Vietnam, the Centre for Reproductive and Family Health (RaFH) found the incidence of RTIs to be 69 per cent in a 1995 study. Nearly all countries reported that there was more information as well as health care services available on STDs than RTIs, implying that the latter was a neglected area. Both Cambodia and Lao PDR reported that screening for RTIs and STDs had not yet been integrated into reproductive health services.

## HIV/AIDS

The Beijing PFA recognised the devastating effects of HIV/AIDS and other STDs on women's health, and called for the involvement of women, especially those who are infected, in all decision-making related to the development, implementation, monitoring and evaluation of HIV/AIDS and STDs policies and programmes. Beijing also asked for all relevant information and education on HIV/AIDS and STDs as well as appropriate and affordable health care services to be made available to women.

From Table 2.3, it can be seen that in countries like Cambodia and Thailand, the estimated number of women living with HIV/AIDS is very high. Most of the country reports indicated an increasing trend in HIV/AIDS infection among women. For example, in Malaysia, although the HIV infected persons were predominantly male, data from the Ministry of Health revealed that from 1986 to 1998, the number of women infected with HIV had increased. In the 1995 report by the National Commission on the Role of Filipino

Women, 45.6 per cent of Filipino women were reported to either have the AIDS virus or have developed full-blown AIDS. In Cambodia, it was reported that ten per cent of the 30,000 commercial sex workers were infected by the HIV virus. In Lao PDR, it was reported that it was mostly young people between the ages of 20 to 29, of which 44.1 per cent were women, who were getting infected with HIV. There was also an increase in HIV cases among pregnant women over the years; however, the number was very small.

Both Cambodia and Lao PDR reported a huge gap in the delivery of basic health care services let alone health care services for HIV/AIDS, although Lao PDR reported having discussed at government level, a National HIV/AIDS/STD Plan for the years 1997 to 2002. In the Philippines, the National AIDS Prevention and Control Programme established in 1987 carried out continuous monitoring and surveillance, as well as provided health care services, counselling and education. However, this programme targeted men in general, and men and women commercial sex workers. To date, it was reported that there were no programmes or services that targeted women specifically. Thailand reported having a national AIDS policy although it was mentioned that this policy lacked a strategic plan for implementation and as a result, there were no community-based government health programmes to empower women, especially married women. Similarly in Vietnam, the government planned to implement HIV/AIDS prevention and control activities in 1995 which included information, education and communication (IEC) activities on AIDS, safety in blood transfusion and quality of health service and management and provision of care for and counselling of HIV/AIDS carriers; but it was not known whether such activities targeted all women or if it was still being implemented to date. As for Malaysia, it was reported that the Malaysian AIDS Council submitted a draft of the National Strategic Plan for the Prevention and Control of HIV Infection to the government for consideration in September 1998.<sup>12</sup>

Control and prevention of STDs has been recognised as a major strategy in the prevention of HIV/AIDS. Some countries such as Lao PDR, Malaysia, the Philippines and Vietnam were able to give information on STD management, screening and treatment programmes or services. For example, in Lao PDR, a national STD Management Unit was being established and integrated into the National AIDS Programme. Furthermore, a National Policy and Strategy for the Prevention and Care of STD was developed and

**Table 2.3: Estimated Number of Women Living with HIV/AIDS (end of 1997)**

<i>Cambodia</i>	60,000
<i>Indonesia</i>	13,000
<i>Lao PDR</i>	520
<i>Malaysia</i>	13,000
<i>Philippines</i>	7,000
<i>Thailand</i>	290,000
<i>Vietnam</i>	17,000

*Data Source:*  
UNAIDS. 1998. *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Diseases*. June. <<http://www.unaids.org>>.

approved by the government in 1998. As for the Philippines, it was reported that the Philippines National Programme on STD had 130 clinics available for STD treatment and management but most of these were found in urban areas. The promotion of HIV/AIDS policies and programmes were reported to have increased in most countries in light of the growing pandemic.

## RECOMMENDATIONS

In light of the above findings, the following further actions are recommended to ensure the implementation of the Beijing PFA:

- ❑ Governments, NGOs and international agencies need to promote and include the rights-based approach to ensuring accessible, affordable, quality and comprehensive sexual and reproductive health services as a critical aspect of reproductive health policy and programmes for women.
- ❑ Governments and NGOs need to clarify and promote better understanding of and commitment in national policies and plans to a broad reproductive health approach including all the possible reproductive health elements among GO and NGO policy makers and service providers.
- ❑ Governments urgently need to develop and implement concrete national action plans to reduce maternal mortality, including the expansion of accessible emergency obstetric services, affordable hospital childbirth and safe legal abortion services
- ❑ Governments and NGOs need to evaluate family planning programmes to assess to what extent the elements of informed choice; male contraception; and safe, effective and affordable contraceptives are understood and accessible to women in need, particularly poor and marginalised women.
- ❑ Governments and NGOs need to identify the barriers and solutions for the extension of availability of safe, effective and affordable contraceptive methods including emergency contraception in countries where contraceptive prevalence is low to moderate, in order to improve women's choices and ultimately their health and well-being.
- ❑ Governments and NGOs need to design and implement pilot project-type reproductive health services that include the participation and collaboration of adolescents and young people so that their needs and perspectives are incorporated.
- ❑ Governments need to develop reproductive cancer screening policy and programmes as an integrated part of reproductive health; and through women-centred research, identify and address barriers to increasing women's access to such services by providing greater media coverage and health promotion.
- ❑ Governments need to conduct regular studies to obtain reliable data on the incidence and health impacts of abortion, particularly unsafe abortion and increase access to legal and safe abortion services.
- ❑ Governments and NGOs need to promote and include screening and referral services for survivors of domestic violence and rape/coerced sex as a core element of the reproductive health approach in order to reduce negative health outcomes for women such as miscarriage, STDs and HIV/AIDS, and psychological problems.
- a NGOs need to promote and monitor women's right to breastfeed by ensuring data on breastfeeding incidence especially that of working women are available and reported on by governments.
- ❑ Governments need to regularly monitor incidence of anaemia in women, including levels for girls and young women, and develop and strengthen national action plans with targets to reduce anaemia incidence.
- ❑ Governments need to develop a plan of action to monitor HIV/AIDS incidence among women and provide accessible, affordable and gender-sensitive prevention and treatment services to address women's needs in collaboration with HIV-positive women and women NGOs.
- ❑ Governments need to obtain additional resources for broad reproductive health programmes within primary health services that allow expansion of services to other elements besides maternal health and family planning.
- ❑ Governments and NGOs need to advocate to donors the need to raise additional funding to strengthen primary health facilities and ensure an adequate number of well-trained staff.

- Governments need to develop and make available a national data collection system which provides up-to-date data on all elements of reproductive health status and service provision to enable the monitoring of progress in meeting women's comprehensive reproductive health needs.

## REFERENCES:

- <sup>1</sup> **Ngamsiriudom, Borworn .** 1998. "Restructuring maternal and child health services to reproductive health services". [Paper presented at the] *Southeast Asian Regional Policy Dialogue on "Women's Health: Monitoring and Implementation of the Beijing Platform for Action"*, 1-4 June 1998, Kuala Lumpur, Malaysia, organised by ARROW and the Gender and Development (GAD) Programme of APDC.
- <sup>2</sup> **\_\_\_\_\_**. 1995. *Philippine Plan for Gender-Responsive Development 1995-2025*. Philippines: The National Commission on the Role of Filipino Women.
- <sup>3</sup> **Tran Thi Trung Chien.** 1998. "Improvements in reproductive health services-maternal health, abortion and contraception in Vietnam". [Paper presented at the] *Southeast Asian Regional Policy Dialogue on "Women's Health: Monitoring and Implementation of the Beijing Platform for Action"*, 1-4 June 1998, Kuala Lumpur, Malaysia, organised by ARROW and the Gender and Development (GAD) Programme of APDC.
- <sup>4</sup> **Malaysian Steering Committee.** 1998. *Country Report of Malaysia: NGO Perspectives*. Selangor: Federation of Family Planning Associations, Malaysia. p.7.
- <sup>5</sup> **\_\_\_\_\_**. 1998. "Cool response to breastfeeding idea". *New Straits Times*. Thursday, July 23. p.7.
- <sup>6</sup> **Patvinder Singh.** 2000. "Child friendliness of hospitals to be assessed". *New Straits Times*. 26 February.
- <sup>7</sup> **UNFPA & the Australian National University.** 1998. *Southeast Asian Populations in Crisis: Challenges to the Implementation of the ICPD Programme of Action*. New York: UNFPA. p.55.
- <sup>8</sup> **The Centre for Reproductive Law and Policy.** 1999. *The World's Abortion Law 1999*. New York: CRLP. [wall chart]
- <sup>9</sup> **Dulku, Kiren.** 1997 "Accessibility of breast and cervical cancer services in Malaysia". *ARROWs For Change*. Vol. 3 No. 3. p.3. Kuala Lumpur: ARROW.
- <sup>10</sup> **The World Health Organisation Databank.** From the IARC website: <<http://www.iarc.fr>>.
- <sup>11</sup> **Rashidah Abdullah.** 1997. "Reproductive cancers: women's access to screening services". *ARROWs For Change*. Vol. 3 No. 3. p.1. Kuala Lumpur: ARROW.
- <sup>12</sup> **Malaysian AIDS Council.** 1998. *Annual Report 1998*. Kuala Lumpur: Malaysian AIDS Council. p.9.

## CHAPTER 3

# VIOLENCE AGAINST WOMEN

*"Violence against women both violates and impairs or nullifies the enjoyment by women of human rights and fundamental freedoms"- Beijing Platform for Action [D.112]*

Violence against Women (VAW) is known to significantly impact on women's overall health and well-being; and yet, its prevalence is often overlooked as an important indicator of women's health status. Women are subjected to serious physical and psychological injuries from acts of violence such as incest, domestic violence, rape, forced prostitution, sexual abuse, sexual harassment and trafficking of women. It was only in 1996, however, that VAW was acknowledged as a public health concern by the World Health Organisation<sup>1</sup> even though VAW had long been a contributing factor to the mortality and morbidity of women.

The Beijing PFA clearly recognises VAW as both a human rights issue as well as a serious women's health problem. It is one of the twelve critical areas of concern in the Beijing PFA and it is also addressed in other critical areas, including women and health. The PFA recognises that the elimination of VAW is essential to ensuring equality, development and peace. It also calls for integrated measures to eradicate VAW and to provide health care services and shelters for affected women. Furthermore, the Beijing PFA stresses the importance of reviewing legislation to ensure policy commitment to eradicate VAW.

The Southeast Asian country reports showed that VAW was a critical concern for all countries. There were some concrete outcomes reported with regard to legislation, policy and services. However, progress towards achieving the Beijing goals has been slow. Gaps in dealing with VAW issues still existed in relation to research on prevalence of VAW and provision of health care services.

### **Text Box 3.1: Main Recommendations from the Beijing Platform For Action:**

*Integrate mental health services into primary healthcare systems or other appropriate levels, develop supportive programmes and train primary health workers to recognise and care for girls and women of all ages who have experienced domestic violence, sexual abuse or other abuse resulting from armed and non-armed conflict. [C.106 (q)]*

*Adopt and/or implement and periodically review and analyse legislation to ensure its effectiveness in eliminating VAW, emphasizing the prevention of violence and the prosecution of offenders... [D.124 (d)]*

*Promote research, collect data and compile statistics, especially concerning domestic violence related to prevalence of different kinds of VAW, and encourage research into the causes, nature, seriousness and consequences of VAW... [D.129(a)]*

## NATIONAL PLANS ON VAW

Since the Beijing Conference, there were some efforts by governments to address VAW issues in National Plans of Action on women. For example, in the Philippines, VAW has been addressed extensively and a chapter was dedicated to it in the Philippine Government's action plan to implement the Beijing PFA, the Philippine Plan for Gender-Responsive Development (1995–2025). Conversely, the Malaysian Government did attempt to address VAW issues in its Action Plan for Women in Development formulated in 1997 as a follow-up to its National Policy on Women (1989). However, VAW did not merit a chapter of its own. Instead it was discussed under the "Women and Family" chapter, which unfortunately, limited VAW to the family context. Both Thailand and Vietnam too had made efforts to include concerns on VAW in their national plan of actions but the recommendations proposed were general in nature. For example, Thailand's Women and Development Plan (1999–2001) addressed VAW in the context of strengthening family and community ties<sup>2</sup>, whereas the Vietnam National Plan of Action (1997) addressed VAW in the context of

protecting the rights and interests of the girl-child.' For the other countries, there was no report of any efforts to include VAW concerns in the National Plans of Action on women.

## PREVALENCE OF VAW

Although, Beijing strongly emphasised the need to document the prevalence of violence through research and statistics compilation, all the country reports with the exception of Malaysia, were unable to provide national prevalence data for the different areas of VAW. Even in cases where some country reports (for e.g., the Philippines country report) were able to provide statistical information on certain areas of VAW, such as domestic violence and rape, this information was usually derived only from available police records. In most instances, VAW indicators from this source are under-reported due to the social and cultural stigmatisation associated with violence. This, in turn, underestimates the extent of the problem. In countries such as Indonesia and Thailand, one reported barrier was that the issue of VAW was still viewed as an individual or domestic problem rather than a public health and human rights issue.

**Domestic Violence:** For countries like Thailand, Indonesia and Vietnam, information on the prevalence of domestic violence was only available through small-scale studies. These studies indicated that many women experienced domestic violence at some point in their lives. For example, a 1995 national household survey carried out in Cambodia found that approximately 16 per cent of women were physically abused by their spouses.<sup>4</sup> Similarly, in Thailand, the Friends of Women Foundation, a non-governmental organisation, reported that 59 per cent of married women were battered daily while 11.5 per cent were battered weekly. Malaysia was one of the few countries that was reported to have carried out a nationwide survey on domestic violence even before the Beijing Conference. This 1992 survey found that 39 per cent of women were estimated to have been battered.<sup>5</sup> In the Philippines, according to the Department of Social Welfare and Development, approximately 59.8 per cent of the cases it dealt with from 1991–1997 were that of domestic violence.

**Rape:** Most country reports were not able to provide up-to-date prevalence rates of rape, although, an increase in rape over the years was reported by both Lao PDR and Vietnam. In Lao PDR, for example, where VAW was yet to be considered a major public problem, and hence, no appropriate measures had been taken to deal with it, the incidence of rape had increased from 21 cases in 1996 to 48 cases in 1997. Similarly, in Vietnam, there had been 1,685 rape cases involving 324 children from January 1993 to July 1995. In 1996 alone, there were 847 cases of rape. In Thailand, it was reported that the statistics for the year 1992 indicated that one woman was raped every three hours and by 1995, it was one rape every two hours. In the Philippines, it was reported that children 15 years and below made up 46 per cent of rape victims. Since the statistics reported were usually based on available police records, the information given would be well under-represented. Furthermore, it has been documented that police insensitivity and the associated social stigmatisation are significant barriers to women reporting rape.

**Trafficking of women and children:** The Beijing PFA addressed the increasing trend in trafficking of women and girls within the broader context of VAW as a matter for urgent international concern. Trafficking of women and children was reported as a national concern in the country reports of Cambodia, Thailand and Vietnam. Other sources stated that the Philippines too had focused on this issue, especially in relation to migrant workers and mail order brides.<sup>6</sup> It was reported that, in most instances, it was difficult to ascertain the number of women and children being trafficked due to the highly organised and covert operations of traffickers. However, small-scale studies showed that the number of trafficked women and children was increasing as a result of poverty and loss of livelihood due to devalued currencies and economic reforms in the region, as well as easy access across national borders. The Cambodian Women's Crisis Centre in a visit to a Cambodian province bordering Thailand learnt that approximately 400 illegal Cambodians, half of them women and children, who had been deceived or forced to work in slave-like conditions, were being deported weekly from Thailand.' In Vietnam, a survey carried out by the Interior Ministry in 28 provinces and cities during the years 1995 and 1996 found 197 cases of women and children who had been trafficked for prostitution. No prevalence data were available for the other forms of VAW mentioned in the country reports such as

sexual harassment and violence resulting from armed conflict, incest and when women are placed in detention.

## LEGISLATION ON VAW

The Beijing Conference called for the review of and implementation of VAW legislation to ensure the effectiveness in eradicating VAW in the long term, as well as in prosecuting those who caused such harm to women and girls. Very few countries have reported reviewing and implementing new legislation on VAW since Beijing and even fewer countries have national laws that provide women protection against violence.

**Domestic Violence:** For countries such as Malaysia, the Philippines and Cambodia, there was increased recognition of domestic violence as a serious problem by both the government and NGOs. This was an outcome of the lobbying efforts of women NGOs and activist groups. However, to date, Malaysia is the only country in Southeast Asia to have a Domestic Violence Act, which was passed in 1994 and implemented in 1996. Although this is a significant legislation, it was reported to have its limitations as it only considered physical abuse and the threat of physical abuse as an offence, and not psychological violence. In November 1997, the Women's Aid Organisation (WAO), a Malaysian NGO, submitted a monitoring report to both the government and NGOs on the implementation of the Domestic Violence Act that highlighted its limitations; but to date there has been no reported outcomes. The Philippines, on the other hand, made efforts to introduce a domestic violence act. In 1997, a Presidential Directive on domestic violence was issued calling on all government officials in the Philippines to campaign against VAW. Cambodia had submitted its domestic violence bill to parliament in 1998 and was waiting for its decision. As for the other countries, some provisions for offences of family violence existed in the Penal Code but such provisions were considered weak in terms of ensuring protection and legal redress for women. Nevertheless, in countries such as Indonesia, Thailand and Vietnam, women's groups and NGOs were reported to be reviewing VAW issues and legislation as well as providing training and education to sensitise the public and judiciary system.

**Rape:** Only the Philippines was reported to have adopted a specific rape law in 1997. This was considered a major accomplishment since the 1995 Beijing Conference. Once again, women activists and NGOs played a critical role in lobbying for the rape law. Another accomplishment was that the Philippines not only reclassified rape from a private to a public offence, but it also broadened the definition of rape, gender-sensitised the law and considered marital rape as an offence, though with the inclusion of a clause that nullifies the crime if the wife forgives the husband of the offence. Marital rape was generally considered a private affair between couples by most countries and hence the lack of legislative measures to deal with this crime. All the other countries, except for Cambodia, reported having some provisions on rape in their Penal Codes. Thailand, in 1997, proposed amendments to broaden the Penal Code's narrow definition of rape.<sup>8</sup>

**Trafficking of women and children:** Trafficking of women and children was addressed through various laws in some countries. For example, in 1997, Thailand reviewed its original Traffic in Women and Girls Act of 1928 in its efforts to combat trafficking of women and children. Cambodia was reported to have passed a law in 1996 on trafficking of women and children and its government had taken steps to ensure that this law is implemented.<sup>9</sup>

**Sexual Harassment:** The Philippines was the only country that reported having enacted a law on sexual harassment in 1995, making sexual harassment unlawful in environments such as employment, education and training. Its limitation however, was that it did not recognise peer harassment. In Malaysia, the Ministry of Human Resource and Development came out with the Code of Practice on the Prevention and Eradication of Sexual Health in the workplace to provide guidelines to employers.

In 1999 in Malaysia, the Code of Practice on the Prevention and Eradication of Sexual Harassment at the Workplace was approved by the Ministry of Human Resources. This was the outcome of joint efforts of women's organisations, the government, the employers and

the unions. Implementation included orientation workshops with the objective of employers voluntarily adopting and implementing the code.

## **RESEARCH ON THE HEALTH CONSEQUENCES OF UAW**

Besides research on the prevalence of violence, the Beijing PFA recommends research on the causes, nature, seriousness and consequences of VAW. In the area of women's health, this would include research on the health outcomes of violence such as death, physical injury, miscarriage, psychological problems and mental illness, and contracting STDs or HIV due to coerced sex. Although some micro studies have been conducted in the Philippines, Thailand and Malaysia prior to or after the Beijing Conference, extensive national research has yet to be done to document the extensive health impacts that have been identified through research in other regions. Data reported were from research prior to the Beijing Conference.

With regard to pregnant women being subjected to domestic violence, only the Philippines and Thailand were able to provide data on the incidence. For example, in the Philippines, a 1993 National Safe Motherhood Survey found that ten per cent of 8,481 respondents had been physically harmed by their husbands, of which three per cent were pregnant at the time. Similarly in Thailand, in 1997, it was reported that 12 per cent of pregnant women were battered by their husbands. The WAO, Malaysia, in the 1992 research, found that 68 per cent of the 60 battered women interviewed had been beaten while pregnant. From case record analysis, it was found that three per cent of women reported miscarriage as an outcome of physical abuse.

As for STD infection, a rape crisis centre in Thailand reported that ten per cent of women clients had contracted STDs as an outcome of rape in 1990. According to the country reports, no data on the prevalence of any immediate or long-term psychological problems, suicide and mental illness due to VAW was revealed through research studies.

## **HEALTH CARE AND SUPPORT SERVICES FOR VAW**

All country reports, except for the one on Lao PDR, reported the availability of support services such as counselling, legal aid and shelters for survivors of violence, though they were often limited in numbers and mostly managed by NGOs. Only Malaysia and the Philippines had reported a joint government and NGO collaboration in the setting up of a multi-disciplinary integrated public health care service (one stop crisis centre concept) for women survivors of VAW. In Malaysia for example, with the introduction of the Ministry of Health protocol, "One Stop Crisis Centre: Inter-Agency Management of Battered Women, Rape Survivors and Child Abuse", was established in 1994 even before the Beijing Conference. The One Stop Crisis Centre concept was acknowledged as an innovative approach in establishing health care services for survivors of violence, and has been promoted as a model for other countries in the region. However, there has been no evaluation of its services in terms of effectiveness, quality and gender-sensitivity. Similarly, in the Philippines, Project Haven (Hospital Assisted Crisis Intervention for Women Survivors of a Violent Environment) is a joint project of the Women's Crisis Centre, an NGO, and the East Avenue Medical Centre, a government hospital. The long-term aim is to institutionalise gender-sensitive services within the government health care system, beginning with this pilot project which will be replicated nationwide. Activities include services for women survivors of violence and training of all levels of hospital personnel. The Philippines had also made some efforts to document VAW statistics through a VAW registry form, which had already been pre-tested at Project Haven, to contribute to the monitoring of the incidence and-prevalence of VAW as part of the national statistical system.

## **RECOMMENDATIONS**

Based on the above findings on VAW, the following are recommendations for further action to be taken:

- Governments need to carry out and publicise regular national prevalence studies in order to provide reliable data and establish trends on domestic violence, rape, coerced sex, sexual harassment, incest and other forms of violence and their health consequences for women.

- ❑ Governments need to establish a VAW registry or data bank which gathers and makes available statistics collected by the police, health services provider and other agencies on VAW in order to monitor trends and plan appropriate interventions.
- ❑ Governments, NGOs and the private sector need to recognise and include screening and referral services for survivors of VAW as a part of a comprehensive package of women's and reproductive health services into public and provincial health care services of all kinds and at all levels, including at hospitals and primary health care centres.
- ❑ Governments, NGOs and the private sector need to include a module on violence against women in the basic and refresher curricula of training courses for medical and health care personnel.
- ❑ Governments need to develop and implement national domestic violence, sexual harassment, anti-trafficking and anti-rape laws that protect women and punish offenders, and recognise marital rape as an offence.
- ❑ Governments need to develop, implement and monitor national plans for the prevention of VAW using clear indicators of progress; and in collaboration with women NGOs, to design and expand gender-sensitive support services.
- ❑ Governments, NGOs and UN agencies need to evaluate new government one stop crisis centres and hospital health care services to ensure that they are women-centred and gender-sensitive rather than medical in their conceptual framework.

#### REFERENCES:

- <sup>1</sup> **Women's Health and Development.** 1997. *Violence Against Women: A Priority Health Issue*, Geneva: World Health Organisation.
- <sup>2</sup> **Ad hoc Committee on the Formulation of Women's Development Plan in the Eight National Economic and Social Development Plan, National Commission on Women's Affairs.** 1999. *Women's Development Plan in the Eight National Economic and Social Development Plan (1997–2001)*. Bangkok, Thailand: Kurusapa Latphroa Press. p.49.
- <sup>3</sup> **National Committee for the Advancement of Women in Vietnam.** 1997. *National Plan of Action for the Advancement of Women in Vietnam by the Year 2000*. Hanoi, Vietnam: Women's Publishing House. p.83.
- <sup>4</sup> **Ministry of Women's Affairs.** 1995. *Household Survey on Domestic Violence in Cambodia. Project against Domestic Violence*. Cambodia: Ministry of Women's Affairs.
- <sup>5</sup> **Rashidah Abdullah; Raj-Hashim, Rita; and Schmitt, Gabriele.** 1995. *Battered Women in Malaysia: Prevalence, Problems and Public Attitudes*. Selangor, Malaysia: Women's Aid Organisation.
- <sup>6</sup> **de Dios, Aurora Javate.** 1996. "Prostitution and sex trafficking of women and girls in the Philippines". *WINAP Newsletter*. No. 19, December. p.2.
- <sup>7</sup> **Oung, Chanthol.** 1997. "Situational analysis on trafficking in women and children and political will to combat the issue". *Article WINAP No. 23*. <<http://www.unescap.org/wid/article23.html>>.
- <sup>8</sup> \_\_\_\_\_. 1997. "Women's rights situation in Thailand". *Friends of Women Newsletter*. Vol 8. January–December. p.9.
- <sup>9</sup> **Oung, Chanthol**, op.cit.

## CHAPTER 4

# GENDER-SENSITIVE HEALTH POLICIES AND PROGRAMMES

*"Women are affected by many of the same health conditions as men, but women experience them differently" - Beijing Platform for Action [C.92]*

The gender perspective involves the understanding and consideration of the different needs, identity and behaviour of women and men arising from their unequal social relations, and the awareness that a policy or programme can benefit women and men differently as a result. This is an important component of health programmes that takes into account the well-being of women according to their own needs and expectations. Health policies and programmes that incorporate the gender perspective thus acknowledge gender as a key determinant of women's health, including control of fertility, and actively involve women in programme planning, implementation and evaluation processes.

Frequent recommendations are made in the Beijing PFA in relation to gender-sensitivity, showing that this is a key strategy for the design and implementation of women's health services. However, the PFA does not define the meaning of the concepts of gender perspective and gender-sensitivity, nor the strategies and steps necessary to successfully mainstream this new approach.

Despite the importance of the approach, the Southeast Asian governments studied have been reported to have made very little progress in implementing the specific recommendations. The approach has not been included in health policies and programmes from national level to delivery of health and reproductive health services. To do so would entail identification of issues to be addressed by health services arising from the acknowledgement of the unequal relations of men and women leading to women's subordination, and its impact on women's health and health services.

### NATIONAL LAWS, POLICIES AND PLANS

The Philippines is an exception in this scenario. On the initiative of the National Commission on the Role of Filipino Women, the Philippine Plan for Gender-Responsive Development (1995–2025) incorporates a gender analysis of issues to be addressed in all areas of women's development, including health. With this clear framework of analysis, the Department of Health has been better able to conceptualise the changes necessary in women's health, reproductive health and family planning services in

#### ***Text Box 4.1: Main Recommendations from the Beijing Platform For Action:***

*...promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes... [C.105]*

*Design and implement, in cooperation with women and community-based organisations, gender-sensitive health programmes... [C.106 (c)]*

*Redesign health information, services and training for health workers so that they are gender-sensitive... [C.106 (f)]*

*Ensure that all health services and workers conform to gender-sensitive standards in the delivery of women's health services... [C.106 (g)]*

*Ensure that medical school curricula and other health-care training include gender-sensitive, comprehensive and mandatory courses on women's health. [C.107 (p)]*

*Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues. [Strategic Objective C3]*

*Promote gender-sensitive and women-centred health research, treatment and technology... [C.109 (b)]*

order to address gender issues at an institutional and organisational level. The Plan identifies issues to be addressed such as the low level of gender consciousness of policy makers, legislators, local government executives and programme managers on women's health needs and concerns, inadequate benefits for community outreach volunteer health workers who are mostly women and the need to strengthen the gender and development (GAD) focal point at the national level and to set up focal points at the sub-national level. The participation of women NGOs was reported in the Philippines to have been essential in the identification of these issues and the planning of strategies to address them in health services.

In other countries such as Malaysia, although the terms "gender equality" and "gender sensitivity" appear in national plans on women's health post-Beijing, the concept has not been clearly defined or operationalised into gender issues and strategies at this planning level in order to enable effective implementation in programmes and services, including women's health. Thus, the Beijing recommendation of redesigning health services and training curricula to be gender-sensitive has not yet been achieved and in fact all countries are at the beginning stages.

## HEALTH SERVICES

The Philippines reported that despite a clear conceptual planning framework, actual implementation of the approach is difficult based on the experiences of the Department of Health up until the middle of 1998. In the Philippines, the Women's Health and Safe Motherhood Project started in 1995 by the Department of Health has focussed first on gender training of their national and regional staff and the development of information materials before implementing the approach in health service delivery. The complexity of the approach and the need for much time and resources in planning was demonstrated by the Commission on Population (POPCOM), which has successfully developed its 1998–2004 Directional Plan for the Philippine Population Management Programme (PPMP) in 1998 followed by nationwide training, as preparatory activities to service implementation.

NGO and academic initiatives in Thailand, Malaysia and the Philippines were reported to have effectively demonstrated at micro level how Beijing recommendations on gender sensitivity in women's health could be addressed on a larger scale by governments. In Thailand, the Centre for Health Policy Studies of Mahidol University in 1997 carried out women-centred health research by consulting women on their experiences and expectations of reproductive health services, including gender issues. The research found that women sometimes were reluctant to seek health care services because they were shy to discuss health problems considered shameful or were embarrassed about exposing their bodies to medical personnel. In December 1997, the principle findings of this research were presented to senior Thai Government health policy makers at meetings in Khon Kaen and Bangkok. The findings were very well received and the implications for future reproductive health interventions were discussed at some length.' In Malaysia meanwhile, the Ministry of Health included the perspectives of service users and clients' rights such as their rights to privacy and confidentiality in the Clients' Charter, and recognised the need to design and implement gender-sensitive health services. In other countries of the region, there was no action reported on similar steps taken.

In 1998, the Malaysian AIDS Council, an NGO, developed a framework on women, AIDS and gender, and recommended the development of a gender-sensitive women and AIDS programme to the Ministry of Health.<sup>2</sup> The Federation of Family Planning Associations, Malaysia (FFPAM) Annual Delegates Conference of 1995 adopted a Gender Policy Statement that stated, "FFPAM shall strive to uphold gender equity and equality in its policies, structure, programmes and operations". FFPAM then introduced a gender training series to ensure it has gender-sensitised personnel (volunteers and staff) to deliver programmes and services.<sup>3</sup> Two branches of the Indonesian Planned Parenthood Association (Yogyakarta and West Sumatera) were reported in the ARROW-APDC Policy dialogue to have begun implementing gender-sensitive reproductive health services.

An engendered health programme is based on the belief that men are also responsible in matters concerning fertility, contraception, safer sex practices and reproductive health care. Male responsibility is thus an important part of gender-sensitive health programmes for reproductive and sexual health. As an example of action since the Beijing conference, during the Safe Motherhood Conference organised by the Malaysian Ministry of Health to

celebrate WHO's 50th anniversary in 1998, the Ministry stated that men and women are jointly responsible for safe motherhood. However, in many other countries, this belief has not been expressed nor has there been any successful interventions reported to increase men's responsibility. The Indonesian Government's family planning programmes, for one, was reported to have always pointed to women as acceptors of family planning rather than men. The government also perceives women as more responsible for reproductive functioning than men.

In the area of service delivery, the Philippine women NGO, the Institute for Social Studies and Action (ISSA), collaborated in 1996 with the International Council on Management of Population Programmes (ICOMP), an international NGO, to implement an innovative pilot project on gender-sensitive and gender-responsive family planning services. Other women NGOs in the Philippines such as Likhaan (Linangan ng Kababaihan, Inc.) and the Women's Health Care Foundation continue to improve on their community-based women's health programme service delivery which addresses gender issues, and involves women in planning and implementing the services. These programmes were not outcomes of the Beijing PFA recommendations, but are in line with paragraph C.106 (c) of the PFA and are important potential models for the government.

## MAIN OBSTACLES

The main obstacles identified or inferred in the country monitoring reports and the ARROW-APDC Policy Dialogue were:

- 3 Insufficient clarity on the concept of gender-sensitivity, in particular gender inequality and the effects of this on women's lives and their health;
- ❑ The lack of recognition that long-term training is required for both government and NGOs involved in health and reproductive health services, in order to change attitudes and behaviour in relation to gender equality. This requires sustained resources;
- ❑ Insufficient information resources and lack of awareness of the existence of resources on gender-sensitive health programmes, such as frameworks, plans, training curricula and best practices;
- ❑ Continuance of social, cultural and religious traditional attitudes related to perceptions of the unequal role of men and women;
- ❑ Lack of sufficient commitment by government agencies to incorporate gender equality in policies and laws and insufficient interest from the community itself in changing the stereotyped perceptions of men's and women's roles; and
- ❑ Continuing lack of disaggregated health statistics and research on women's health and gender, which would greatly help to support the planning, design and implementation of gender-sensitive health services.

## RECOMMENDATIONS

In order to further strengthen the implementation of the Beijing PFA recommendations, it is suggested that:

- ❑ Governments, NGOs and the private sector promote the concept of gender-sensitivity in health based on the need to be aware of and overcome gender inequality and the negative effects on women's health, rather than use the retrogressive concept of sensitivity to the needs of both men and women which is not in line with the Beijing PFA;
- ❑ Governments, NGOs and the private sector need to engender those involved in designing, planning and implementing health programmes by including gender analysis of health and family planning programmes and an awareness of gender issues in their training so that, instead of merely accepting gender perspectives at a surface level, they internalise and put it to practical use in the course of their work;
- a Governments and NGOs need to develop indicators that embody the gender perspective, which capture both objective and subjective aspects of women's and men's health experiences to monitor the impact of changes and develop intervention programmes;
- ❑ Government health and women's ministries need to gather sex-disaggregated data and gender-sensitive information to be used in the formulation of gender-sensitive statistical indicators for monitoring and assessing women's health status;

- ❑ Governments, in collaboration with women NGOs and health NGOs, need to develop and implement plans on gender sensitivity and women's health, which would include a clear framework, conceptual operationalisation, health provider training and service delivery components;
- ❑ Governments and UN agencies need to support pilot projects to explore the effectiveness of implementing a gender-sensitive approach, which are planned and implemented in collaboration with NGOs or initiated by NGOs and include community women's involvement in the design and feedback on services;
- ❑ UN agencies and donors need to support efforts of NGOs regionally and internationally to produce and disseminate information resources, which include sharing of models of national plans, frameworks, training curricula and pilot projects;
- ❑ Governments, NGOs and UN agencies need to address any cultural and religious stereotypes that support the continuance of gender inequality as a key aspect of information materials and gender training;
- ❑ UN agencies and donors need to plan for and provide long-term financial and human resource support required for the institutionalisation of gender perspectives in governmental and non-governmental organisations, training programmes and service delivery; and
- ❑ Governments, UN agencies and women NGOs need to monitor and evaluate action to mainstream gender issues in health policies and programmes and provide comprehensive reports.

#### REFERENCES:

- <sup>1</sup> **Boonmongkon, P., M. Nichter, J. Pylypa and K. Chantapasa.** 1998. *Understanding Women's Experience of Gynecological Problems: An Ethnographic Case Study from Northeast Thailand*. Nakornpathom: Center for Health Policy Studies, Faculty of Social Sciences and Humanities, Mahidol University.
- <sup>2</sup> **Malaysian AIDS Council.** 1998. *Women and AIDS Conference*. Kuala Lumpur: Malaysian AIDS Council.
- <sup>3</sup> **Federation of Family Planning Associations, Malaysia.** 1999. *Country Report of Malaysia: NGO Perspectives*. Selangor: Malaysian Steering Committee c/o Federation of Family Planning Associations, Malaysia. p.28.

## CHAPTER 5

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# WOMEN'S HEALTH DATA

## PROBLEMS OF AVAILABILITY, RELIABILITY AND ACCESSIBILITY

Country researchers reported a number of critical problems in obtaining the necessary data to assess the progress in improving women's health status and the provision of services.

### NON-EXISTENCE OF NATIONAL DATA ON MOST WOMEN'S HEALTH PROBLEMS

Data referred to in the framework of indicators often did not exist. For example, the incidence of unsafe abortion, reproductive cancers, RTIs/STDs, and gender-based violence was not available in almost all of the countries. Either national evidence studies had not been carried out, or available data at health centres or hospitals had not been collected and collated nationally. The only national data available in all countries was maternal mortality ratios and contraceptive prevalence, with contraceptive data being the most reliable. This reflects the past emphasis of health programmes for women on family planning and indicates the neglect of women's comprehensive health needs.

### NON-EXISTENCE OF NATIONAL DATA SHOWING THE DIVERSITY OF WOMEN'S HEALTH NEEDS

Data available were primarily national data reflecting national averages. Country researchers were generally unsuccessful in obtaining data that were already analysed and disaggregated by:

- Age
- Geographical location (rural and urban)
- Class/income
- Religion/culture
- Indigenous and ethnic groups

Identifying rural and urban inequalities and differences among women, as suggested in the Beijing PFA [C.89] as a necessity for an in-depth approach to improving women's health, was thus not possible. For example, it was difficult to ascertain which women are more at risk in acquiring cervical cancer and less likely to seek screening or treatment in specific countries; and which women are dying in pregnancy and childbirth — young women or older women, indigenous women, women of a particular religion or culture, or poor women.

### LACK OF UP-TO-DATE DATA

When data such as contraceptive prevalence and maternal mortality did exist, they were frequently not up-to-date but were about five years old or even more out-dated. This meant that monitoring progress and outcomes or impact of actions taken to implement the Beijing PFA recommendations on women's health, was almost impossible. Thus, the Beijing objective of reducing maternal mortality by half by the year 2000 could not be assessed as current data were not available.

### LACK OF RELIABLE DATA

A lot of data problems related to reliability were found, particularly in maternal mortality data, both in the collection and the analysis of data. Differences in methodologies for

measuring maternal mortality ratios by WHO and national ministries of health were an additional problem.

## **LACK OF ACCESSIBLE DATA**

Even when data did exist such as in-country information on contraceptive use or breastfeeding, researchers reported that they did not know where to obtain the relevant report. When they did know the source, permission was not always granted for them to access the information. Government information was more difficult to access than NGO information. In the absence of any national information centre on women's health or updated comprehensive listings and research studies, it was difficult also to have access to the information that did exist. There was also the problem of differing perceptions of accountability by government departments. Data were not generally seen as public data which NGOs were entitled to access as part of the right of civil society to monitor government's actions.

## **LACK OF INFORMATION ON WOMEN'S HEALTH PROBLEMS AND EXPERIENCES**

Qualitative information from women themselves on their own perception of their health problems and their level of satisfaction with health services was usually not available except from small NGO research studies in some countries.

## **LACK OF DISCUSSION AND AGREEMENT ON INDICATORS TO MONITOR WOMEN'S HEALTH**

Country reports stated that in most countries, the Beijing recommendations on women's health had been given little serious attention by health policy makers. Related to this is that there are not yet agreed upon core indicators to monitor the new broad concept of women's health and rights. Without a commitment to seriously monitor women's health, gaps in data availability and accessibility would not be seen as problematic and would remain unaddressed.

## **RECOMMENDATIONS**

- ❑ Governments, NGOs, and international agencies need to agree on indicators to adequately assess women's health and rights within the framework of the Beijing PFA, going beyond the limited indicators of life expectancy, maternal mortality and contraceptive prevalence rates.
- ❑ Governments need to address the data requirements for monitoring women's health at country and decentralised levels so that critical information on women's health is available, reliable and accessible.
- ❑ Governments, NGOs and international agencies need to design, fund and implement more innovative research to obtain information from women themselves on their health problems and experiences and the exercise of their rights.
- ❑ Governments and NGOs need to establish a comprehensive monitoring system on women's health and rights at country and decentralised levels, to make available the information needed to monitor women's health status, the existence and quality of health services, and actions taken to implement the women and health section of the Beijing PFA.

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[Note: As of 30th September 2001, the SEAGEP office  
officially closed its operations at the end of a  
successful project term of five years].

## **ANNEX 2**

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# **ABORTION & SEXUALITY RIGHTS AN EXTRACT FROM RASHIDAH ABDULLAH. 2000. A FRAMEWORK OF INDICATORS FOR ACTION ON WOMEN'S HEALTH NEEDS AND RIGHTS AFTER BEIJING. KUALA LUMPUR: ARROW. PP.13 & 14**

The first draft of this framework in 1997 was used to guide the preparation of the country papers. The framework has since then been revised to include new additions, and published by ARROW. In 2001, the framework was translated into two languages: Indonesian and Vietnamese. The Indonesian translation and publication was undertaken by *Serika Perempuan Anti Kekerasan* (SPEAK), while the translation into Vietnamese was done by the Vietnam Women's Union.

Recommended Actions of the Beijing Platform for Action	Women's Health Status	Health Service Provision, Use and Quality (Noting Specific Action Post-Beijing)	National Laws, Policies, Plans and Regulations (Noting Specific Action Post-Beijing)
<b>2.2 Contraception (cont'd)</b>			
	What is the number of women who want no more children but are not using any form of contraception?	find out if menstrual regulation or the Emergency Post-Coital Contraception is available for women whose contraception has failed to prevent pregnancy?	
<b>2.3 Abortion</b>			
<p>Recognise and deal with the health impact of unsafe abortion as a major public health concern, as agreed in paragraph 8.25 of the Programme of Action of the International Conference on Population and Development. [C 106 (j)]</p> <p>... consider reviewing laws containing punitive measures against women who have undergone illegal abortions. [C 106 (k)]</p>	<p>What is the number of abortions and the rate? Give information on legal and illegal abortions; safe and unsafe abortions—note that some legal abortions are not safe. Is there data available on the abortion rate by class, ethnicity and geographic area?</p> <p>What percentage of women who underwent abortions died as an outcome? Give the percentage and number.</p>	<p>To what extent are abortion services available (i.e. existent) within the law in both the public or private health services?</p> <p>How affordable are the services?</p> <p>Is abortion permitted in cases of incest and rape?</p>	<p>Describe and assess the current abortion <b>laws/code</b> and give the date they were first passed and of any amendments since 1995.</p>

<b>Recommended Actions of the Beijing Platform for Action</b>	<b>Women's Health Status</b>	<b>Health Service Provision, Use and Quality (Noting Specific Action Post-Beijing)</b>	<b>National Laws, Policies, Plans and Regulations (Noting Specific Action Post-Beijing)</b>
<p><b>2.3 Abortion (cont'd)</b></p>	<p>Has recent research been done nationally on abortion, particularly unsafe abortion and its impact on women's health?</p>		
<p><b>2.4 Sexuality Rights</b></p> <p>The human rights of women include their right 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. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences. [C 961</p>	<p>Is there data on the extent to which women experience sexual coercion or abuse (i.e. violation of their sexual rights) by:</p> <ul style="list-style-type: none"> <li>■ male family members (incest);</li> <li>■ their husband or boyfriend?</li> </ul> <p>Is there data on the extent to which women experience sexual pleasure:</p> <ul style="list-style-type: none"> <li>■ with their partner;</li> <li>■ through masturbation?</li> </ul>	<p>Are information and services on issues concerning sexuality, such as sexual dysfunction and loss of pleasure available to all irrespective of age and marital status?</p> <p>Has the concept of sexual rights been operationalised in practical terms in health service delivery?</p>	<p>Are there any laws related to sexual practices that limit women's rights?</p> <p>Is marital rape recognised as a violation of a wife's sexual rights and/or as a crime? Is this recognition reflected in the laws on rape?</p> <p>Is homosexuality recognised as a right in national policies and laws?</p>